Differential Response in Nevada
Final Evaluation Report

Prepared for the
Nevada Department of Health and Human Services

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Preface and Acknowledgments

Child protection agencies are engaged in a critical mission, protecting the most valuable but vulnerable treasures a society can have. It is not surprising that those within these agencies, as well as others with natural concerns about the welfare of children, seek to find ways of improving the responsiveness and effectiveness of public child protection systems. The Nevada differential response pilot project is such an effort.

Nevada began implementation of its differential response pilot project in early 2007, and by 2009 the project was operating in all but the most rural parts of the state. In 2008, during the second year of the project, the Children's Bureau established a Quality Improvement Center of Differential Response, an indication that the approach had gained sufficient traction nationally to be viewed as an important new paradigm for child protection.

This report describes the evaluation of the Nevada DR pilot project conducted by the Institute of Applied Research. It is the fourth multi-year evaluation of a differential response system conducted by IAR, which include pilot projects in Missouri (1995-1998), Minnesota (2001-2003), and Ohio (2007-2009). In each of these four projects we have been impressed by the dedication and intelligence of the people who have devoted their lives to protecting the lives and wellbeing of children. In these and other projects we have also learned that changing human service systems is more difficult than most people outside these systems generally realize. This report documents the many positive accomplishments of the DR pilot project. It also describes challenges involved in developing the DR approach further and includes recommendations for this development.

The evaluation is the responsibility of IAR, but it would not have been possible without the assistance and support of many people in Nevada. We are most grateful for the aid and cooperation of the administrators, supervisors and case workers with the Nevada Division of Child and Family Services, the Clark County Department of Family Services, and the Washoe County Department of Social Services. We want to thank as well the directors, supervisors and case workers of the Family Resource Centers and the Children's Cabinet for their time, cooperation and able assistance. We want to acknowledge the work and assistance of members of the Differential Response Steering Committee, and we would like to publicly thank Aruna Vaddamani for her help providing the SACWIS data that was indispensable for the evaluation.

Within the Department of Health and Human Services, a special acknowledgement is due to Mike Wilden, Director, whose efforts and judgment provided the foundation and administrative framework for the project and the evaluation, and who had the wisdom to appoint one of the ablest program managers we have ever had the privilege to work with, Betty Weiser; and a special thanks is also due to her colleague Toby Hyman. A large number of families also responded with invaluable feedback about their experience. Thank you all.

Executive Summary

Differential Response is a relatively new approach to child protection that has been implemented in one form or another in all or parts of approximately 20 states. In its most common form, incoming reports of child maltreatment are screened into one of two groups or response tracks. Reports involving more severe abuse or neglect, situations in which the safety of children is at imminent risk, are investigated in the standard manner. Reports that are less severe receive a family assessment, a procedure designed to be less stigmatizing and more preventative, seeking to address underlying causes of a family's current, sometimes chronic problems. Family assessments are not less focused on the safety of children than investigations, and if concerns about child safety surface during an assessment, the system response is changed and an investigation conducted.

Begun in early 2007, the Nevada DR project was phased in over a three-year period and family assessments became available to families in all but the most remote parts of the state. The Nevada DR model is unique among states with DR programs in involving community-based FRCs in all DR family assessment cases from start to finish. Ten FRCs and the Children's Cabinet in Washoe County provide DR services in 11 Nevada counties where over 98 percent of the state's population resides.

Findings

- Nearly all families who receive a family assessment express satisfaction with the way they are treated and with the help they receive or are offered. Most feel their families are better off for the experience. The response of Nevada families has been as positive as families in other states who participated in similar evaluations of DR programs.

- Many of the families who receive a family assessment are poorer and less well educated than other families in the state. Many describe being stressed, for emotional and financial reasons or because they are socially isolated with few people to turn to for help.

- Importantly, families who receive services through DR tend to be those experiencing significant problems related to the wellbeing of their children, who often live in poverty, and with problems that are sometimes acute and often chronic in nature.

- Feedback from families and FRC case workers indicate that the DR program has been implemented with model fidelity, that is, as designed, both in terms of the protocol—the manner in which families are approached in response to a report of child maltreatment—and in terms of the assistance and services provided to them, often to address basic needs.

- Both FRC-DR workers and CPS case workers express a need for more training about DR.

The DR program has achieved significant improvements in the outcomes of families when compared with similar families who have received a standard investigation, including: fewer subsequent reports of child maltreatment, fewer new investigations or family assessments, and fewer removals of children from their homes.

Major Challenges

- The strength of DR in Nevada arises from the strong social work orientation of staffs of local FRCs and the hard work of many people throughout the state. However, the current DR model restricts family assessments to a relatively small percentage of cases. During the pilot project about 11 percent of reports received a family assessment and the maximum capacity of the system currently is a little over 20 percent. (Currently, Minnesota selects about 70 percent of reports statewide for a family assessment.)

- Because state statutes currently require an investigation of reports in which a child under the age of six is identified as a potential victim of abuse or neglect, the state child protection system is faced with a predicament: families with the youngest, most vulnerable children, those who often need family assessments the most, are least likely to receive them.

- Sustaining the forward momentum of any effective program is difficult. Expansion of an effective program such as DR is doubly difficult in the current economic environment.

Recommendations

- Include DR in the strategic plans of DCFS, CCDF, and WCDSS and retain the full involvement of FRCs for Priority 3 reports, which contain the least severe allegations.

- Given current financial realities, and until additional funds become available for more services families need, adopt the original Missouri DR model, with CPS case workers utilizing the family assessment protocol for Priority 2 reports.

- In all reports involving children under the age of six, conduct a family assessment following the original investigation for all substantiated reports and all other reports when conditions are observed that suggest a child's wellbeing is potentially threatened by factors included or not included in the report.

- Within each region of the state, establish guidelines for how to utilize effectively FRC-DR workers who do not have full caseloads. One way is to permit referral to FRCs of some Priority 2 reports by requiring that the FRC respond in the time designated. Another is to use FRCs for back-up family assessments for families with children under six.

- Provide additional training of DR and CPS personnel on DR and the family assessment approach. Limiting the intensive phase of this training to a small core group of FRC-DR supervisors and CPS supervisors within each of the service regions of DCFS, CCDF, and WCDSS would produce a cadre of local trainers.

- Provide additional information about the DR approach and its effects to key stakeholders in the community, including judges, prosecutors, educators, policemen, child and family advocates, and representatives of public and private community resources.

Table of Contents

Chapter 1. Introduction

This is the final evaluation report of the Nevada Differential Response (DR) pilot project. Implementation of the project began in 2007 and proceeded in a series of stages over the next three years. The evaluation has focused on the new DR family assessment response track that has been integrated into the state's child protection system. The study is an examination of the implementation of the new track and an analysis of its effects. The research design and methodology are similar in many ways to those employed in IAR studies of differential response programs in other states—notably Minnesota, Missouri and Ohio[1]--but the study was adjusted to suit unique aspects of the Nevada DR program and the state's child protection system. This introductory chapter contains a review of what differential response is, a summary of the design and scope of the evaluation that was conducted, and an outline of subsequent chapters of the report.

What is Differential Response?

Differential response arises from the view that it is in the best interest of children and their families that not all child maltreatment reports should be treated the same; just as child maltreatment comes in many forms there should be flexibility in responding to it.[2] For decades, the standard response to child maltreatment reports has uniformly involved a formal investigation of all "accepted" reports. Accepted reports are those that meet a state's threshold statutory requirement for a response from the child protection system (CPS). The investigation of accepted reports has historically focused on the specific allegations of child abuse or neglect, much like a report of suspected criminal behavior. As in the case of a suspected crime, a standard investigation of a report of child maltreatment has sought to find evidence that the specific report can be substantiated and, if it can, determine what can and should be done to ensure the safety of the child. The introduction of differential response recognizes that there are significant differences among the many child maltreatment allegations that are reported, some much more serious than others, and that the response should vary in some measure that is congruent with the report. While differential response has begun to be implemented in a number of states, there is one model that is most commonly seen.[3] This model involves the differentiation of reports into two groups.

[1] Copies of IAR evaluation reports of DR pilot projects in these three states can be retrieved at www.iarstl.org.

[2] "Differential response…recognizes variation in the nature of reports and the value of responding differently to different types of cases." Child Welfare Information Gateway Issue Brief (2008). *Differential Response to Reports of Child Abuse and Neglect, p.3*. Washington, DC: US Department of Health and Human Services. Taken from Schene, P. (2001). Meeting family's needs: Using differential response in reports of child abuse and neglect. In *Best Practice, Next Practice*. Spring, 1-14.

[3] cf. Online survey of state differential response policies and practices: Findings report. National Quality Improvement Center on Differential Response in Child Protective Services. Washington, DC: Children's Bureau, U.S. Department of Health and

The first group includes allegations of a more severe nature that may involve criminal acts and/or represent an imminent safety threat to the child. Reports in this group are judged to require a formal investigative response, sometimes with co-investigating police authorities accompanying child protection staff. The second group of reports involves allegations of problems or situations of a less severe nature, often involving conditions that are more chronic and less acute and in which the risk to the child is real but not imminent. This second group has come to be viewed as benefiting more from a broader assessment of the family situation that is carried out in a less threatening and more friendly manner, seeking the cooperation of the family in identifying its problems and its strengths. While the second approach, sometimes referred to as an alternative response or family assessment, also focuses first on the safety of the child, its priority is not identifying and accusing a perpetrator but understanding and untangling the broader dynamics of the family and enlisting the help of everyone in the family in resolving and improving the situation.

Child safety is the primary goal of the child protection system generally. In this, an assessment response is no different from an investigative response; the safety of children is no less important when family assessments are done than when formal investigations are done. However, by eliminating the need for a formal determination or finding of fault, the family assessment seeks to approach the family in a more positive manner from the very beginning and involve families sooner and more fully in resolving problems that may adversely affect the well-being of children in the near or longer-term. If, at any point in a family assessment process, new concerns arise about the safety of children, the response can be changed and a full investigation conducted.

Most children coming into CPS, despite what is sometimes assumed, do not face imminent safety risks, and the family assessment pathway is primarily designed for these cases. Historically, unless an allegation is substantiated and children are assessed at high risk, few reports lead to post-investigation services. The goal of differential response is to protect more children more of the time by making CPS more flexible and responsive to the varying family problems with which it is presented and by increasing the number of reports in which some service or needed assistance is provided.

A Note about Terminology and Response Tracks. It should be noted that the term differential response was originally used to refer to a child protection system with more than one response track. The term is sometimes used, however, to refer to the new family assessment track that was added to the child protection system. In Nevada, differential response, or DR, is generally used in this way, as a shorthand way of speaking about the new track and family assessments. Thus, when

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Human Services. Retrieved on October 10, 2010 at http://www.differentialresponseqic.org/assets/docs/qic-dr-findings-report-jun09.pdf

a maltreatment report is received and screened as "appropriate for DR," this means it is seen as appropriate for a family assessment response rather than a standard investigation.

It should also be noted that while the most common multi-track CPS model consists of two response tracks or pathways, investigation and family assessment, in some locations there are more than two. Minnesota, for example, has added a third, early intervention pathway for reports that would normally not be accepted for either a family assessment or an investigation and where no home visit would have been made. Through proactive outreach to families this pathway seeks to avert future incidents of child maltreatment. Some California counties have a similar prevention response track. Massachusetts has adopted a three-pathway system and Kentucky purportedly has four. Sometimes additional pathways reside outside the formal child protection system, sometimes within it. As time goes on we are likely to see more states develop differential response systems with additional pathways.

A Brief, Early History of Differential Response

It is the Minnesota model that has been the most influential in spurring an increasing number of child protection systems to adopt a more flexible, differentiated approach to child maltreatment. But when Minnesota developed its differential response model it adopted and adapted an approach that had been first tried and tested in Missouri. The Missouri model grew out of an old-fashioned Missouri compromise. It was an effort to improve the effectiveness of the state's child protection system, but it was also a reaction to increasingly vocal critics who viewed the child protection agency as over-reaching its mandate and too often interfering with families' responsibilities to rear their children. Too many families, these critics maintained, were being traumatized unnecessarily in the name of child protection. The child advocacy community, on the other hand, thought the state should err on the side of child well-being and were concerned about alterations in investigative procedures. There were areas of general agreement between the groups, however. Both thought the state should act aggressively whenever a parent committed a crime, including assault against their children. Neither thought the state should be placing the names of parents on a central registry that stigmatized them and harmed them economically unless there were grave reasons to do so. A possible solution was found in an approach that was part of CPS reforms taking place in Florida. There, a dual-track response approach had been proposed and it made sense to key Missouri legislators and state agency administrators. While the Florida initiative would soon whither, the approach was tested in Missouri in a two-year pilot project, 1994-1996, before being implemented statewide.

The Missouri model was commonly referred to as a two-track system. Investigations remained unchanged, but an alternative to an investigation, called a family assessment, was permitted when

the report received did not allege criminal behavior or suggest a child was in imminent danger. Unlike an investigation, a family assessment would not focus on whether or not an allegation of maltreatment was true but whether the well-being of the child and family required some kind of assistance that could be provided. The family assessment response was not to be police-like in any way, but positive and supportive, identifying problem areas that needed to be addressed. The children's services worker was to seek to form a collaborative relationship with the family and build on its existing strengths. Services offered to families were voluntary and, whenever possible, provided through community resources. Child safety remained as important in family assessments as in investigations, and at any time the response track could be changed by the CPS worker from a family assessment to an investigation. However, while children's services workers were asked to reach out to families, to assess their needs across a broad array of areas, no additional funds were authorized to pay for needed services. These were to be found, somehow, from pre-existing community resources.

Minnesota, meanwhile, had been testing the efficacy of providing services to families who were reported for child maltreatment but who would not have typically received post-investigative services. By the mid 1990's results of this testing showed positive results and counties were encouraged (Minnesota has a county administered child protection system) to implement innovative child welfare programs. Even before Missouri's two-track pilot project was completed, Olmsted County in Minnesota had established its own dual-response system, and in 2000 the state established a 20-county pilot project. The Minnesota model placed the same emphasis on changing the way families were approached in family assessments, but it placed much greater emphasis than Missouri had done on providing services to families. The adoption of the second response track in Minnesota was not meant as an indictment of traditional investigative methods, which were viewed as always striving to incorporate a family-centered and strength-based approach to CPS interventions. Rather, it was an attempt to remove any barriers to family-centered practice that an unnecessarily forensic investigation might create and, whenever possible, to begin the engagement with the family with a respectful, friendly, supportive approach that sought to facilitate the involvement of the family in what happened next. In 2003, based on the results of the state's pilot project and the attitudes and experiences of state and county administrators and staff, the Department of Human Services began phasing in its dual-response model statewide.

The Differential Response Model

In 2008, the Children's Bureau established a National Quality Improvement Center on Differential Response in Child Protective Services. As part of this project DR demonstration programs have been established in three states, Colorado, Illinois and Ohio. In articulating the program model for the QIC and the demonstration programs, it is the Minnesota model that has been taken to be the standard. In this model, stripped to its essential, distinguishing parts, there are two basic elements of the family assessment approach. The first involves the manner in which families are approached; the second involves how children and their families are helped. The first component involves approaching a family from the start as a unit in a respectful, supportive, friendly and non-forensic manner consistent with sound family-centered practice, focusing broadly on the family's strengths and needs, and involving family members in decisions about what to do. The second element involves providing services and assistance, often of a basic kind, that fit the needs and situations of the family, utilizing its strengths and natural support network and linking the family to community resources when helpful.

A. Approach: The Protocol

The first component of the model involves the manner in which families are approached. Family assessments are intended to get beyond the reported allegations, which may be just the tip of the iceberg of issues that could affect child welfare. The objective is to discover not just what may have been the causes of this incident, but to discern the broader set of underlying issues within the family that may produce future risks to a child.

1. Focus
    a. There is no formal finding in a family assessment; reports are neither substantiated nor unsubstantiated. Typically, the family assessment response does not focus on the reported incident other than by way of explaining to the family what precipitated the interest of the child protection agency and as a guide to establishing the immediate safety of the child.
    b. The focus of the assessment is broad and holistic, with a comprehensive examination of the family's situation, strengths, resources, problems and needs.
    c. The focus of the assessment is not just child protection but family welfare because the two are firmly coupled. The logic is that if you attend more thoroughly to the whole family you have a greater likelihood of ensuring child safety, whether threats are imminent or potential, low or high. If you know more you can do more and make better decisions.

2. Engagement

    a. Families are approached in a manner that is respectful, supportive, positive and friendly and not confrontational, accusatory, or coercive.
    b. On the first visit with the family, if at all possible, the worker meets with all family members, parents and children, as a unit. (There may be exceptions to this related to safety concerns.) Throughout, the family is treated as a unit and, in turn, part of a larger, communal context of extended family and social networks.
    c. The family is the center of decision making. Members of the family are encouraged to take the lead in the assessment, in the identification of problems and ways of resolving them, and to be active participants in any decisions and plans that are made. The CPS worker is both social worker, assisting in resolving problems and bringing needed assistance to the family immediately, and facilitator, seeking to involve the family in what happens next, how to move forward, and establishing who is going to do what.
    d. A family assessment seeks the voluntary participation of family members. Consensus and a collaborative relationship between worker and family must be established. Family cooperation and worker patience and understanding are essential. It is up to the family to accept or reject offers of help or services, unless safety threats compel more formal intervention.

3. Pathway Change

    Because the safety of the child is always the primary concern, if there is reason to do so, the pathway can be changed at any point from a family assessment and an investigation ordered.

B. Services

The second component of the differential response model involves addressing key problems and needs that are identified during the assessment. As the assessment is a broad exploration of the family's situation, the practical response will also be broad and often, given the complex problems facing many families, multi-faceted. As the assessment has involved the family at its center, the service response will similarly be shaped by the family's views. Seven objectives of the family assessment service component can be identified and measured.

1. More families receive some assistance or service.
2. Assistance and services provided to families targets a broader set of problems and needs.
3. As many of the families will be poor, the service response will more often address basic needs.
4. The natural support network of families, including the extended family, will more often become involved in the resolution of problems and needs that are identified.

5. The services and assistance provided to families will more frequently fit their needs as both family members and workers understand them.
6. Services and assistance will more frequently be sufficient to address the needs of families and, therefore, more likely to be effective.
7. There will be an expanded involvement of community resources.
    a. More families will be linked to resources available in the community.
    b. Workers will become more knowledgeable of community resources.
    c. Workers will be in closer contact with community resources.
    d. There will be more community outreach to involve the public and private sector.

Evaluation Methods and Data Sources

The family assessment model outlined above was the frame of reference used by evaluators in designing the current study. The study, which began in October 2008, nine months after the start of the pilot project, had two main parts, an examination of the implementation of the DR-family assessment track within the state's child protection system and an analysis of program outcomes. The research design for the study of program outcomes was quasi-experimental. An experimental design, involving randomly selected experimental and control groups, was not possible. Instead, a comparison group of families was used. These families were selected through a group matching procedure. Comparison families received a standard, formal investigation but were similar in all apparent respects to families selected for a DR-family assessment. The design and development of group-matching procedures and required software programs needed for the selection of the comparison group were completed in September 2009.

There were six major data sources for the study: the state's child welfare information system, which is called UNITY; site visits and interviews with state, regional and county professionals; surveys of families; surveys of state, county and community agency workers; and case reviews of a sample of families completed by case workers; and a review of the case notes of workers on a sample of families.

1) UNITY. Every state is required by the federal Administration of Children and Families to have a statewide automated child welfare information system, or SACWIS. In Nevada the system is called UNITY and contains current and historical data on child maltreatment reports, investigations, family assessments and outcomes. Evaluators received monthly downloads of extracts from this system. Data extracts were converted through a multi-step process into a research database that was updated each month. The last extract received in time to be utilized for analyses in this report was in August 2010 and consists of program data through July 31. These extracts provided monthly and cumulative information on maltreatment reports and the screening and selection of reports for

either a DR-family assessment or for a standard investigation. UNITY was also the source of data on the number and types of prior maltreatment reports and child removals as well as any new reports or removals. UNITY was an important source of data on families selected for a differential response family assessment and use for the selection of comparison families.

2) Site visits and interviews. Evaluators conducted eight site visits during the course of the pilot project. An initial visit was made in October 2007 to meet with state project managers and UNITY personnel in Carson City and with staff in Clark and Washoe counties. Seven subsequent visits were made to interview state and county administrators, supervisors and case workers involved in traditional CPS activities and in DR family assessments. Offices in Clark and Washoe counties and Carson City were visited in January 2008 and in May site visits were made to Elko and Clark counties. All DR sites were fully operational by January 2009, and three more visits were conducted during that year. In April site visits were made to Clark and Nye counties and Carson City (where interviews were also conducted with supervisors and workers from Churchill and Lyon counties). In June a site visit was made to Washoe County and in September offices in Clark were visited. Two final visits were made during the last year of the evaluation, one in the western part of the state (Washoe, Churchill, and Lyon counties and Carson City) in May 2010 and another to Clark and Nye counties in August 2010. Two remote interviews were also held with DR personnel in Elko County, once in January 2008 and once in September 2010. Additionally, evaluators were present for DR training sessions in January 2008 and May 2009 and attended two county-wide meetings (called "Big DR meetings") in Clark County.

3) Surveys of Families. Feedback from families affected by the new program was considered an essential part of the evaluation. Obtaining this feedback proved to be a major challenge, presumably due to the transient nature of many of the families involved. After false starts and stops a successful methodology was devised for contacting DR families through the assistance of the community workers serving them. Families received $20 for completing and returning a written survey form, and 371 completed questionnaires were received and analyzed. However a successful method was never established for obtaining feedback from comparison families. To provide some context for the responses of DR families, therefore, feedback from family assessment and comparison families from three other studies of differential response pilot programs conducted by the evaluator—in Minnesota, Missouri and Ohio—has been included in this report.

The family survey was designed to provide primary source data about four things. First, it tells us what families think and feel about their DR experience, whether they were satisfied with the way they were treated and whether they think their family benefited or not from the experience. Family satisfaction has been a required outcome element on Children's Bureau demonstration projects for over a decade. Secondly, the survey provides a perspective on what is actually taking

place when DR workers meet with families and whether family assessments are being conducted in a manner consistent with the DR model. Third, we learned about the kinds of services and assistance being provided to families and how effective and sufficient this help was viewed by them. And fourth, through the survey we were also able to obtain some indication of general family and child well-being as well as useful information about family composition and socio-economic status. All of this information is, of course, from the family's point of view, but it is an important point of view.

4) Surveys of Workers. Another important perspective is that of the case workers involved in conducting investigations and family assessments. Program-related surveys of these workers were conducted in 2008 and again in 2010. Results of the 2008 survey were reported in the first of two earlier annual reports. In 2010, 112 workers completed the internet-based program survey; 91 were supervisors or case workers involved in standard CPS investigative work and 21 were DR workers in community-based Family Resource Centers (FRC). These surveys were designed to capture the general attitudes, perspectives and working knowledge of these staffs about the new differential response program as well as the standard child protection system in place around the state. These surveys also provided data on the types of services case workers provided to families on their caseloads and their expressed need for additional training related to differential response.

5) Case-Specific Reviews. A random sample of families was selected for case reviews that sought more detailed information on families and worker activities than is generally found in state information systems. This was an internet-based survey completed by the case workers responsible for the selected cases. A total of 217 case reviews were completed by workers, 155 by FRC workers of families who received DR-family assessments and 62 by CPS workers of families who had reports that were investigated. Workers were surveyed after the agency's last contact with the family. In some cases, last contact occurred after the initial assessment or investigative visit to the family's home. In others, it was after numerous visits and the provision of services.

6) Case Notes Review. To augment the case-specific surveys, the case notes of an additional 110 cases were pulled from UNITY and examined. This sample of cases was likewise random and included 61 DR families who received family assessments by FRC workers and 49 families with reports that were investigated by CPS workers.

Additionally, IAR analysts have provided technical assistance and consultation through the last three years as requested by state contract managers. This has included participation in monthly and quarterly meetings of the DR steering committee, recommendations and considerations provided in two interim annual reports on the project, and consultation through meetings with contract managers.

Organization of the Report

Following this introductory chapter, the remainder of the report covers the results and findings of the process and outcome study conducted of the Nevada DR pilot project.

Chapter 2 describes the organization of CPS in Nevada, the nature of the differential response program in the state and its phased-in implementation and integration into the child protection system. Chapter 3 describes the selection of reports for a differential response family assessment and discusses the issue of system capacity. Chapter 4 provides a description of the characteristics of families who receive family assessments.

Chapter 5 and 6 address the two central components of the family assessment approach, the manner in which families are approached and the services and assistance they are provided. Chapter 7 addresses the overall response of families to family assessments, their satisfaction and their perception of the well-being of their children and families. Chapter 8 presents the perspectives of workers on the differential response program and on the broader child protection system.

Chapter 9 presents the results of the outcome study and examines how effective family assessments are compared with investigations in achieving the goals of child protection. Chapter 10 provides the results of additional analyses of the pattern of recurrence among CPS families.

Chapter 11 concludes the report with commentary about recurrence and safety issues, a discussion of program challenges, and concludes with recommendations.

Chapter 2. Implementation of Differential Response

The Nevada Differential Response pilot project was phased in over three years. Initial implementation occurred in February 2007 in two service areas in Clark County, the state's most populous county where Las Vegas is located. The program was extended to additional counties in 2008 and, by January 2009, differential response was available to families in all but the most rural parts of the state. The project was initiated as part of the Program Improvement Plan developed in response to the Child and Family Services Review conducted by the Administration for Children and Families in 2004, in part on the recommendation of the Children's Bureau. Interest in differential response in the state, however, predates the CFSR and the PIP, as noted in the National Study on Differential Response in Child Welfare.[4] In 1999 legislation was adopted in Nevada that permitted an alternative to an investigation in response to certain reports of child maltreatment, and this laid the statutory foundation for a multi-track child protection system.

CPS and the Geography of Nevada

Nevada has a distinct child protection system. In the state's two most populous counties, Clark and Washoe, CPS is county administered with state oversight. In the 15 other counties in the state, a region referred to in this report as rural Nevada, CPS is administered and supervised by a state agency. CPS in Nevada, therefore, is composed of three service regions, one for Clark County, one for Washoe County, and one for the rest of the state.

Seven out of 10 (71 percent) Nevada residents live in Clark County. The Clark County Department of Family Services (CCDFS) itself is divided by zip codes into seven service zones. Five are in the greater Las Vegas area and are referred to by their geographic location—Central, North, East, South, and West. The rural part of the county is divided into two service areas, North Rural and South Rural.

Washoe County, with 16 percent of the state's population, stretches from the city of Reno in western Nevada up to the border with Oregon and is served by the Washoe County Department of Social Services (WCDSS).

[4] Merkel-Holguin, L., Kaplan, C., & Kwak, A. (2006). *National study on differential response in child welfare*. Washington, DC: American Humane and Child Welfare League of America.

The state's 15 other counties, with approximately 13 percent of the population, are served by the state Division of Child and Family Services (DCFS) within the Department of Health and Human Services (DHHS). DCFS serves rural Nevada through an organization of four districts. District 1, in the north, includes six counties—Elko, Eureka, Humboldt, Lander, Lincoln and White Pine—served by offices in Elko, Winnemucca, Battle Mountain, and Ely. District 2, in west central Nevada, includes Carson City, Douglas and Storey counties, and is served by the office in Carson City. District 3 includes the four counties of Churchill, Lyon, Pershing and Mineral (and is served by offices in Fallon, Silver Springs, Yerington, Lovelock, and Hawthorne). District 4, in the south central part of the state, includes Esmeralda and Nye counties and is served by offices in Pahrump and Tonopah.

The state director of DCFS and the county directors of CCDFS (Clark County) and WCDSS (Washoe County) form a *de facto* governing structure of the child protection system in the state. Each is responsible for child protection in a particular geographic region, but consensus among them is effectively required to adopt policies and practices that affect all parts of the state.

Table 2.1 shows the most recent population figures available from the Bureau of the Census for Nevada counties and provides a demographic context for the DR pilot project. The table includes selected demographic data often correlated with the relative number of child maltreatment reports. The reader will be aware that parts of the state have been especially hard hit by the recent recession and this will have impacted some of the figures in the table.

Differential Response Phase In

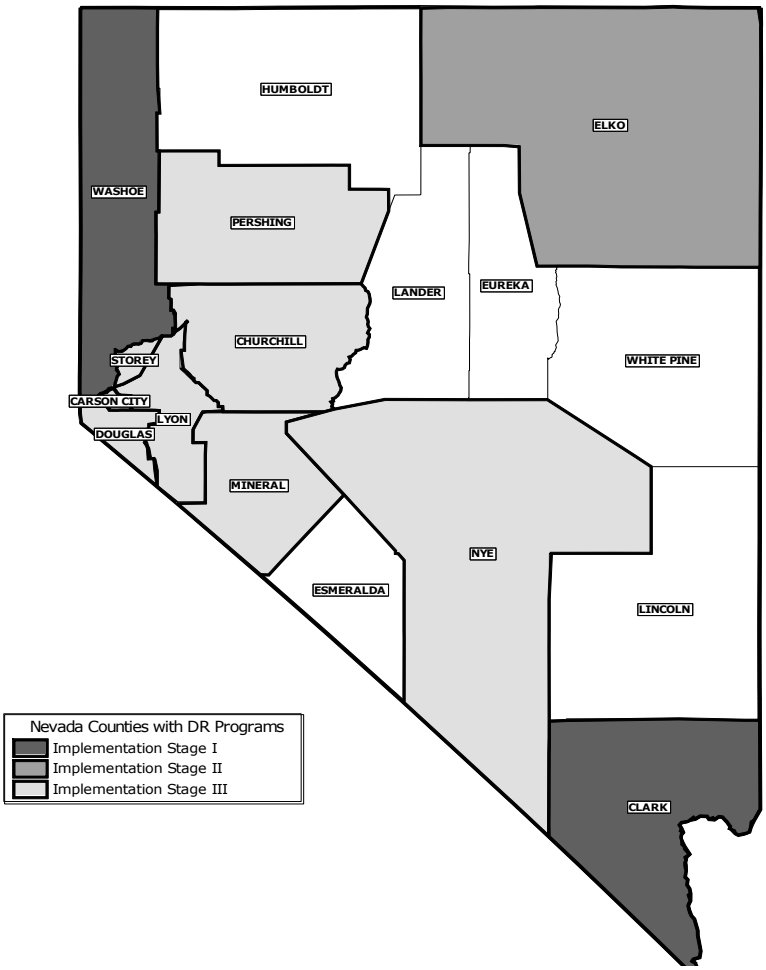
The Differential Response pilot project originated at the initiative of the state director of DHHS in the spring of 2006 working with DCFS, CCDFS, WCDSS and representatives of Family Resource Centers, community-based organizations established by state statute. The project was placed under the management of the Grants Management Unit of DHHS and a steering committee was formed in the summer of 2006 of representatives of the state agency, the two county agencies and the FRCs. By February 2007—blinding speed by any measure—differential response was rolled out in two service areas within the city of Las Vegas. From the beginning, therefore, the differential response program in Nevada has been a partnership, between the state and counties, and between the established child protection system and community-based service organizations.

The introduction of Differential Response in Las Vegas in early 2007 was the first of a three-staged implementation process and included the service zones of the East and South Las Vegas offices of the Clark County Department of Family Services. The second stage occurred in early 2008 when DR was implemented in Washoe County (in January), Elko County (in February), and in the Central and North Las Vegas offices in Clark County (in March). The third stage occurred in January 2009 when

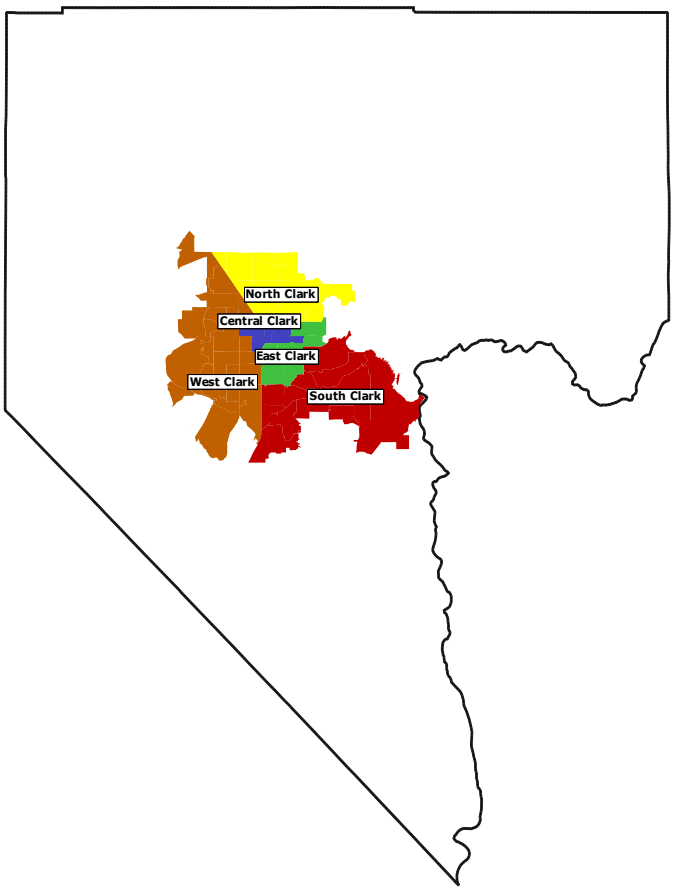
Table 2.1. Selected Population and Demographic Data

DR Program Counties	*Population (2006 estimate)*	*Percent of state's population*	*Percent of persons with children under 18 (2006 estimate)*	*Median household income (2004 estimate)*	*Percent of the population below the poverty level, 2004*	*Living in the same house in 1995 and 2000*
Carson City	55,289	2.2%	23.1%	$45,133	10.2%	46.1%
Churchill	25,036	1.0%	28.0%	$45,720	10.2%	45.4%
Clark	1,777,539	71.2%	26.0%	$45,793	11.6%	34.5%
Douglas	45,909	1.8%	19.2%	$54,520	7.0%	48.9%
Elko	47,114	1.9%	28.9%	$52,202	8.7%	47.6%
Esmeralda	790	0.0%	18.1%	$37,283	12.4%	53.1%
Eureka	1,480	0.1%	22.7%	$42,790	9.0%	59.4%
Humboldt	17,446	0.7%	28.4%	$47,532	9.8%	45.8%
Lander	5,272	0.2%	28.6%	$49,257	9.5%	56.0%
Lincoln	4,738	0.2%	23.4%	$38,226	13.0%	55.8%
Lyon	51,231	2.1%	23.5%	$46,078	9.0%	44.1%
Mineral	4,868	0.2%	21.7%	$33,302	14.8%	56.0%
Nye	42,693	1.7%	20.5%	$41,025	11.9%	41.1%
Pershing	6,414	0.3%	22.5%	$38,821	13.0%	48.4%
Storey	4,132	0.2%	18.1%	$49,043	5.1%	49.1%
Washoe	396,428	15.9%	24.5%	$50,167	10.1%	41.2%
White Pine	9,150	0.4%	20.3%	$39,420	12.4%	52.5%
Nevada State	2,495,529	100.0%	25.4%	$47,231	11.1%	37.4%
United States	299,398,484		24.6%	$44,334	12.7%	54.1%

DR was implemented in the West Las Vegas service zone in Clark County, in southern Nye County, and in rural counties in the western part of the state. These latter included Carson City, and Churchill and Lyon counties, and other rural counties served by offices in these counties, including Storey, Mineral, Pershing and Douglas. At that point, differential response was available in all but six very rural counties that, combined, accounted for less than 2 percent of the state's population. **Map 1** shows the counties where DR has been implemented. The different shadings in the map indicate DR roll-out stages, from early (dark) to more recent (light). **Map 2** shows the Las Vegas service zones within Clark County where DR has been implemented.



Map 1. Nevada Counties with DR Programs.

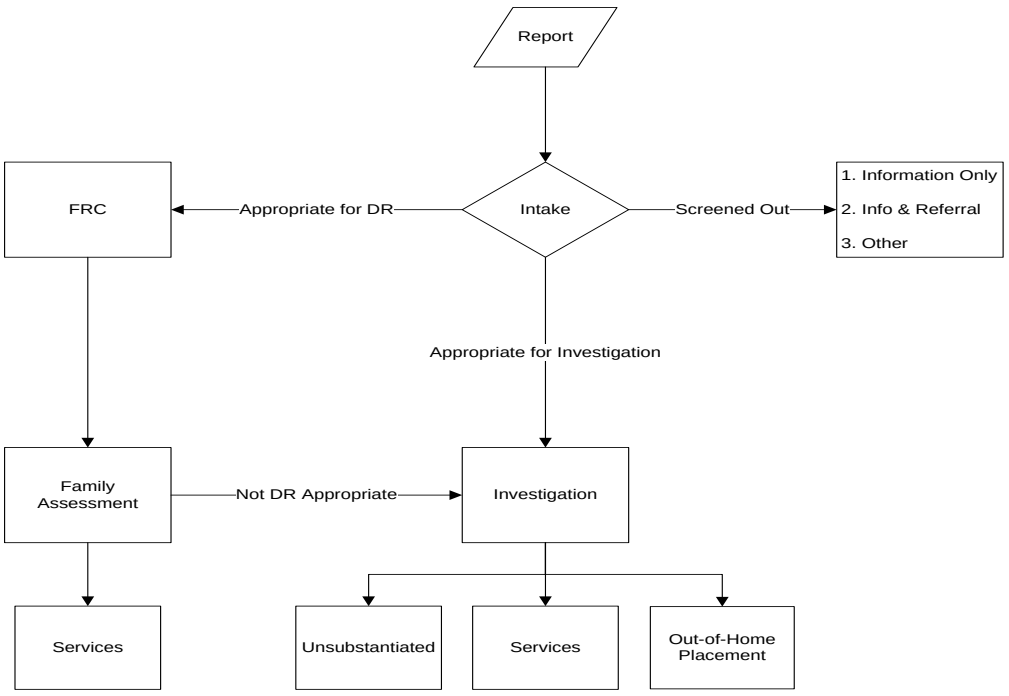


Map 2. Clark County Service Areas with DR Programs

The Nevada DR Model

Among states that have differential response programs, the Nevada model is unique in the immediate and direct involvement of community-based service providers in family assessments. Maltreatment reports screened for a family assessment by county CPS supervisors or intake workers are referred immediately to a local Family Resource Center (FRC). FRCs were originally established by the state legislature in 1995 to work with state and county agencies to assist residents and families access support services they may need. FRC service areas coincide geographically with state and county child protection service areas.

When the operation of the state's DR program was designed, FRCs were asked to play a central role in the differential response program, taking on assessment and case management functions that in other states have been handled primarily by state or county agencies. In practice, in any specific location the DR program involves the relationship between the local state or county office responsible for child welfare and the FRC responsible for the same geographic area. Staff at FRCs are contracted to provide the initial family assessment, which includes a risk and safety assessment of the family's children, for any subsequent case planning and service provision, and for entering case data on DR families into UNITY, the state's child welfare information system. Following the initial assessment, any family that is deemed inappropriate for the DR-family assessment track by the FRC is referred back to the county office for a formal investigation. The flow chart below provides a schematic overview of the Nevada Differential Response Model.



Criteria for DR Selection

In Nevada, accepted maltreatment reports are classified into three priority levels. Reports are considered Priority 1 if they contain elements that suggest there is an immediate threat to the child's safety; a CPS response must be made within 2 hours to such reports. Reports are classified as Priority 2 if there is a potential safety threat to the child within the foreseeable future and require a CPS response within 2 to 12 hours. Reports of child neglect or less severe physical harm, such as from inappropriate disciplining, that indicate maltreatment but not an imminent threat to the child's safety are classified as Priority 3 and require a response within 12 to 72 hours. Reports that may be referred to an FRC for a family assessment are limited to those classified as Priority 3. Typically, Priority 3 reports involve such things as educational neglect, environmental neglect, physical or medical neglect, improper supervision or inappropriate discipline with non-severe physical harm.

At the start of the DR pilot project, there were certain reports that were not allowed to be referred for a DR-family assessment, either by state agency policy or statute, even if they were classified as Priority 3. Such exceptions included reports on families that had a substantiated report in the previous three years or had had a child made a ward of the court. Families who had three or more prior unsubstantiated reports could be referred for a family assessment if the child welfare agency supervisors documented that these reports had been reviewed before referral to an FRC. These exceptions currently have been withdrawn. However, state statutes (NRS 432B.260, paragraph 2a) require an investigation of any report in which a child aged 5 or younger is identified as a possible victim of abuse or neglect. This requirement has been in place from the start of the DR program and remains unchanged.

Family Resource Centers

County and state CPS had working relations with their local FRCs prior to the DR pilot projects and these agencies have been a source of direct services and service referrals for CPS families from their inception. The language of the statute that established the agencies recognized the problems of many poor families in the state and almost prefigured the involvement of the FRCs in differential response. In explaining the need for FRCs the statute states that "many neighborhoods in this state do not provide the basic necessities of life or the resources or services designed to promote individual development and family growth." The statute goes on to say, "Nevada's most vulnerable families and children live in these neighborhoods [and] many such families not only live in poverty, but also experience divorce or are headed by a single parent....[Furthermore] children who are raised in such neighborhoods frequently experience physical and mental abuse." (Senate Bill 405, 1995. Section 1, paragraphs 2 through 6.) The statute requires all FRCs to provide certain services

directly or through referrals to other resources, including "education on caring for infants and day care services for infants," "education on parenting," "health care services for children, including all required immunizations," and "day care for children who are old enough to attend school, both before and after school" (Section 15, paragraph 2). FRCs are encouraged to provide an array of other assistance to poor families including "services that will assist families with physical and mental health issues, the special needs of children, food and nutritional needs, recreational needs, housing problems, domestic violence and substance abuse" (S.B. 405. Section 15, paragraph 3c).

Ten Family Resource Centers and an independent community agency have contracts to provide DR-family assessment services in the state. Four of these 11 organizations are in Clark County and provide DR services in five of the county's service zones in the metropolitan Las Vegas area. In Washoe County there is one FRC that provides DR services along with the Children's Cabinet, a community organization that predates the development of the FRC system. In the other 15 counties, which are sparsely populated, there are five FRCs that provide DR services to families in eight counties.

At the time this report was prepared there were 22.5 contracted staff in these agencies providing DR-family assessment services. These are dedicated DR caseworkers and they are contractually limited to a caseload of 15 DR families at any one time. DR caseworkers work under the direction of an FRC supervisor. The supervisor is the liaison between the FRC and the county or state CPS office in their region. **Table 2.2** on the following page lists the 11 community organizations under contract to provide DR services, their service area, the number of contracted DR staff at each organization and the start month for the DR program in each service area.

CPS, FRCs and DR by Region

The following summaries of DR and CPS programs across the state was derived from interviews conducted during site visits.

CPS in Washoe County. Washoe County is one of Nevada's three defined geographic areas for child welfare and social service provision. Like Clark County in the southeast, the agency is county administered. Strongly supportive of family-friendly services, Washoe County Department of Social Services (WCDSS) operates from a central site in the city of Reno. Reports are screened by the Intake unit, and each referral is then assigned to a "Paired Team" based on a rotating schedule. With the Paired Team structure, reports are investigated (Washoe County uses the term assessment rather than investigation) and, if necessary, transferred to a permanency worker under the same supervisor. WCDSS believes that families benefit from more consistency and communication with this type of agency organization.

Table 2.2. Nevada Community Organizations with DR Contracts

County	Service Area	Family Resource Centers	DR Staff	DR Start Month
Clark	Las Vegas East	East Valley Services FRC	2	February 2007
	Las Vegas South	HopeLink FRC	2	February 2007
	Las Vegas Central	East Valley Services FRC	2	March 2008
	Las Vegas North	Olive Crest FRC	2	March 2008
	Las Vegas West	Boys and Girls Club FRC	2	January 2009
Washoe	Washoe County	Children's Cabinet	3	January 2008
	Washoe County	Washoe FRC (Sparks)	2	January 2008
Rural Nevada				
Elko	Elko County	FRC of Northeastern Nevada	2	February 2008
Carson City	Carson City and Storey Cos.	Ron Wood FRC	1	January 2009
Churchill	Churchill County	FRIENDS FRC	1	January 2009
Lyon	Lyon, Pershing, Mineral Cos.	Lyon County Human Services FRC	2	January 2009
Nye	Southern Nye County	Nevada Outreach Training FRC	.5	January 2009

Of the cases that are transferred to an ongoing worker, the majority are court-involved. A small percentage of cases that continue past the investigative/assessment stage are in-home, voluntary cases, but these are required to be "high-risk." County staff indicated that lower-risk cases are typically provided some services or service referrals during the investigation/assessment period and then closed. Depending on the risk factors identified, WCDSS can connect the family with community resources, such as the FRC, or provide access to contracted services, such as substance abuse evaluations, drug testing, and family counseling.

DR in Washoe County. Washoe County has been a supporter of family-centered practice and DR for many years. The current DR program operates in two community organizations: The Children's Cabinet and Washoe County FRC in Sparks. DHHS funds the two DR staffs that are housed in the local FRC, but to maximize DR in the region, the Washoe County consortium of community agencies and local government decided to finance additional DR staff independently through the Children's Cabinet.

The Children's Cabinet is the primary social service provider for the City of Reno and Washoe County and operates a significant array of programs for the local community. To accommodate DR, the agency transitioned a few of its existing case management staff into new roles. Supervisory responsibilities for DR casework were taken up by the former Counseling Coordinator, who came to the position with a number of years of experience working with youth and families. In addition to a supervisor/coordinator, there are three full-time DR case workers.

The Washoe FRC is a county-wide organization that operates out of five sites. It provides a range of community-based services to meet family needs, including emergency assistance, parenting education and support services. DR is housed at the Sparks FRC location, and employs two workers that carry DR case loads.

Intake workers at the county office consult with the Intake Supervisor/DR liaison about Priority 3 reports that may be appropriate for DR. The DR liaison considers the expertise, availability, and current caseloads of the DR workers and emails the case to one of the contracted agencies. The agency then accepts the case and initiates contact with the family.

CPS in Clark County. Nevada's Southern CPS Region, which includes Las Vegas and the surrounding rural areas, is a county administered system. Child protective services in Clark County are organized into geographic service zones, including five in greater Las Vegas—Central, North, East, South, and West—with a CPS and FRC office in each zone. Servicing a population that is approaching 2 million, CCDFS employs approximately 90 investigation workers in 18 units. The North site has four regular investigative units, while the other regions have two units per site. Additionally, there are two special '5 and Under' units, two sexual abuse units, and two Emergency Response Team units. Each unit has a supervisor and five to six workers. Units work 4-day weeks, either Wednesday to Saturday or Sunday through Wednesday. Open on-going cases, most of which are out-of-home and formally court involved, are served by several permanency units at each site. In-home cases are served by a separate unit and workers. All child abuse and neglect reports and referrals are received by a central hotline, staffed by 18 workers and two supervisors on rotating shifts.

CCDFS has undergone significant changes in its policies, procedures, and service provision in recent years. A statewide federal Child and Family Service Review in 2004 resulted in a Program Improvement Plan to address system deficiencies in several areas. In this document, Clark County in particular was a focus for new strategies, initiatives, and reorganization. A new CCDFS director was hired in 2006, and a series of substantial action steps have been undertaken and planned to improve child safety, permanency and well-being. Interviews indicate that work with CPS families has become more structured, service oriented, family focused, and permanency driven. A greater emphasis has been placed on ensuring that reasonable efforts are made to prevent the unnecessary

removal of children and to reunify removed children with their families. New case workers have been hired, policies have been reviewed and rewritten, and some internal reorganization has taken place to make the county system run more effectively. For example, between 2007 and 2009, workers were trained on a new investigation protocol and risk assessment tool, the hotline was relocated and intake policies were revised, and several steps were taken to reduce the number of children and the length of stay in Child Haven, the temporary emergency shelter specifically cited in the 2004 CFSR. A distinct in-home unit was established at each geographical site, and voluntary on-going cases are currently being piloted at the North site. These and other actions have led to service improvements and a reduction in the number of children removed from their homes in recent years. Performance issues still remain, however, and work is underway to remedy them. Budgetary limitations, a sparse service array, and strained relationships between CCDFS and other community institutions hamper progress in some areas.

In a typical investigation, an assessment is conducted and closed within 30 days, unless there is a need for court proceedings. If a safety risk is identified during the assessment, the investigator will staff the case with the supervisor, review the safety assessment tool, and determine if a safety plan can be effectively established. If the family agrees to take measures to ensure safety, then the child may be allowed to stay in the home for the short-term (3-6 months) with in-home services monitored by the court; if safety cannot be established, then the child is removed. The emergency shelter, Child Haven, is used as a temporary placement for children for no longer than 24 hours until its Receiving Team can find a relative or appropriate foster home. Workers are encouraged to refer families to services during the investigation and to attempt to resolve safety threats that may be present before filing for protective custody.

However, due to the volume of cases that CPS workers receive, they are often not able to advocate actively on their families' behalf to connect them with appropriate community resources. The ability to follow-up on families' progress is limited in a 30-day period, and investigators are not always trained to make the best use of available services. The DR program, therefore, has allowed many lower-risk cases to obtain more attention and monitoring than they otherwise would. Educational neglect cases, for example, are closed rapidly out of necessity in the CPS system but are often serviced for several weeks in DR. CPS investigators and supervisors who were interviewed see DR's value in addressing more comprehensively the needs and problems of families and providing services to them more often and more quickly.

DR in Clark County. Differential Response has been active in Clark County since February 2007. Over the course of the pilot, the DR program has become a strong, positive addition to the child protective system there. Families that are referred to DR are offered open-ended, supportive services that are designed to fit their needs and goals. The DR workers, 10 in total for the Las Vegas

area, describe themselves as confident to address any risks or problems their assigned families may face and view the DR approach as active and responsive to families. Extra time to work with the family and creative exploration of resources allow DR workers to engage families more deeply, secure necessary services and ensure that the family follows through with their case plan.

The five urban CPS zones in Clark (Central, North, South, East and West) are serviced by four agencies that house the corresponding DR staff and regional FRC. East Valley Family Services accepts DR referrals from Central and East, Olive Crest accepts referrals from the North, the Boys and Girls Club of Las Vegas services the West zone, and HopeLink covers the South. East Valley Family Services has been active with DR since the program's inception. Olive Crest was the last agency to be granted a DR contract; DR referrals began in this agency in July 2009. Each of the five zones has two full-time case managers assigned to the DR program.

Central intake hotline staff at the Central Office assign cases directly to the appropriate FRC DR programs. A hotline supervisor approves the assignment of reports to FRCs for DR and sends the referral to the geographically-appropriate FRC. Communication between DR staff and CPS is maintained through regular phone calls, emails, and meetings.

CPS in Rural Nevada. The Division of Child and Family Services is responsible for child protection in the 15 counties outside of Clark and Washoe. Geographically large but sparsely populated, this region is served by one main administrative office and a network of 12 child welfare offices in four regional districts. A District Office is located in the main city in each of the regions (North, West Central, East Central and South) and eight field offices are located in smaller towns throughout the counties. Some offices are responsible for responding to child maltreatment reports in more than one county. Each agency conducts the full range of child welfare services, including intake, investigation, and case management, as well as child removals and foster care. Staff numbers in each office vary according to the population size of the service area; Carson City has five investigators, Battle Mountain in Elko has only one. The normal caseload for a DCFS rural caseworker is between 20 and 22 families.

DR in Rural Nevada. The differential response program is available to families in 9 of the 15 rural Nevada counties—Elko (in District1), Carson City, Douglas and Storey (in District 2), Churchill, Lyon, Pershing and Mineral (in District 3), and southern Nye (in District 4). DR services are provided to the 9 counties through 5 FRCs: the Family Resource Center of Northeastern Nevada (in Elko), the Lyon County Human Services FRC, FRIENDS FRC (in Churchill), Ron Wood FRC (in Carson City), and Nevada Outreach Training FRC (in Pahrump). All of these FRCs provide a broad array of services in areas that often have few other resources and assist families in accessing other public services, such as WIC and Food Stamps, for which they may be eligible. Due in part to the lack of community

services in some rural areas, the FRCs have always been a strong partner for DCFS. Both before and since the start of the DR program, DCFS offices have referred families with maltreatment reports to FRCs for services—including families whose reports were investigated, whether substantiated or not, or were classified as I/R or FASS (through which IV-B family preservation and prevention services were provided).

DCFS supervisors in district offices screen incoming maltreatment reports and refer those they consider appropriate for DR-family assessments to the geographically-appropriate FRC by email, phone or fax. FRC DR workers receive all the current and historical information about a family who is referred to them, except for any criminal history. Other contact and communication between DCFS and FRC staff is frequent, and DR workers in all locations are usually able to call or meet with the supervisor in the area DCFS office for any concern or question about a case.

Most DR workers were new hires by the FRCs, but about half have had some prior experience working for CPS. Workers must often travel large distances to cover their service area and find that transportation is a huge barrier for rural families that need services. DR is therefore a critical program for connecting families to resources in the surrounding areas. Though there are no current plans to expand DR into other rural towns, workers and directors of existing DR programs suggested that many of the other counties would greatly benefit from a DR program.

Similarities and Differences

The results of site visits and interviews conducted across the state indicated that while there was uniformity in the DR program being implemented across the state, there was, at the same time, a great deal of difference in the child protection systems in Clark, Washoe and the rural counties. Differences in CPS within the state are also reflected in recent Child and Family Services Reviews (2004 and 2009) and, as will be seen in the next chapter, in UNITY data as well. The implementation of a new program is never an easy task. In Nevada, the task of implementing the differential response program was all the more daunting since the CPS foundation on which the new DR program was constructed varied from one building site to the next.

Chapter 3. Child Maltreatment Reports and Screening for DR Family Assessments

Differential response involves the selection or screening of reports considered appropriate for a family assessment from among all child maltreatment reports received by a child protection agency. Before examining those reports selected for a DR-family assessment, we will briefly review the full population of reports received.

Reports and Allegations

Child Maltreatment Reports. Reports involving the welfare of children are received by county and state CPS offices. Some of these reports are accepted as requiring a system response that involves a home visit, others do not. Those that do not may simply involve the provision of information needed by a family; these reports are classified as information only (IO). Some reports involve the provision of information about the availability of services or assistance and a specific referral to a service resource, and they are classified as information and referral (IR). Then there are those that are judged to meet the statutory requirement for a home visit by a county or state child protection worker because there is reason to believe a child may be in need of protection. These latter reports of potential child maltreatment, as noted in the previous chapter, are separated into three priority categories. Priority levels 1 and 2 require an investigation, while priority level 3 may be referred to an FRC for a family assessment.

Since the start of the differential response pilot project in Nevada there was a decline in the number of accepted maltreatment reports requiring a home visit by a CPS worker from the start of the differential response pilot project through late 2009. Judging from the pattern in 2010 the decline may have stabilized. **Figure 3.1** plots the monthly number of these reports over the 40-month period from the start of the DR project in February 2007 through the end of July 2010. The figure plots the number of child maltreatment reports for the state as a whole and then for Clark County, Washoe County, and the rest of the state combined. The hills and valleys of the graph are typical of fluctuations in reports received by state child protection systems and are generally associated with the school year and reports made by school personnel.

The decline in reports in Nevada was most impacted by the decline in reports in Clark County, which accounted for 71 percent of the state's population and 61 percent of all CPS reports. Statewide stabilization of the decline was due to a slight increase of reports in this county in 2010 relative to 2009. The relative relationship between the parts (counties) and the whole (state) can be seen in

Figure 3.2. This chart shows the percent of statewide maltreatment reports received since the DR program began. Counties with DR programs accounted for over 95 percent of all accepted reports.

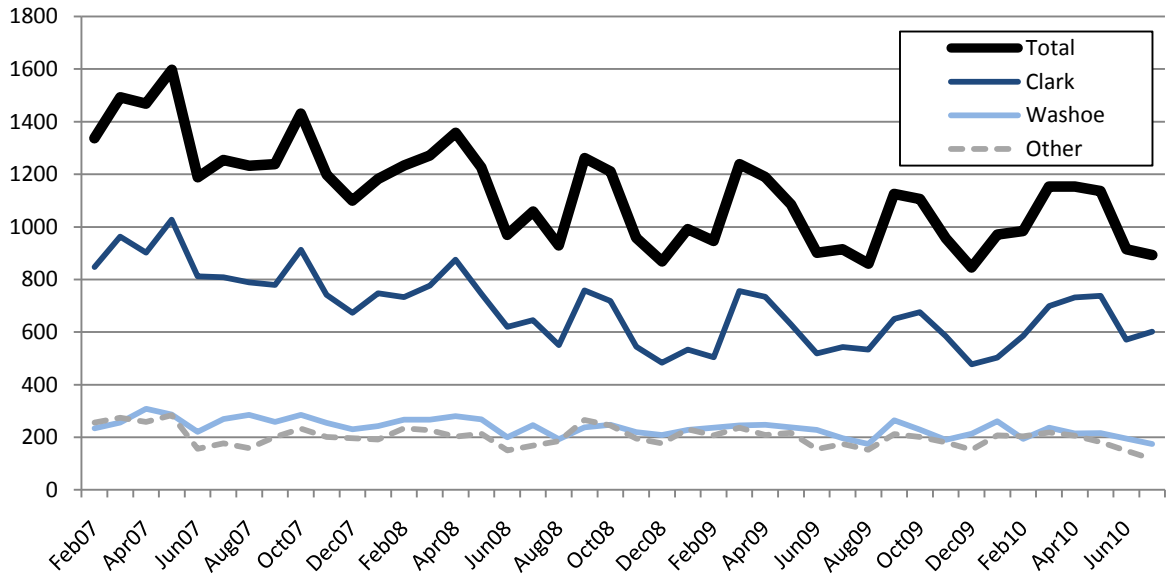


Figure 3.1. Monthly number of CPS reports statewide and by county

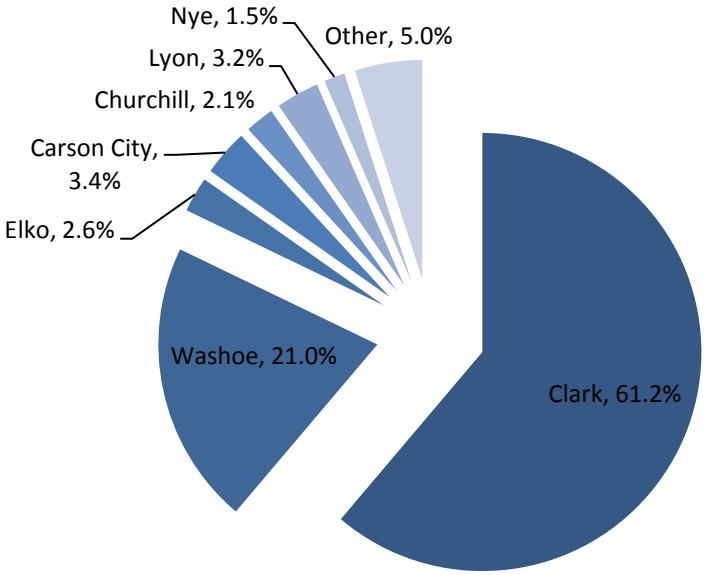


Figure 3.2. Percentage of maltreatment reports by county, from February 2007 through July 2010

Nationally there was a downward trend in the number of child maltreatment reports over the last several years. In Nevada, one change that may have had some impact on the number of accepted reports was the expansion in 2008 of the central intake unit to 24/7 in Clark County. Previously, reports made outside of office hours and on weekends were received by law enforcement personnel. Whatever was behind the falling numbers in Figure 3.1, Clark County CPS workers reported during Fall-2009 site visits that they had been less busy. Part of this was attributable to the referral of some reports to FRCs for family assessments. But Clark CPS workers also reported that they had an insufficient number of DR-appropriate reports to refer to FRCs to keep DR workers fully occupied.

Figure 3.3 shows the number of reports by disposition type that were received from 2000 through mid 2010.[5] Yearly totals are shown and the final year 2010, for which data were available through July, is projected to the end of the year. The graph includes four types of dispositions: referrals to FRCs for a differential response family assessment (DR); investigations (INVS); information and referral (IR); information only (IO). The difference between IR and IO cases is essentially that in an IR case some action follows the report, generally the reporting party is given a referral to another community resource. (Prior to the introduction of DR there were a few reports classified as NAAS, which involved families referred to other agencies for services that were funded through CPS.)

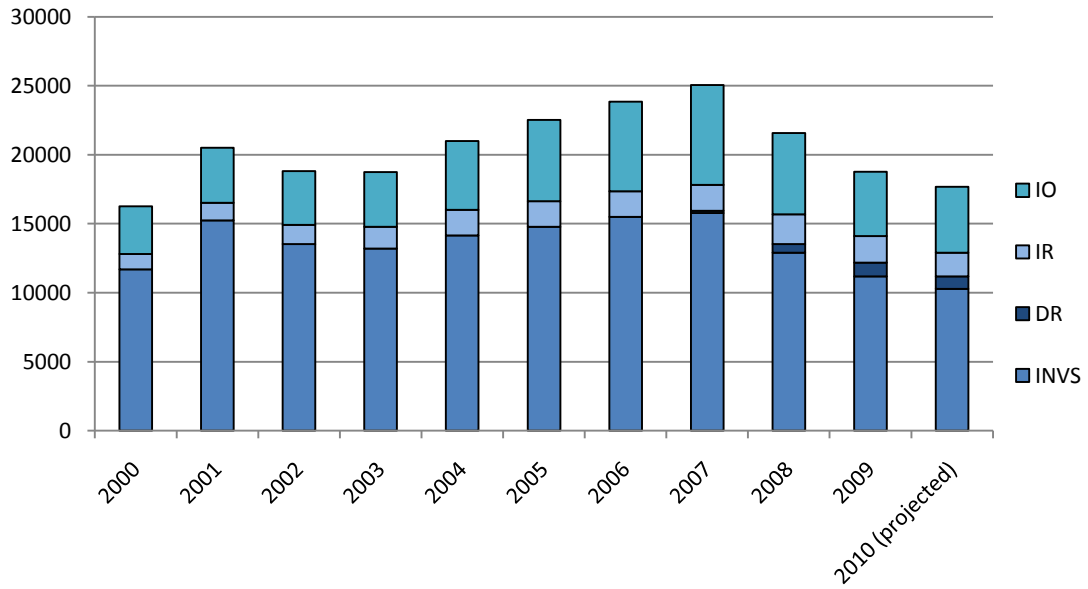


Figure 3.3. Yearly totals of child abuse and neglect reports received by county and state CPS offices, 2000-2010

[5] The data in Figure 3.3 were obtained through UNITY extracts, and evaluators do not know whether data for the early years shown here are as reliable as more recent data.

The number of investigations peaked in 2007, the year DR began. DR operated in only two Clark County areas during 2007. Monthly referrals to FRCs for DR averaged about 15 per month in 2007 but then rose to 53 per month in 2008, as Washoe and Elko Counties implemented DR, and to 64 per month in 2009 when the remaining rural counties implemented the DR program. Referrals for DR appeared to be on track to maintain this monthly average during 2010. However, the chart in Figure 3.3 illustrates that DR cases in Nevada continue to represent only a small portion of the total families that are reported to CPS.

Types of Allegations. The nature of child maltreatment reports is a central factor in determining whether a report is judged appropriate for a DR family assessment. Accepted reports of child maltreatment have averaged 1.3 different types of allegations per report (and there is little difference in this in Clark, Washoe and the rural counties). **Figure 3.4** shows the relative frequency of different types of allegations in accepted reports since the start of the DR program. The most common involved the lack of basic needs (18.5 percent), such as inadequate food, clothing or shelter, and lack of supervision (20.0 percent). A broad category included in many reports (14.7 percent) was parental or family problems of various kinds, which included such things drug or alcohol abuse, mental or physical incapacity, hospitalization or incarceration or domestic abuse. Other major allegation categories were physical abuse (17.5 percent), and conflict or emotional abuse (11.4 percent). Less frequent allegations included sexual abuse, medical abuse and educational neglect.

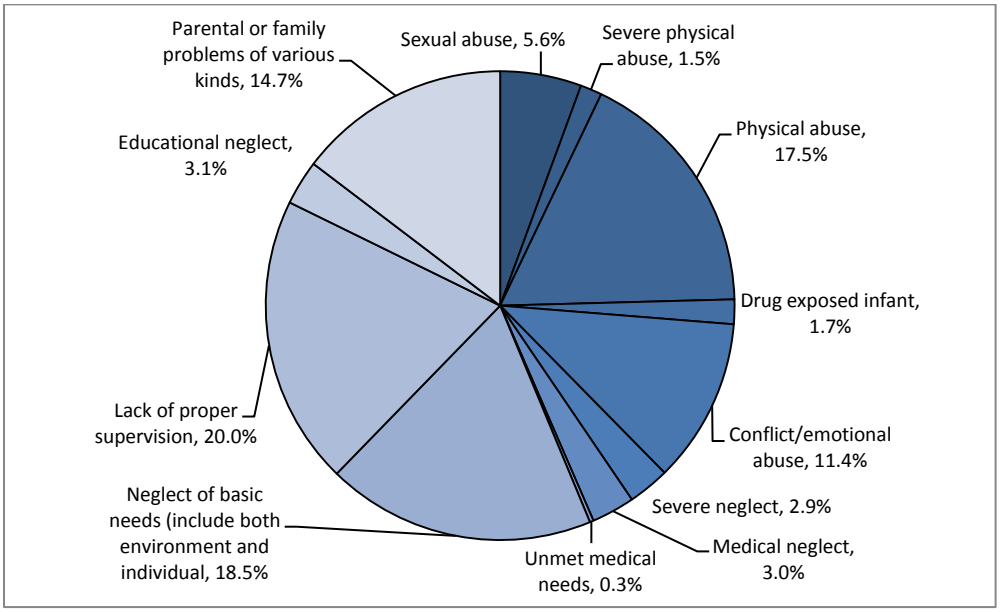


Figure 3.4. Frequency of different types of allegations in all reports of child maltreatment statewide

Overall, about one in four (26 percent) reports included an allegation of lack of supervision, and nearly as many (24 percent) involved children who lacked basic needs. At the more severe end of the maltreatment spectrum, about 2 percent of reports included allegations of severe physical abuse and 2 percent contained allegations of a drug exposed infant, while about 7 percent of reports included allegations of sexual abuse.

There were some differences in the types of allegations in maltreatment reports in the three service areas, as can be seen in **Figure 3.5**. Reports in Washoe County were somewhat more likely to include allegations of neglect of basic needs than reports in Clark County. On the other hand, Clark County reports were somewhat more likely to include allegations of various parental and family problems and physical abuse, while rural counties received a higher percentage of reports with allegations of parent-child conflict or emotional abuse. Overall, however, the pattern of allegations in child maltreatment reports in the three areas was more similar than dissimilar, and a large number were the kinds of reports that typically receive a family assessment response in states with mature differential response programs.

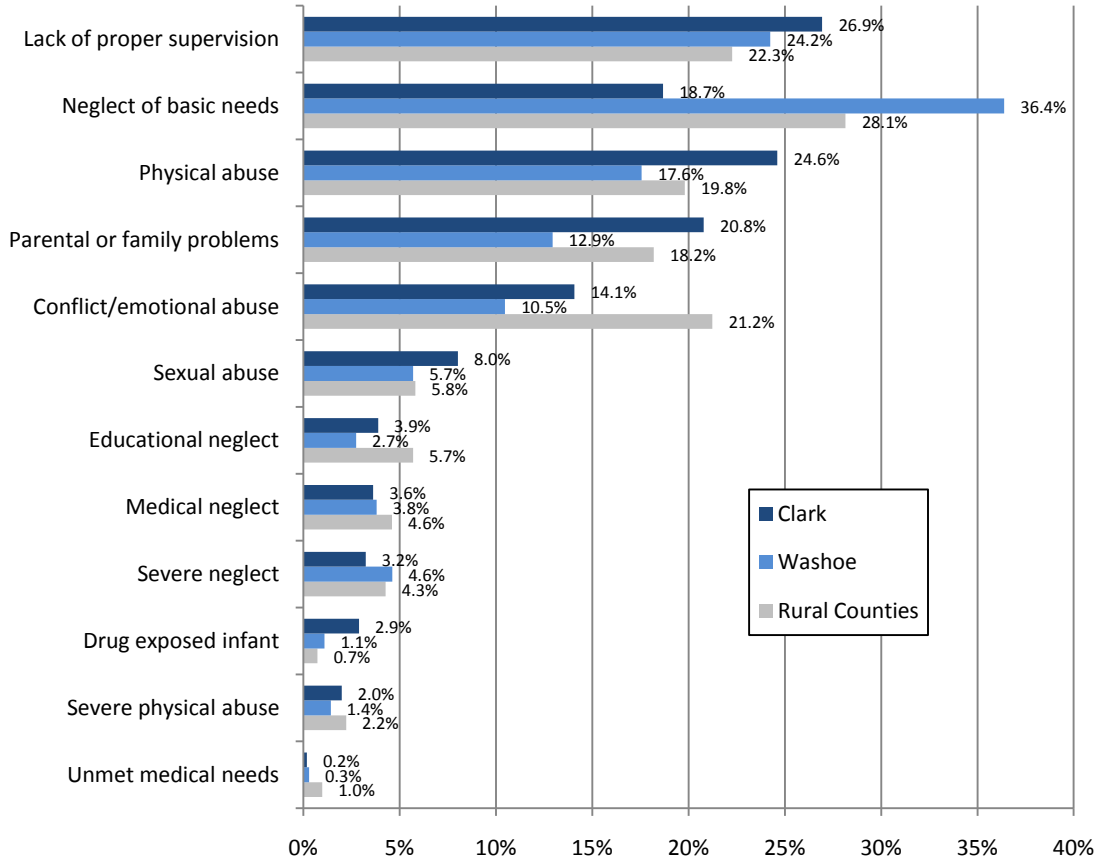


Figure 3.5. Percent of reports that contain specific allegations of child maltreatment

Reports and Dispositions

Figure 3.3 above broke down the various kinds of responses made to reports of child maltreatment statewide. Two of the dispositions, investigations and DR family assessments, involve reports where some formal response, with a visit to the family home and an assessment of a child's relative risk and safety, is considered obligatory—these are reports that are commonly referred to as "accepted". The other dispositions—information only, or information and referral—are used when a report is screened out.

Washoe County dispositions a higher proportion of hotline reports as Information Only or Information and Referral than other counties. The pie chart in **Figure 3.6** shows the percent of reports that received any disposition in Washoe County in 2009. Nearly 6 reports in 10 were classified as either information and referral or information only based on UNITY data. Slightly less than 4 in 10 were judged to require a home visit with a formal assessment/investigation (36.7 percent) and 4 percent were referred to the Children's Cabinet or the Washoe County FRC for a DR family assessment. The year 2009 was chosen because the differential response program was fully operational across the state as of that year (and the general pattern of the dispositional responses to hotline reports in 2009 is reasonably representative of those found throughout the decade, both in Washoe County and in the other service areas).

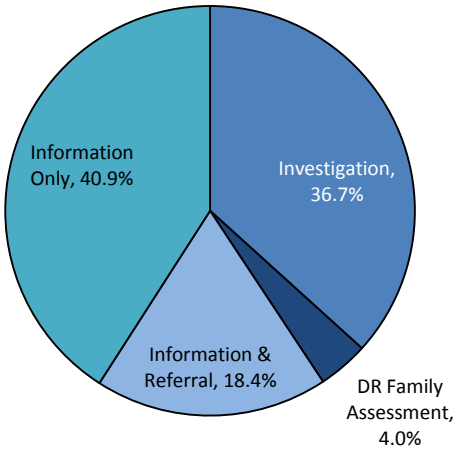


Figure 3.6. Percent of all reports that received specific dispositions in Washoe County

Figure 3.7 shows the same information for Clark County in 2009. Here we can see that a large percentage of incoming reports that required disposition were investigated (82.5 percent) and 5.2 percent received a DR family assessment. Relatively few reports had other dispositions: 10.6 percent were classified as information only and 1.7 percent as information and referral.

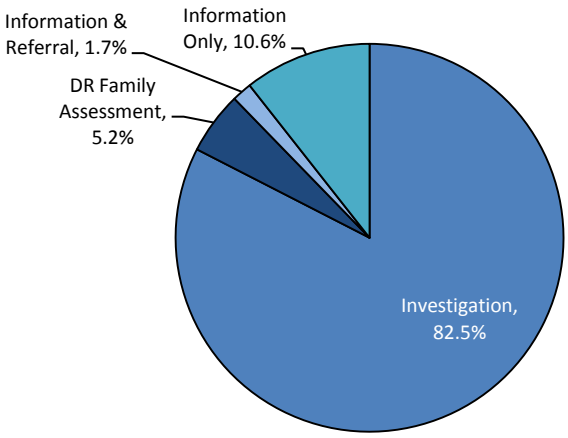


Figure 3.7. Percent of all reports that received specific dispositions in Clark County

Figure 3.8 shows the dispositional response to all reports received in 2009 for rural counties that had implemented the DR pilot project. The pattern in the classification of reports falls midway between what was seen in the two larger, urban counties above.

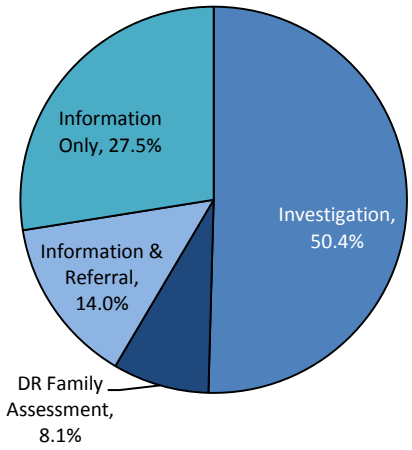


Figure 3.8. Percent of all reports that received specific dispositions in rural counties

A possible interpretation of these variations is simply that Clark County "accepts" more reports for a formal response and tends to investigate them than is the case in Washoe County. In fact, this is not the complete story. Considering the relative population size of the counties, we find that in 2009 Clark had a hotline report rate of about 5 per 1000 people and conducted 1 investigation for every 265 persons in the county. Washoe, on the other hand, had a referral rate of about 17 for every 1000 people, more than 3 times the rate of Clark, and conducted 1 investigation for every 163

individuals in the county. In the rural counties the rate was 13 per 1000 and the ratio was 1 to 159. If we consider this, we find that Washoe tended to receive more reports from their community and, while screening out the majority, conducted proportionally more investigations in the general population than Clark. Investigations were a more common response to a report in Clark, but a smaller proportion of reports were received overall. The reason why there is such a large difference between the rates of referrals across the state is unknown.

Having made this general point it should be noted that all further references in this document to maltreatment reports refer to reports that are accepted for a formal response involving either an investigation or DR family assessment.

Reports Screened for DR Family Assessments

In the most recent UNITY extract available to evaluators (received August 2010), there were 2,407 reports with DR family assessment dispositions. This figure is the number of DR family assessment dispositions in counties or sub-county regions with a DR program from February 2007 through July 2009. All of these reports should have been referred to an FRC for a family assessment. Some of them, however, were returned to the county CPS agency, either because of concerns about the safety of children, because FRC-DR staff was working at full capacity at the time, or because the family could not be found or would not cooperate. We estimate that 402 reports were initially designated as DR appropriate but were returned to CPS over the entire data collection period (as of 07/31/10). Included in this number are those that were subsequently investigated as well as some that were simply closed and no further action taken.[6]

Figure 3.9 shows the cumulative number of DR dispositions by county from the beginning of the program through July 2010. Somewhat less than half (46 percent) were Clark County families and 30 percent were families in Washoe. The other families (25 percent) were from the state's more rural counties. It should be noted that for rural counties the source of service location obtained from the data system was often that of the Family Resource Center and not necessarily the county of residence of the family; but in most instances these were the same.

[6] We were able to determine that 332 reports with an initial disposition of DR received investigation findings of *substantiated* or *unsubstantiated*, which shows that a change of disposition from DR to INVS occurred for those reports. This represents an average of about eight reports per month for all sites over the entire pilot period. FRC respondents also informed us of 102 reports that were returned to CPS for various reasons and for which no DR family assessment was conducted. Some of these were cases in which families could not be located. The two lists overlapped somewhat leaving a final total of 402.

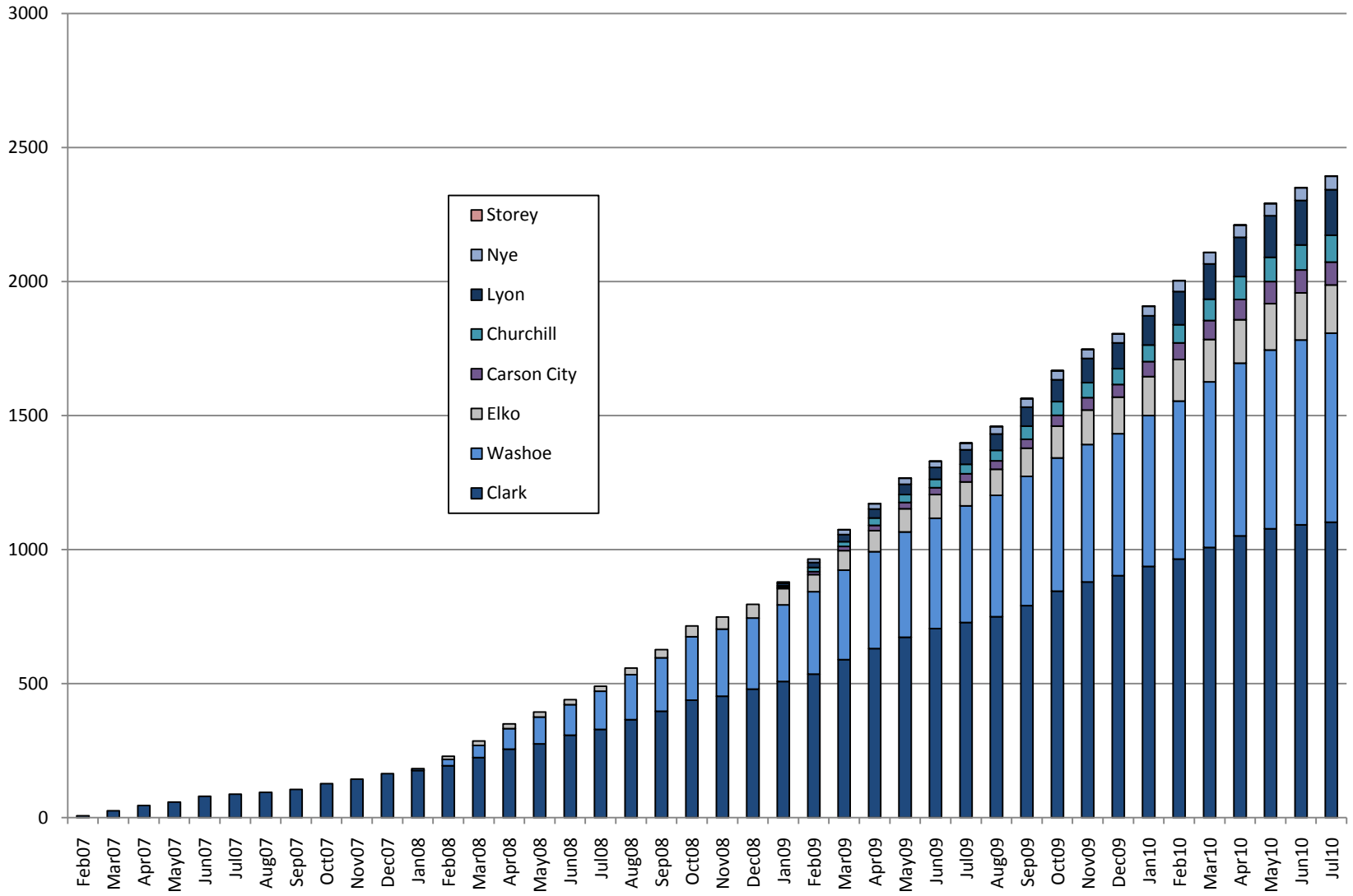


Figure 3.9. Cumulative number of DR-Family Assessment referrals by project month and county

Since February 2007 there have been 18,582 accepted reports of child maltreatment in areas where the DR program was operational. These were reports given either an investigation or DR family assessment disposition. The 2,407 reports screened appropriate for family assessments represent 13 percent of these, although the percentage drops to 11 percent when the 402 reports returned to CPS are taken into consideration. **Figure 3.10** shows the percent of accepted reports screened for DR each month from the beginning of the program in locations in which DR was operational. The percent fluctuated from month to month and ranged from 3 to 11 percent. Since February 2009, when the program was expanded to its current level with the addition of a number of rural counties and the inclusion of the Clark West service zone, the percentage of family assessment cases averaged 9 percent.[7]

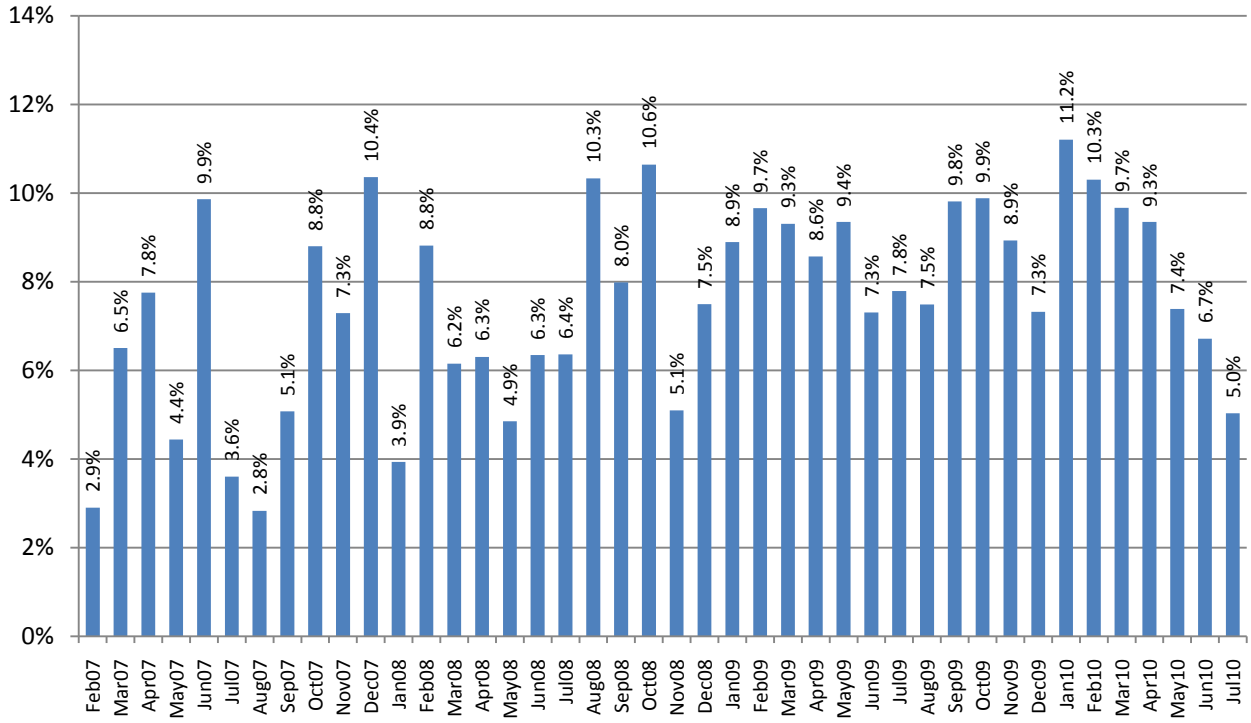


Figure 3.10. Percent of reports selected for DR-Family Assessment referrals in areas with an operational DR program

Overall, the rural counties screened a higher percentage of maltreatment reports for the DR family assessment track than the state's two larger and more urban counties (See **Figure 3.11**). Combined,

[7] Whenever there is a reference in this document to the percent of reports screened for DR, the calculation is always based on and limited to locations where the DR program was operational. For example, during the first year of the program (from February 2007 through January 2008), when DR had been implemented in Clark South and East service zones only, the calculated percent of reports screened for DR is based on reports only from these parts of Clark County; and the percent of reports screened for DR is equal to DR/(DR+INVS).

the figure for rural counties stands at 19.8 percent. Nye, Lyon, Churchill and Elko Counties all had rates over 18 percent. Lyon, Churchill and Elko Counties each had rates of over 20 percent. Washoe County screened 1 in 10 (10.0 percent) of their reports for the family assessment track since the program was implemented there in January 2008. Clark County has screened the lowest percent of reports for family assessment (5.5 percent).

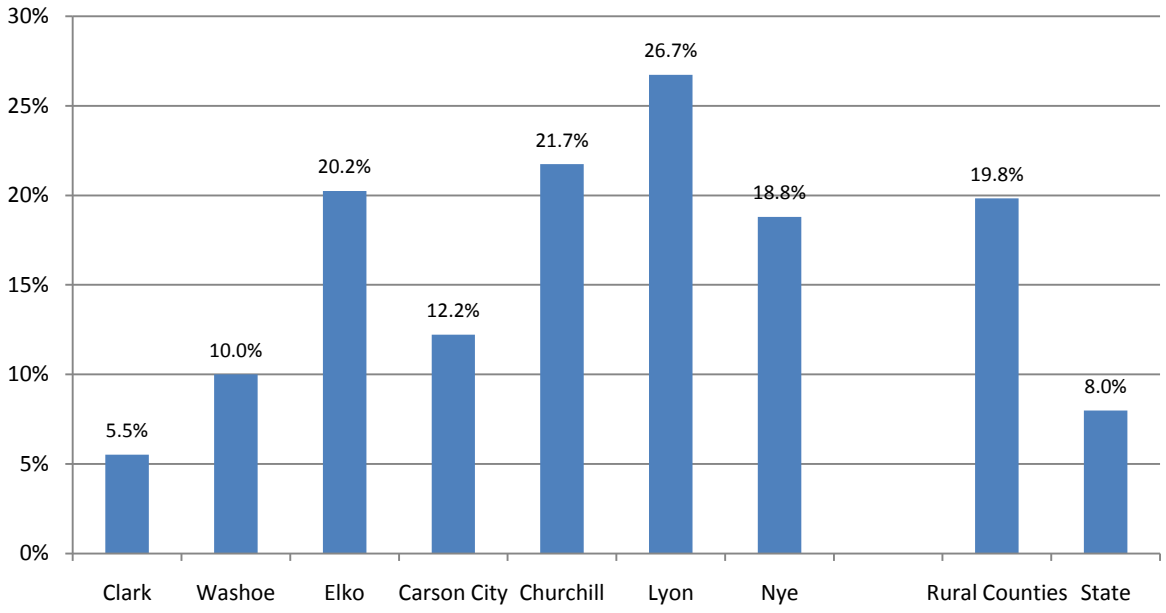


Figure 3.11. Percent of reports selected for DR-Family Assessments by County

Figure 3.12 shows the percent of child maltreatment reports screened for family assessments by month for the state (in areas where DR was implemented) and for the three major CPS service areas—Clark County, Washoe County, and the rural counties with DR programs.

Length of Family Assessment Cases. DR family assessment cases have remained open an average of 40 days. **Figure 3.13** shows the average length of cases for the three major county groups. The average length of cases was consistent and not substantially different across the three areas. **Figure 3.14** shows the average length of DR family assessment cases broken down by service area and FRC office. The average length of the cases ranged from lows of 27 to 29 days in Clark South, Elko and Nye, to highs of 49 and 54 days in Carson City and Churchill. The mean days for individual FRCs vary from month to month because of a small number of cases held open for longer periods than most others. The majority of cases are open for two weeks or longer with only 16.8 percent statewide closed within 14 days of the initiating report.

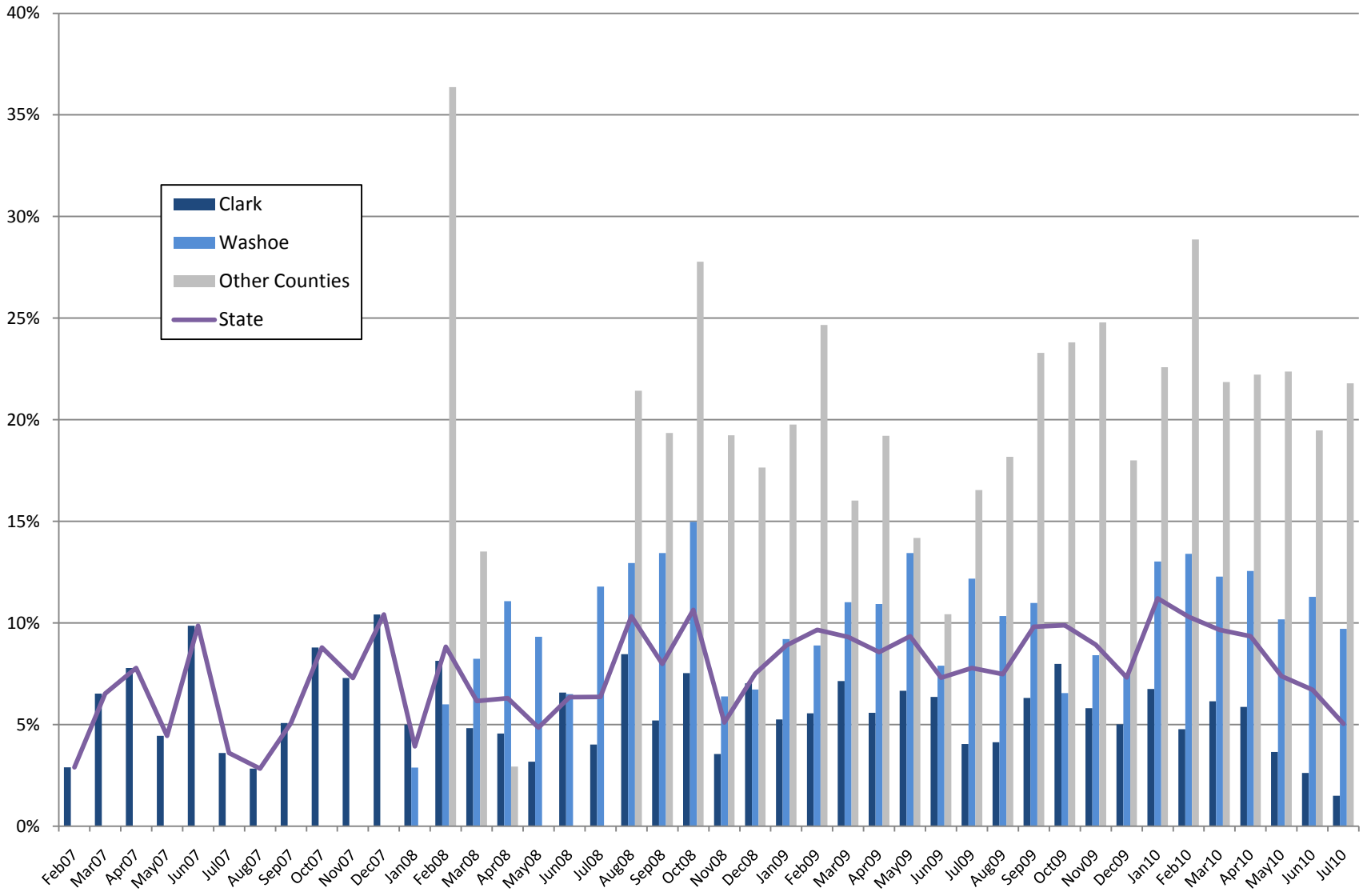


Figure 3.12. Percent of child maltreatment reports screened for DR-FA by county and month

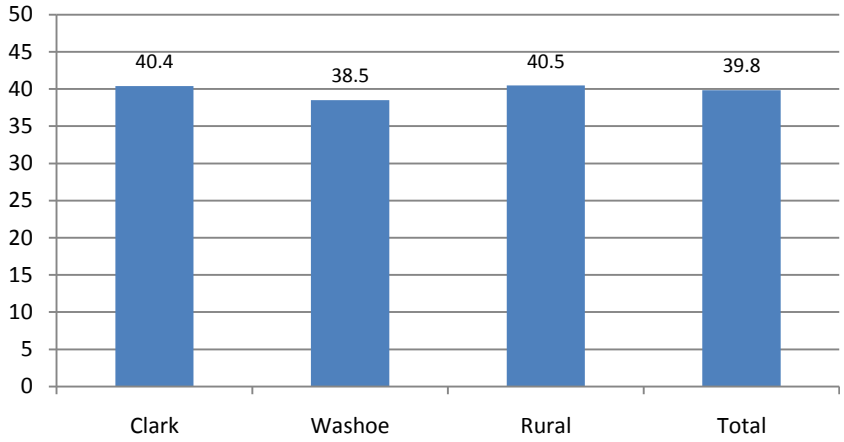


Figure 3.13. Mean number of days DR-FA cases remain open by county

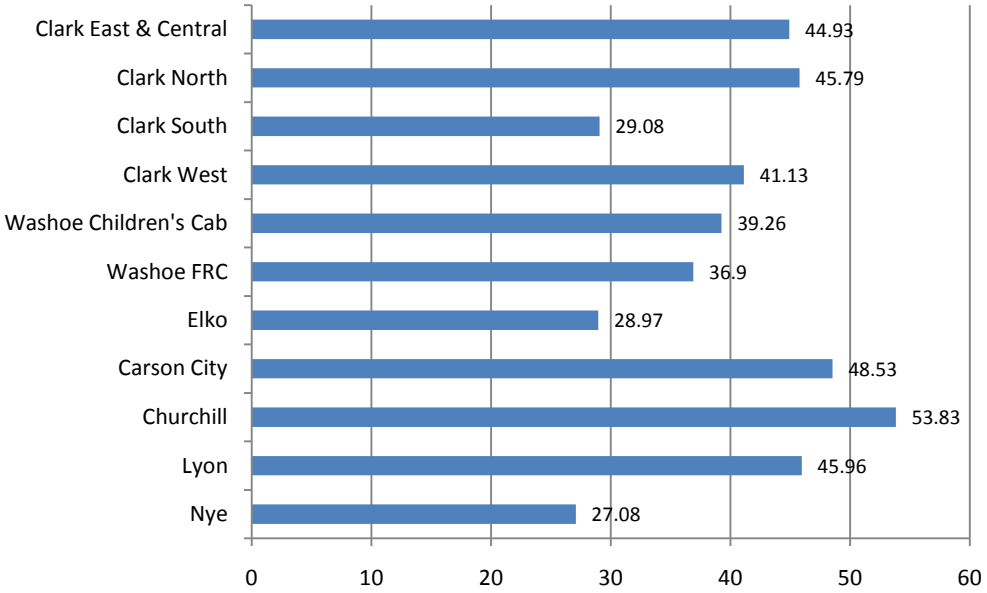


Figure 3.14. Mean number of days FA cases remain open by service area and FRC office

An analysis of comparison cases revealed DR cases remained open slightly longer than investigated cases. Similar investigated cases in Clark County were open an average of 35.6 days compared to 40.4 days for DR cases. In Washoe investigated cases were open for an average of 44.6 days compared to 38.5 days for DR. However, the comparison sample was small in Washoe. In the rural areas investigated cases remained open for 32.1 days compared to 40.5 days for DR. Statewide, investigated cases remained open an average of 34.8 days compared to 39.8 for DR.

Age of Children. The age of children is significant because, as noted in Chapter 2, state statutes require an investigation of any maltreatment report in which a possible victim age 5 or younger is identified. **Figure 3.15** shows the percent of children (alleged victims in the report) by age group in families selected for a family assessment or an investigation. As can be seen there were few very young children in families that were referred for family assessments, compared to families with investigated reports. Of the children in families that received a family assessment response, 49.4 percent were aged 6 to 10 years; 45.8 percent were teenagers. Correspondingly, investigations frequently involved families with very young children: 65.5 percent of the children in these families were aged 5 or younger.

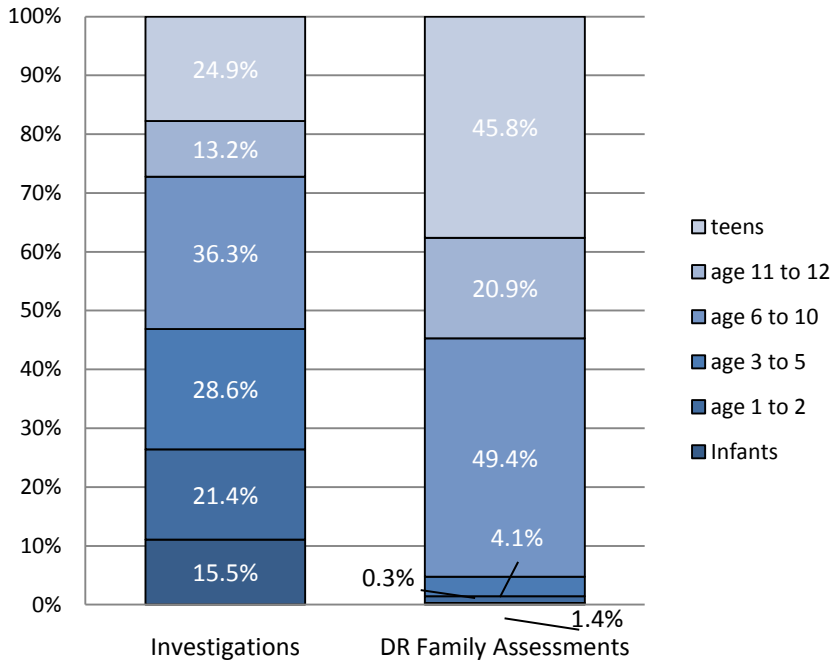


Figure 3.15. Percent of children by age group in DR-family assessments and traditional investigations

Allegations in Reports Selected for DR Family Assessments. The frequency of different types of allegations found in reports that were screened for family assessments can be seen in **Figure 3.16.** Reports involving claims of educational neglect were the most frequently referred (26.8 percent), followed very closely by reports of children who lacked basic needs (26.0 percent). Also common among these reports was a lack of proper supervision (17.1 percent) and medical neglect or unmet medical needs (10.2 percent). Other allegations in reports involving these families were conflict or emotional abuse (7.6 percent), parental or family risk factors (3.3 percent), physical abuse (6.6 percent), severe neglect (1.4 percent) and a small number of others (1.0 percent).

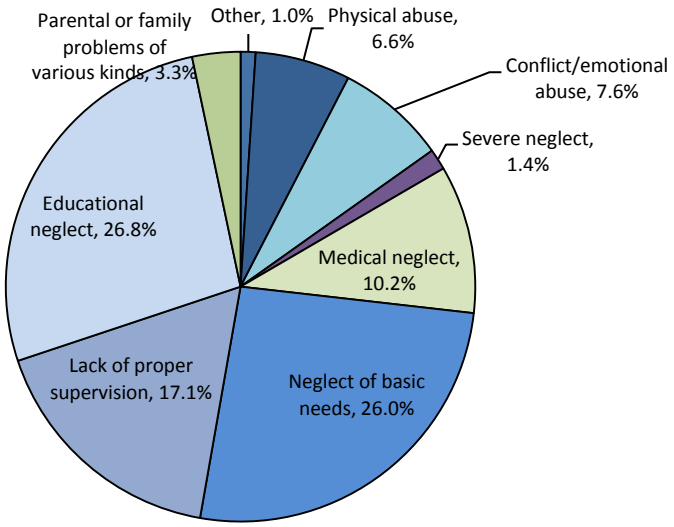


Figure 3.16. Types of allegations in reports screened for DR-FA, February 2007-July 2010

Since January 2009, when the third implementation phase brought DR to most of the state, a majority (62.1 percent) of educational neglect allegations were referred to FRCs for a family assessment. During this period slightly less than a quarter (23.3 percent) of medical neglect allegations received a family assessment, as did 15.1 percent of allegations for neglect of basic needs, 11.5 percent of conflict or emotional abuse allegations and 5.4 percent of improper supervision allegations.

The bar graph in **Figure 3.17** shows the percent of specific allegations that received a family assessment or an investigation between January 2009 and July 2010. The line running through the bars in the figure indicates the percent of all reports that included specific allegations. Thus, while a majority (62.1 percent) of educational neglect reports received a DR family assessment, educational neglect reports accounted for only 3.8 percent of all reports.

Similar information is shown in a different form in **Figure 3.18,** which shows the total number of allegations between January 2009 and July 2010. The chart is based on data for 23,089 allegations received through 19,369 reports; some reports involved multiple allegations of child maltreatment. By showing the number rather than percent of DR cases within each category, we can see areas in which increases in family assessments may be possible. DR is employed to address only small numbers (and small proportions) of lack of supervision, physical abuse and neglect of basic needs allegations. These, along with medical neglect, each represent areas in which DR might be usefully expanded. There are other issues that must, of course, be considered, such as the ages of children and the level of potential danger to children.

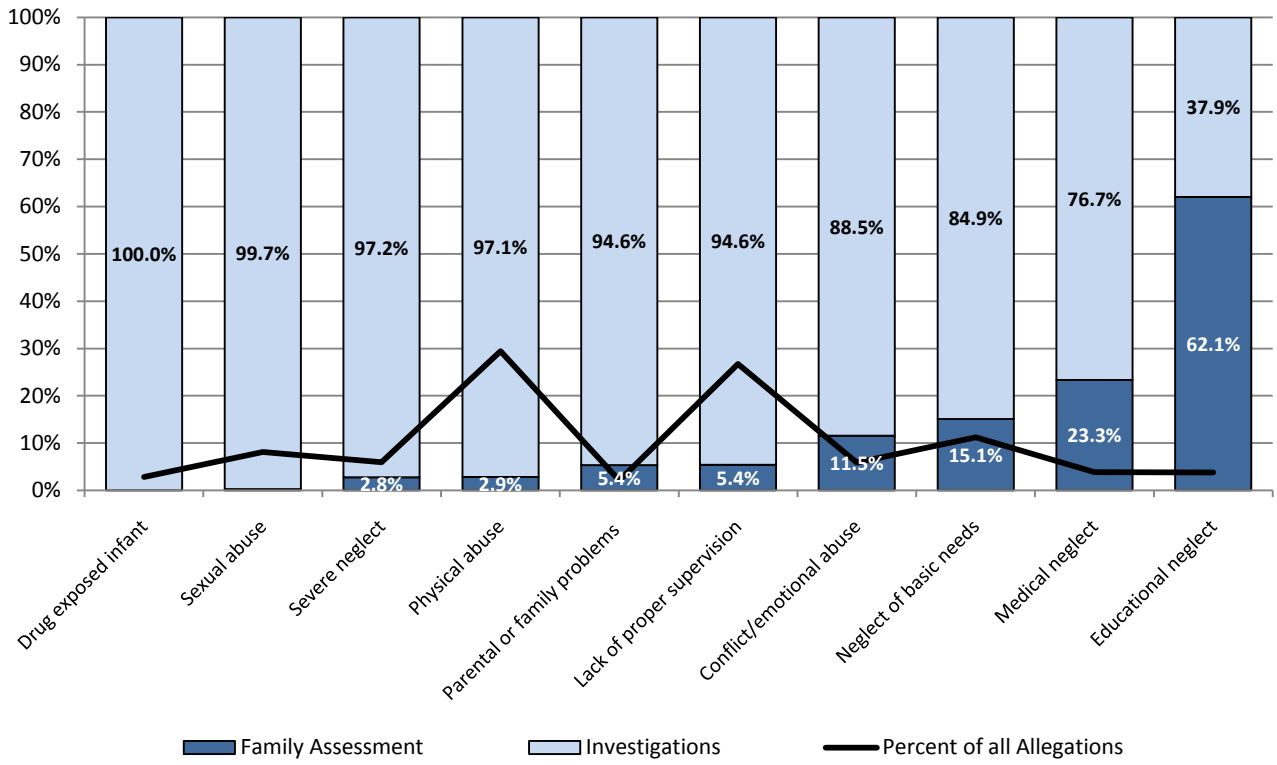


Figure 3.17. Percent of different allegations in reports screened for family assessment versus an investigation and the percent of each type of allegations in all reports, January 2009-July 2010

DR Referrals and Returns

It was apparent from site visit interviews that, with time and experience, case managers and supervisors across all the DR programs have become comfortable with the referrals received from CPS and have growing confidence in their own abilities to address the concerns families present. In most agencies, the communication between CPS and DR has been open and frequent enough to allow questions about a case to be discussed in a timely manner. DR supervisors rarely, if ever, refused a referral based on the content of the report. Cases were only occasionally returned to CPS because the safety assessment revealed that the case was in fact out of the scope of DR capability or authority. As a supervisor in Clark County stated, "We take them, we finish them. We don't refuse them, we don't return them."

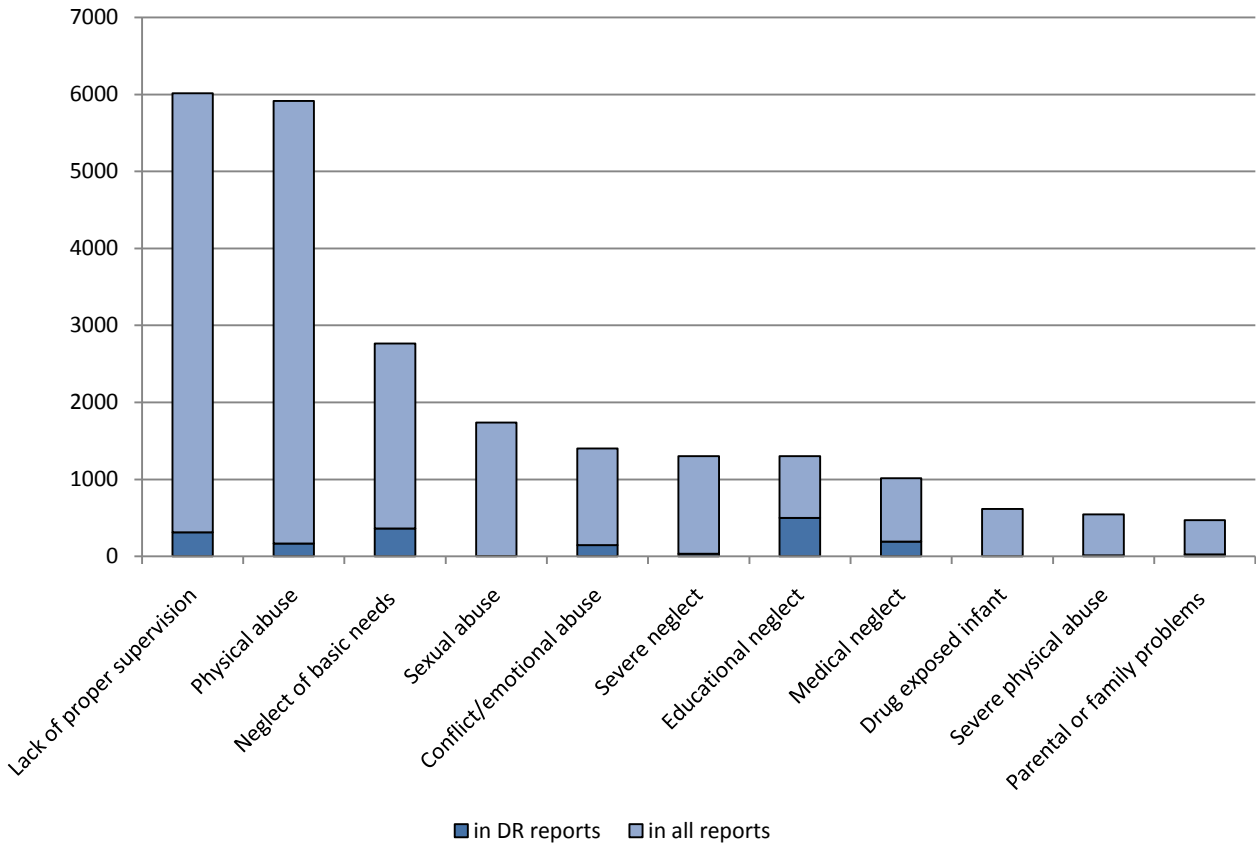


Figure 3.18. Number of specific allegations that received a family assessment versus an investigation (January 2009-July 2010)

Monthly meetings (or in rural counties, telephone conferences) brought together county CPS and FRC staffs to work out kinks in the referral process, review the status of DR cases and caseloads, and address ongoing and emergent issues. Working relationships between DR and CPS were generally reported to be strong in all the districts. A mutual understanding developed that DR workers would contact CPS if anything needed their attention.

> "A lot of the cases we see are those that have been seen [previously by CPS]. Any type of expertise that we can get from individuals [caseworkers] that have worked with the family, we are more than open to that. So I would say that we are in contact once a day." (rural DR worker)

> "We know that if we got into a jam where there is an issue we aren't prepared to handle, or the family needs to know that there is more authority, we get with CPS." (urban DR worker)

If and when CPS was consulted for a possible return, it was more often because the family could not be located or the family initially refused to meet with the DR case worker. In a few cases referrals were returned to CPS when new reports of abuse and neglect were made or when a worker considered a situation too complicated for DR and the family was unable or unwilling to access needed services. More often than not, however, CPS advised the DR worker to close the case at that point if there was no identified safety threat, preferring not to open an investigation.

> "Sometimes we have to conference things with CPS, procedurally, but the advice they give is nothing that we could not have done ourselves. We are required to have contact with CPS in certain circumstances. And the normal response of CPS is "Is the child safe?" And if the child is safe there isn't anything else CPS can do."

DR workers often observed that CPS supervisors would much prefer that the FRC keep a case, rather than have it returned for an investigation, and often strongly encouraged the DR worker to continue to try to engage the family. In the view expressed by both sets of workers this was because CPS understands that DR has the ability to serve these families to a greater degree than they can. As one CPS worker said: "We can't help them; you can help them." However, based on interpretation of state statutes, when certain circumstances in a case (such as the discovery of a very young child in the home) conflict with agency protocols, CPS supervisors might insist on its return.

DR Capacity and Referrals

As noted earlier, the average length of a family assessment case is about 40 days. This means that if the 22.5 FRC-DR workers had full caseloads, and were available to work 9 of 10 days, they could handle about 228 cases per month—22.5 workers x 15 cases x .75(30/40) x .9. As was seen above, the average monthly number of accepted reports is about 1,000. This then means that the current system in the state has the capacity to conduct family assessments on about 23 percent of its reports, leaving 77 percent to be investigated. Except in some rural counties, the actual average percentage, as has been seen, is considerably less than this.

The change in 2009 in the eligibility criteria for DR family assessments (discussed in Chapter 2) was meant to increase the pool of potential DR families, and it did expand the pool somewhat. However, the new criteria did not have an appreciable impact on the proportion of reports screened for DR family assessments. The percentage of such reports remained largely unchanged in Washoe County and in the rural counties and, in fact, actually declined in Clark County, and, because of the size of Clark County, for the state overall. Why?

The Pool of Possibilities. The number of referrals that may be made by CPS intake workers to FRCs for DR family assessments is restricted by state statute and state policy: Family assessments may not be carried out when a child aged 5 years or younger is identified in a maltreatment report as a possible victim of abuse or neglect (state statute) nor when a report is classified as either Priority 1 or 2. Considering all reports from February 2007 through July 2010 in areas covered by the DR pilot project, 22.3 percent were classified as Priority 1, 51.1 percent as Priority 2, and 26.6 percent as Priority 3. Splitting Priority 3 cases into the relevant age groups we find that 5.9 percent of these reports included children under the age of 6 and 20.7 percent included only children who were older. This latter figure, 20.7 percent of reports, is the pool of possible referrals to FRCs for DR family assessments. (See **Figure 3.19**.)

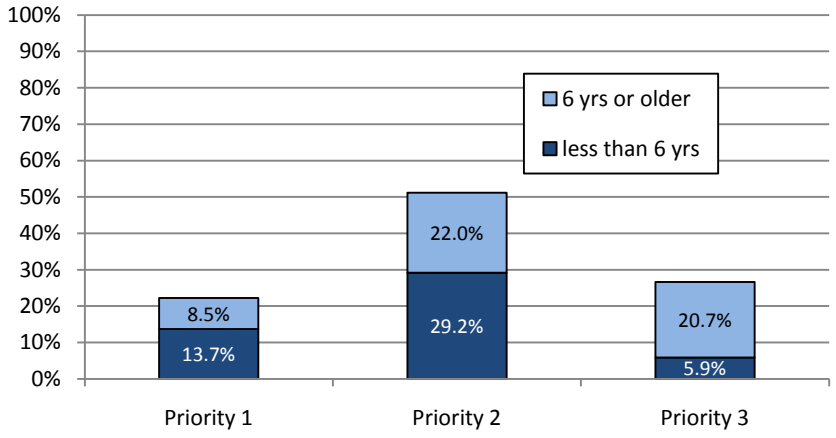


Figure 3.19. Percent of Reports by Priority Level and Age Group of Children February 2007 – July 2010

The classification of reports into priority levels varies somewhat by service area, as can be seen in **Figure 3.20**. Of the three areas, Washoe County classifies the smallest percentage (20.3 percent) of its reports as Priority 3. Clark County classified 26.9 percent as Priority 3 and the rural counties classified a third (33 percent). This may help explain some of the difference among the areas in the percentage of reports referred for family assessments (as was seen in Figure 3.11).

Considering only hotline reports classified as Priority 3, there are differences related to the age of children that also help explain some of the differences among the service areas in referrals for family assessments. As can be seen in **Figure 3.21**, while Washoe County classified the smallest percentage of reports as Priority 3, most of these reports involved children who were older and in which a family assessment could have been conducted. Priority 3 reports in Clark County, on the other hand, were more likely to include children under 5 years of age. In the end, just 18.8 percent

of the reports in Clark County were available for referral to DR based on the minimal criteria for a family assessment.

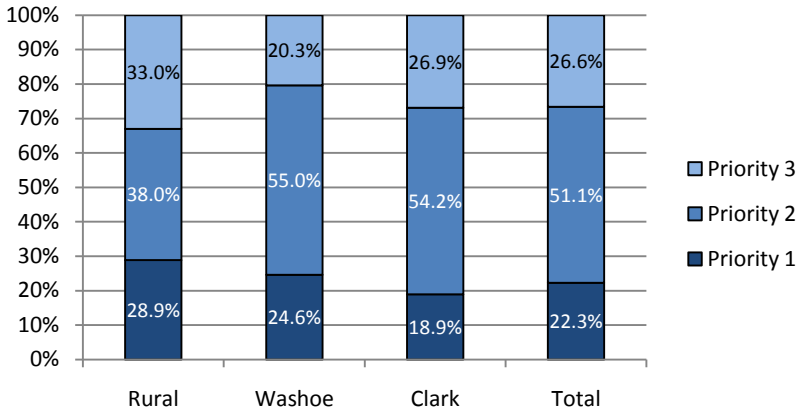


Figure 3.20. Percent of Reports Classified as Priority Level 1, 2, and 3 by Service Area

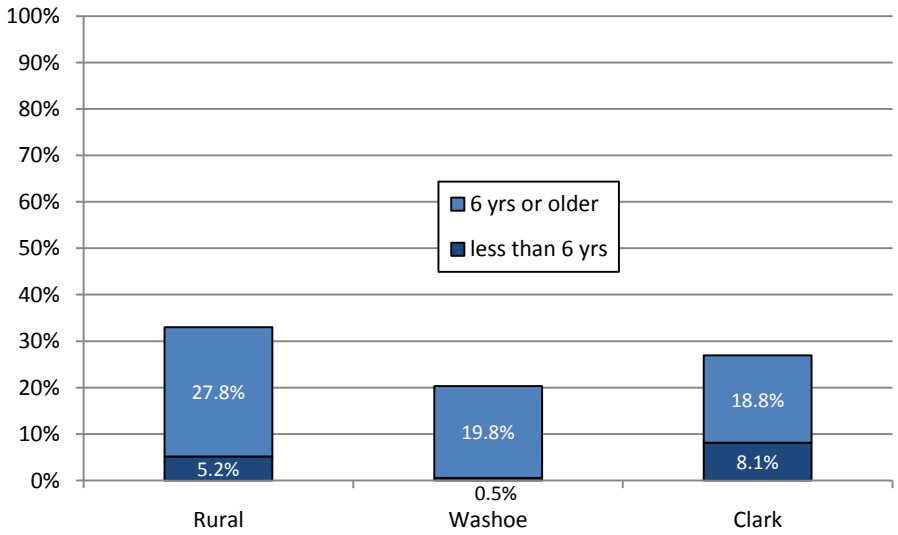


Figure 3.21. Percent of Priority 3 Reports Involving Involve Children Over and Under Age 5 By Service Area

Capacity Limits. Capacity can also be affected by the simple logistics of the referral process. Some reports that might otherwise have received a family assessment response were prevented from doing so because FRC-DR staffs were operating at full capacity at the time, or were thought to be at

capacity. For the most part, this could only realistically have happened much in certain rural counties, where the average number of active DR cases was closer to the 15 case cap. It should not have happened very often in Washoe or Clark, unless there was a lack of communication or bad timing. Even in some rural counties, DR referrals remained low: Nye County reduced the DR case worker position to half time due to insufficient referrals.

Of the five Clark County DR programs visited in August 2010, only one, Boys and Girls Club of Las Vegas in the West zone, reported operating at full capacity. The four other zones have been holding caseloads closer to 12 or 13, with fluctuations through the year. Workers in Clark West attributed the higher numbers in their area to the supportive relationship they have with their CCDFS supervisors and to the special school district that operates year round. From the standpoint of the DR workers and program directors in Clark County, the main barrier to maximizing the services of the DR program was the limited number of reports that fit the criteria for the DR pathway. Workers in Washoe County reported they were operating at close to full capacity during 2009-2010, while previously caseloads were lower. According to the supervisor at the Children's Cabinet, broadening assignment criteria contributed to an increase in volume.

Most, although not all, rural DR workers reported managing caseloads that were usually at or near the full capacity of 15. When evaluators reviewed active DR cases in UNITY, this appeared to be more often the case in Churchill, Lyon and Carson City, and less often the case in Elko and Nye. Elko tended to average caseloads of between 12-14 families, while use of DR in the Nye County, the rural area west of Las Vegas, remained low. Pahrump, a small town of less than 25,000, houses one DR worker at the Nevada Outreach Training organization, a domestic violence service provider and FRC. Originally, this worker was full time and expected to carry a full case load of 15 families. In the past year, however, the worker's caseload regularly dipped below half this number. The primary reason according to the director of the agency, was that many of the families in the area have young children and were precluded from DR. Conversations between the director and the DCFS staff in the Pahrump office suggested that intake supervisors were sending the majority of appropriate reports to DR but finding that fewer than anticipated qualified for the program. Due to the limited number of ongoing referrals, the director opted to cut the DR position to half-time and allow the worker to take on other responsibilities in the organization.

Local Practices and Policies. The manner in which counties prioritize reports lead some reports to be investigated that could qualify for a family assessment. Sometimes it was the expectation of the reporter that follow-up be conducted by CPS and not an FRC. A CPS supervisor in a rural region noted that in small communities, if a family had prior substantiated reports or if a child had a visible mark or bruise, the report was often bumped up to Priority 2. This was also sometimes the case when the report came from law enforcement personnel. State statutes require an investigation

whenever a child “has been placed in custody by a law enforcement agency.” However, there is no statutory requirement that all reports coming to the child welfare agency from police officials be investigated. The statute requires CPS to evaluate the report “to determine if the situation or condition of the child makes child welfare services appropriate or whether the child and his parents may be referred to an agency which provides family assessment services. Such an evaluation must be the practice even when the referral has been made by a professional or official person on the basis of his specialized knowledge.” (NRS 432B.190, par 1) The statute makes the child welfare agency and not the police department responsible for the decision that is made. If key professionals from institutions and agencies within the community with whom child protection professionals interact on a regular basis do not have an adequate understanding of a new program, misunderstandings and misinterpretations can be expected to occur frequently.

Local screening guidelines that are inconsistent with those under which the new program is meant to be operating may also restrict the population of reports able to be referred to DR. For example, Clark County hotline policy and procedures list four examples of what should be considered priority level 2. One example describes “children 6 and 7 years of age live in a home where there is rotting garbage covering the floor.” Another example is a 10-year old who “is regularly left alone for a period of two hours.” These are examples of types of reports that some might consider to be especially fitting for a family assessment.

Evolving Practice

Criteria for selecting reports for DR family assessments were always designed to satisfy dual goals: the safety of children and agency reform. Because DR was to be placed outside of the county DFS agencies, there was initial uncertainty about how to mitigate the risk of diverting accepted reports to community organizations. Involving independent organizations that had not previously been directly responsible for child protection cases was seen by some as a leap of faith. Creating successful collaborations with the FRCs meant that DFS needed to develop trust that DR workers could adequately assess safety and risk, as well as address family concerns. Without assurance that DR assessments would meet both objectives of reform and safety, the criteria for assignment were purposefully limiting.

Over the course of the project, confidence that child safety was not being jeopardized increased within CPS, just as confidence to handle complicated family situations increased among DR workers. At the same time there remained CPS personnel who viewed DR as outside the child protection system and primarily appropriate, as one CPS supervisor commented, for reports in which "the family didn't have a real child abuse or neglect issue."

This last opinion must be viewed in the context of many CPS supervisors and workers who have become more comfortable referring families to FRCs for family assessments. One CPS worker reflecting on cases referred for DR commented: "CPS would have handled these types of cases with the traditional 'knock and talk' and two weeks later would have closed the case. Whereas FRC DR workers are persistent and insist on change or they won't go away."

Chapter 4. Characteristics of DR Families

Before assessing the impact of a new program such as Differential Response it is useful to know something about the families and children most impacted by it, beyond the allegations made by others. This chapter reviews some of the things family respondents said about themselves in the survey conducted for the evaluation. This includes a variety of social and economic characteristics of the families, issues related to child and family wellbeing, and the level of stress and relative isolation reported by respondents. The final section of the chapter is a brief look at issues related to family functioning observed by case workers who worked with DR families.

Social and Economic Characteristics

Household Composition. The households of DR family survey respondents averaged 4.2 members, including an average of 2.4 children and 1.8 adults. A minority of the households, 36 percent, consisted of two parents and their children. More often than not, therefore, these were single-parent households, and three out of four single-parent households were headed by single mothers. At the same time there were frequently other adults living in the households. Most often the other non-parent adult was either a boyfriend or girlfriend of a single parent (14 percent) or a grandparent (12 percent); but the households also included siblings of a parent (6 percent) or friends (8 percent). Altogether, 75 percent of the households included more than one adult.

In describing their household, a few (3 percent) respondents reported no children living with them at the time of the survey. One in four (26 percent) of the households had one child, 32 percent had two children, and 40 percent had three or more. See **Figure 4.1**. The most children in any of the households was eight.

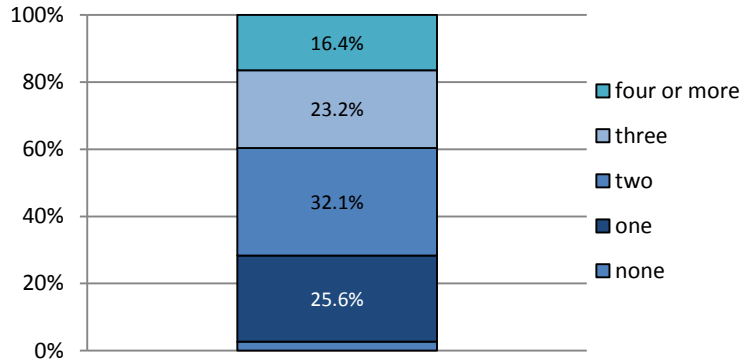


Figure 4.1. Number of children present in DR-FA households

Marital Status. Family survey respondents had a lower rate of marriage and a higher rate of divorce compared with state averages. A little more than a third (35 percent) of those surveyed said they were married compared to 50 percent of adults statewide; and about twice as many reported being divorced as is the case in the state as a whole (27 vs 13 percent). The percent of survey respondents who said they were divorced was higher in the rural counties (36 percent) than in either Clark (24 percent) or Washoe (23 percent) county, while the percent who said they were married was highest in Washoe County (43 percent), followed by the rural counties (37 percent), and lowest in Clark (29 percent). The percentage who said they had never married was highest in Clark (29 percent) and lowest in the rural counties (12 percent); the figure for Washoe was 16 percent.

Education Level. Overall the educational level of survey respondents was lower than state figures for adult residents. A majority of respondents (73 percent) had at least a high school diploma or GED, while over a quarter (27 percent) did not; among the three areas, this latter figure was highest in Clark County (34 percent). Statewide, 17 percent of the adult population does not have a high school diploma, while 83 percent do. Over one in five (21 percent) adults in the population statewide has a undergraduate college degree compared with 5 percent among DR survey respondents; this figure was highest among respondents from Washoe County (9 percent). Three respondents in 10 (35 percent) had had some college courses.

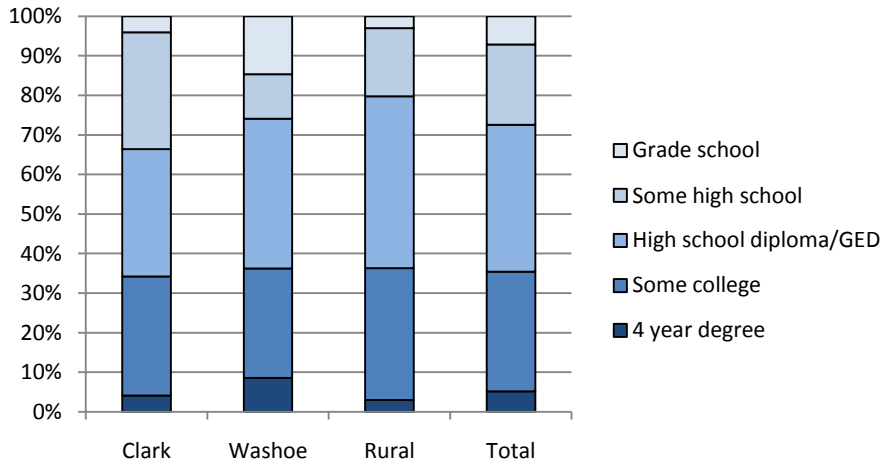


Figure 4.2. Education level of DR-FA survey respondents

Employment. On average, survey respondents were employed less than 6 of the previous 12 months. Less than a third (28 percent) said they had full-time jobs, and another 14 percent said they were working part-time. Less than half (44 percent) said either they or someone else in their household was employed full time. Just 56 percent reported that anyone in their household was employed either full time or part time. As **Figure 4.3** shows, less than half of the respondents from

each of the three areas reported that anyone in their household had a full-time job, and less than 60 percent in each area reported any household member had employment of any kind.

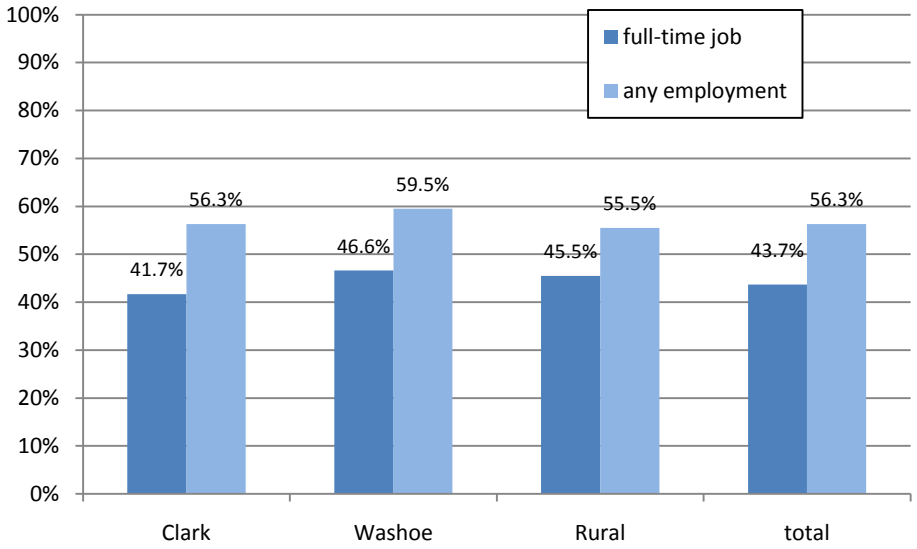


Figure 4.3. Percent of DR-FA households in which anyone had a full-time job or any employment

Income. All but a few of the families reported having very low household incomes, this includes income from all sources including employment, public assistance, social security and other sources. About one in five families reported a yearly income of less than $5,000. Nearly half (48 percent) said their total household income during the previous 12 months was under $15,000. This is $3,310 less than the 2010 Federal Poverty Guidelines for a family of three and $7,050 less than the poverty level for a family of four. Across the state of Nevada, about 10 percent of families have incomes less than $15,000. More than 9 out of 10 families in the survey population reported an income less than the state's median family income of $56,432 (2008). Moreover, nearly 6 in 10 (59 percent) respondents said their income had decreased in the past year. The income distribution for all families surveyed is shown in **Figure 4.4**. While there were some differences in household incomes in different parts of the state, the differences among the families surveyed were not large. (See **Figure 4.5**.)

Public Assistance and Income Support. Given the low income of many of these families, it is not surprising that many received various forms of public assistance and support. Just over half (54 percent) had received food stamps within the last 12 months and children in 40 percent of the households participated in school meals programs. One in five (21 percent) households included a member who was receiving social security disability payments. (See **Figure 4.6**.)

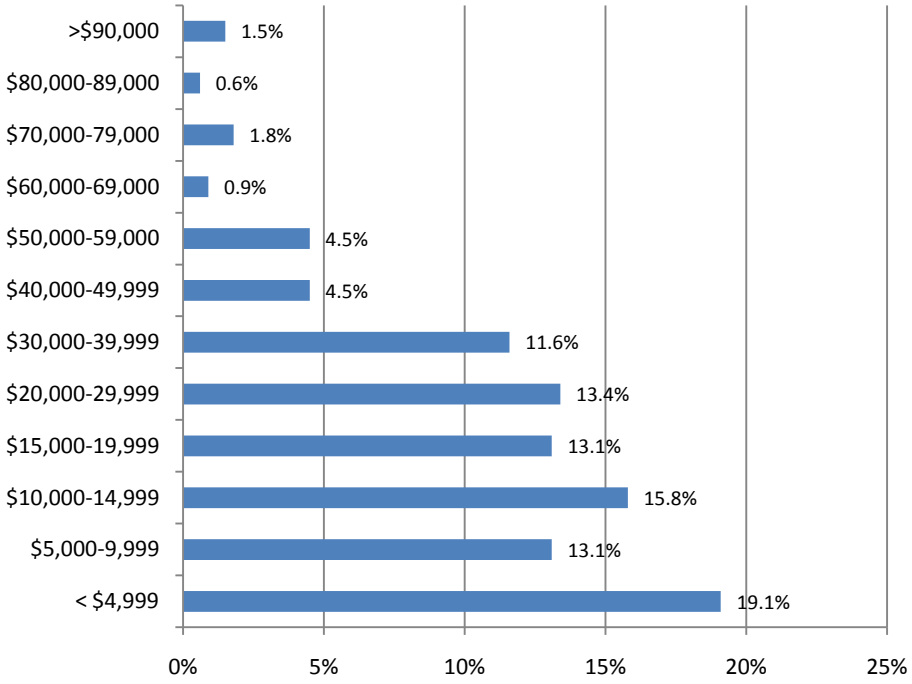


Figure 4.4. Distribution of household income of DR-FR families

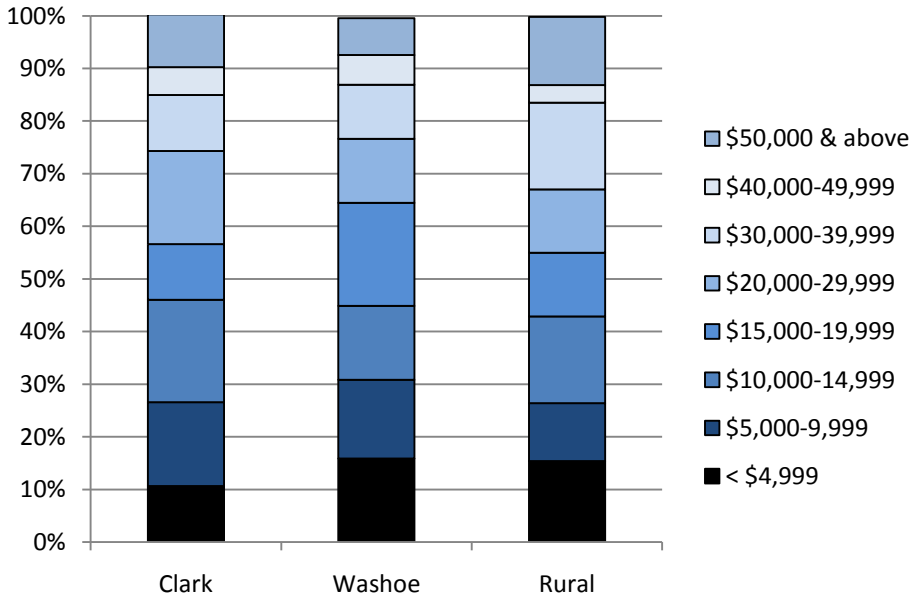


Figure 4.5. Distribution of household income of DR-FR families by region

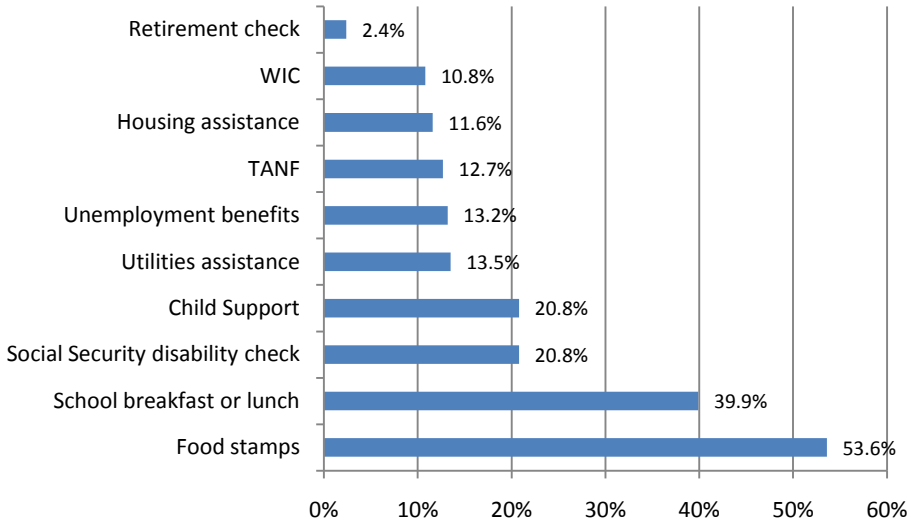


Figure 4.6. Percent of DR-FA households receiving public assistance and other support payments in the last 12 months

Housing. Just under half (45 percent) of family respondents said they had changed their residences within the past year. This figure was higher in Clark County (54 percent) than in Washoe County (45 percent) or the rural counties (37 percent). Among all respondents, 10 percent said they had changed their residence three or more times in the past year (15 percent in Clark, 8 percent in Washoe, and 6 percent in the rural counties) and 13 percent said they had changed their residence two times in the last 12 months (17 percent in Clark, 10 percent in Washoe and 11 percent in the rural counties. The relative impermanence of residence for many of the families is reflected in **Figure 4.7**. When asked how long they had lived at their present address, 47 percent said one year or less; among Clark County families this figure was 56 percent, compared with 41 percent for families in Washoe and the rural counties. Seventy-one percent of families from Clark County reported living at their current address for two years or less; for the rest of the state this figure was about 60 percent.[8]

Among all respondents, 81 percent said they were satisfied with their current living arrangements. The others, about 1 in 5, described their housing as unsatisfactory, with a small number reporting their housing conditions to be "unacceptable." The percentage who reported satisfaction with their housing was somewhat higher in rural Nevada and lower in Clark County.

[8] The relatively frequent changes of address helped explain the difficultly evaluators had in reaching many families with a mailed survey.

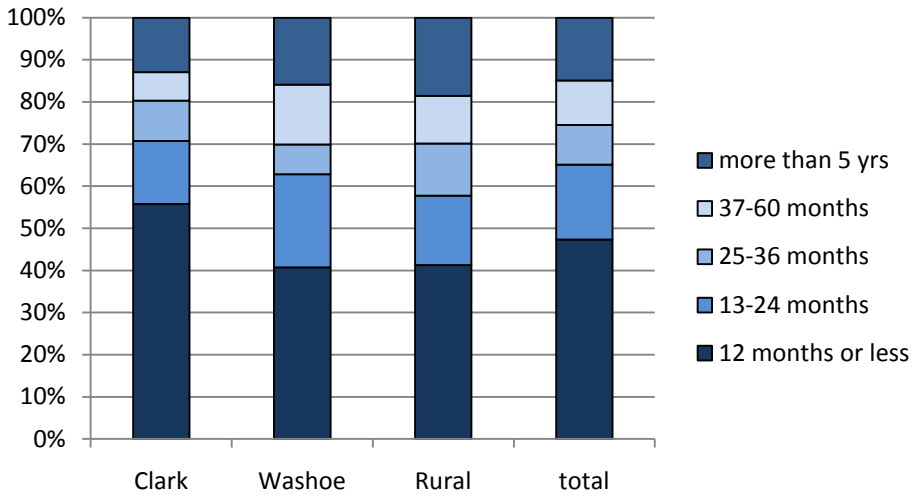


Figure 4.7. Length of time DR-FA families had lived at their present address

Health Insurance. A minority of children in the families surveyed, 23 percent, had no health insurance coverage at all according to survey respondents. Of those children with insurance, over half (52 percent) were reportedly covered through Medicaid and 26 percent through their family's private insurance policy. Among the respondents themselves, over a third (35 percent) said they had no health insurance and 39 percent said they were covered under Medicaid, and the rest (26 percent) said they had private insurance coverage.

Child Well-being

The well-being of children is the basic consideration for CPS. Frequently a variety of psychological, behavioral and health-related problems and conditions are found in children in families with reports of child maltreatment. Sometimes these problems are the result of maltreatment by an adult, sometimes they are related to poverty conditions in which the family lives, sometimes they occur or become chronic conditions due to ignorance of child development on the part of parents who may themselves be only recently out of childhood. For CPS, both the problems and their causes are important to discover so that appropriate remediation can occur.

In the survey, family caregivers were asked about a variety of problems and conditions and whether they were present among any of the children in their household. Frequencies of reported problems are shown in **Figure 4.8**. Respondents most often indicated that one of their children acted out to get attention (34 percent) and had trouble learning in school (29 percent). Significantly, a quarter (26 percent) said a child in the family acted in ways that were difficult to control and 21 percent said a child acted aggressively. Among other behavioral problems reported, 19 percent of

caregivers said a child in the family had a hard time getting along with teachers and with other children in school. One respondent in five (20 percent) said a child in the family missed school often and 16 percent said a child refused to go to school. Nearly one in 5 (18 percent) said a child engaged in occasional delinquent behavior.

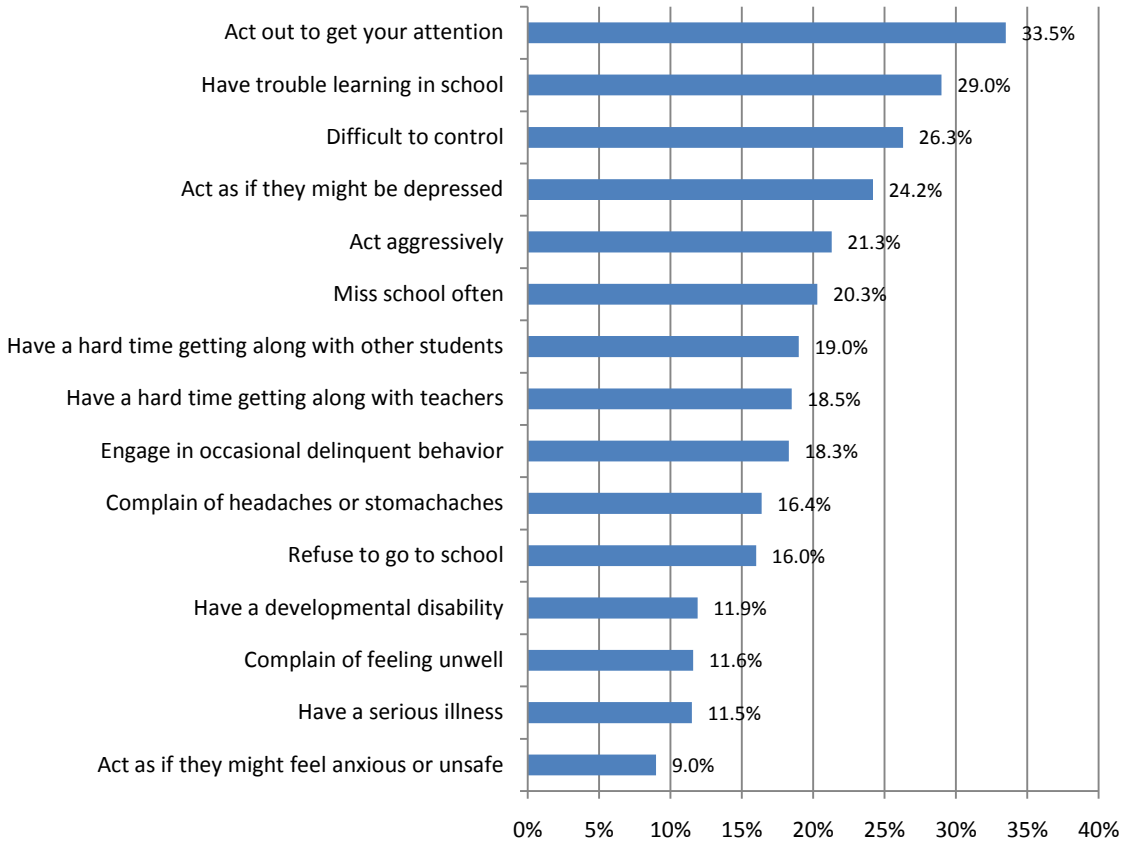


Figure 4.8. Percent of DR-FA survey respondents who report children with particular problems

Respondents also reported indicators of emotional and physical problems among their children. Nearly one in four (24 percent) said a child acted as if he or she might be depressed and 9 percent reported a child was anxious or acted as if he or she felt unsafe. A number of respondents said a child complained of headaches or stomachaches (16 percent) or otherwise complained of feeling unwell (12 percent). Twelve percent of respondents said a child in the family had a developmental disability and the same percentage described a child as having a serious illness.

About a third of the families surveyed reported none of these problems or conditions were present. Among those who did report problems, clusters of three to five conditions were common, particularly those involving behavioral and emotional issues. All of the problems listed in the figure are indicators of potentially serious matters that threaten the well-being and even safety of children and indicate the need for some form of intervention, assistance or remediation.

Caregiver Stress, Isolation and Support

Challenges with employment, housing, meeting basic needs, and problematic behavior of children translate into emotional stress for many of the families. In the survey families were asked about the general sources of stress in their lives. Their responses can be seen in **Figure 4.9**. As can be seen, many reported high levels of stress related to their economic outlook and their employment situation. Although less acute in their reporting, over half also expressed some level of stress related to their relationships with other adults and their children and with the overall well-being of their children. Given the problems faced by many of the respondents, as evidenced by data already discussed in this chapter, the levels of stress displayed here do not appear surprising; nonetheless, because the wellbeing of children is directly affected by the wellbeing of their caregivers, the sources of stress of parents cannot be ignored.

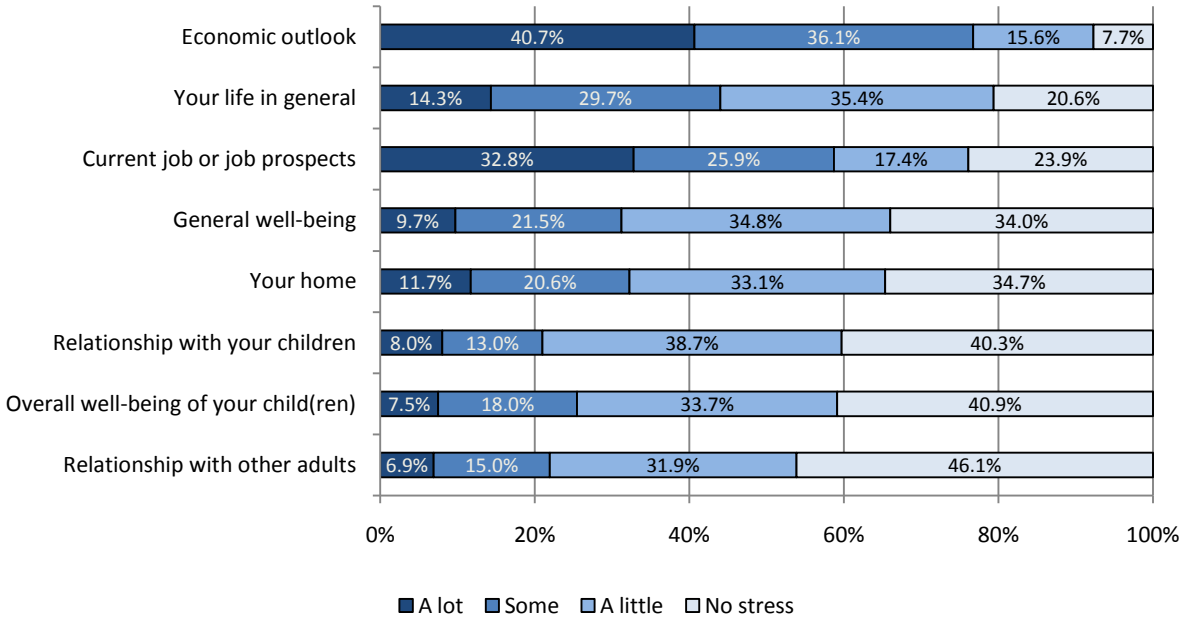


Figure 4.9. Sources of stress reported by DR-FA survey respondents

In the survey, caregivers were asked a series of questions concerning the support and assistance available to them. Questions explored whether the caregivers had anyone to turn to for financial help, practical assistance, or emotional support. As can be seen in **Figure 4.10**, about half said that there was generally someone they could turn to for emotional or practical assistance when they needed. Least available to most was someone to who could help them financially. Beyond this, the main issue would seem to be those individuals, between a quarter and a third of respondents, who indicated they never or only rarely had someone to help them when they needed help, whether their need was practical, such as transportation or child care, or emotional.

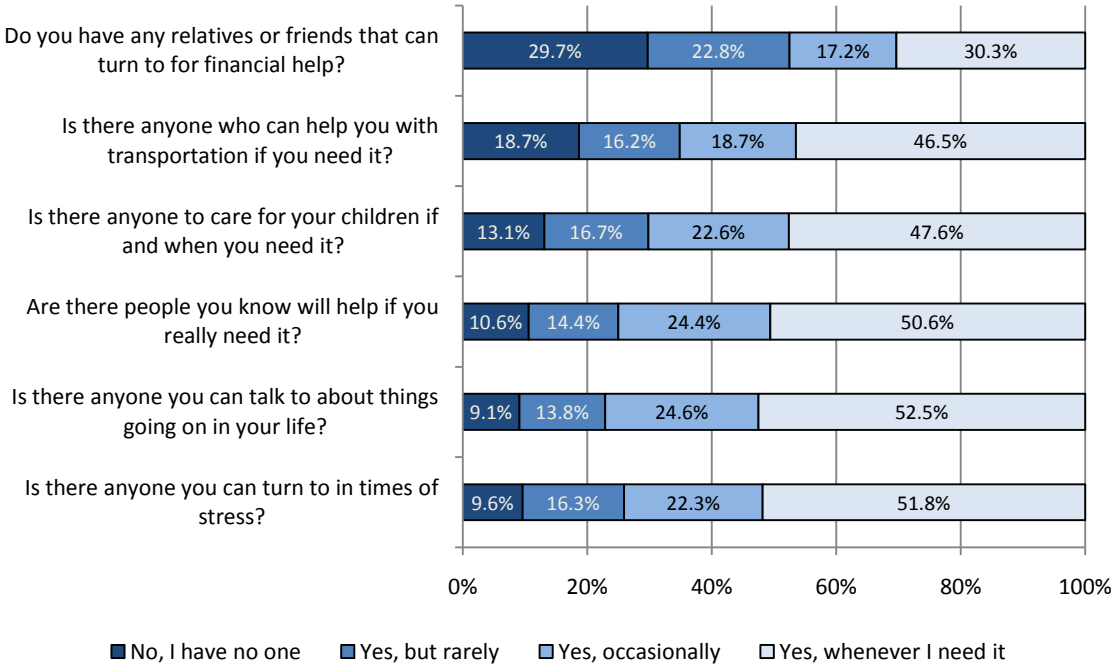


Figure 4.10. Sources of support reported by DR-FA survey respondents

Family Functioning: Views of Workers

In the case reviews, DR workers provided a wide range of information about the nature of their work with families. The assistance provided to families by the workers followed an assessment of need, a joint process between the worker and family members. What workers found in this assessment was meant to guide their work with families, but it also provides a view into the lives of these families.

Figure 4.11 shows the percent of families in which workers identified specific areas of family needs that represented potential risks to children. The first six items in the list, those most frequently noted by workers, are an echo of what family respondents themselves reported about problem areas related to their children—issues related to the difficulties of parents controlling the behavior of their children, problems related to school attendance and a child's work in school. Also in the upper half of the list are problems associated with financial difficulties and poverty: unemployment, lack of income, problems providing sufficient food and clothing, the structural soundness of the family's residence, the family's inability to pay their rent or utility bills. The presence in some households of issues related to mental health, physical health, developmental disabilities and the stability of relationships can also be found.

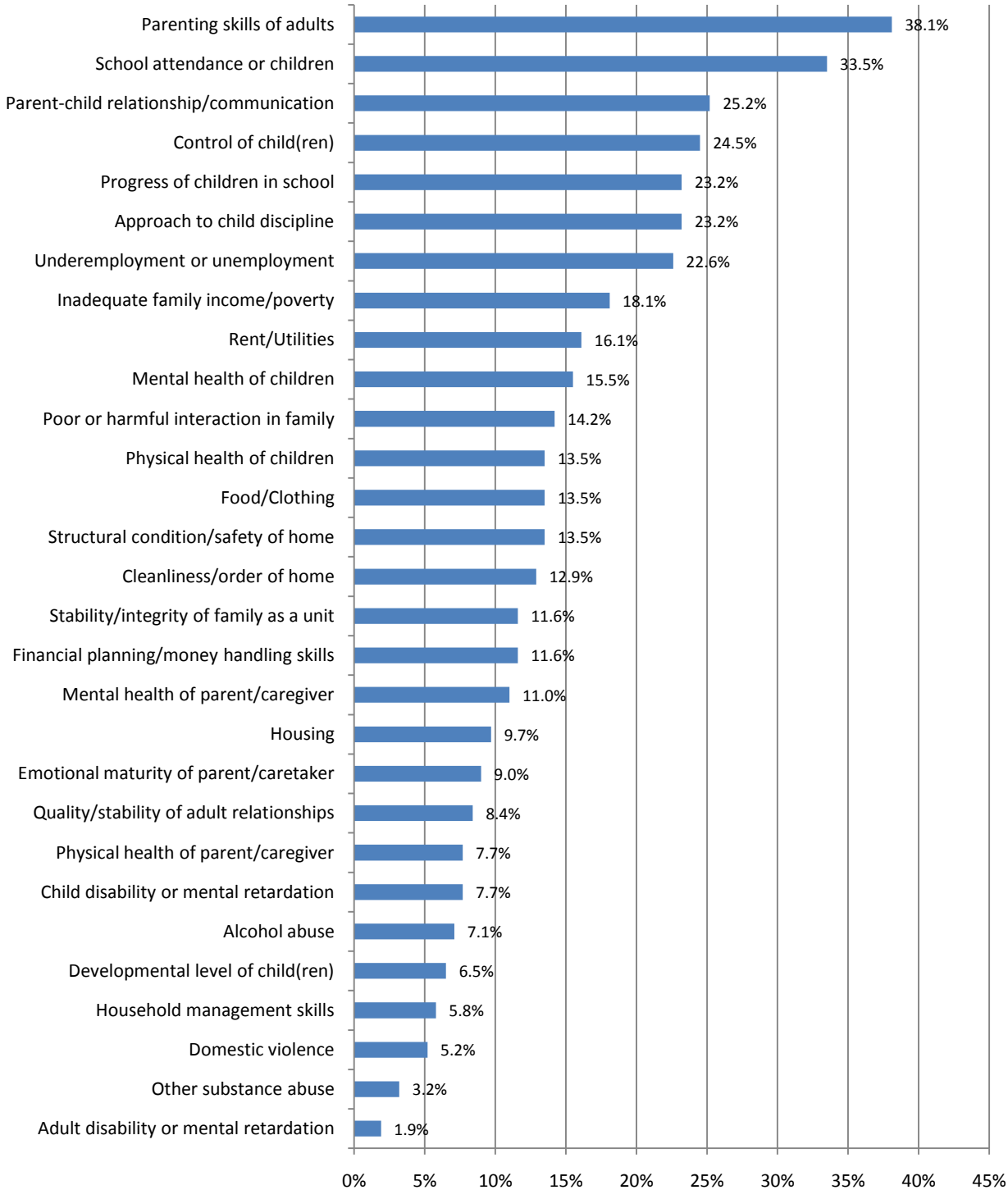


Figure 4.11. Family functioning problem areas and risk conditions identified by DR-FA workers

Summary

Overall, DR families were poorer and less well educated than other families in the state. A majority of the families were headed by single mothers and only a minority of households had anyone with a full-time job; in more than 40 percent of the households there was no one in the household with a job, whether full-time or part-time. Nearly half said their total annual household income was under $15,000, well under the 2010 Federal Poverty Guidelines for a family of three or four. More than 9 in 10 DR-FA families reported an income below the state's median family income of $56,432 (2008) and a majority said their income had decreased in the last year. Over half of the DR households received food stamps, a common proxy measure for poverty, and their living situations were considerably less stable than other residents. Many of the families reported a number of concerns about their children, who often had trouble learning in school, missed school often, were depressed, acted aggressively, and/or were difficult for their parents to control. A significant minority of children were described as being or acting unwell, or having emotional or developmental conditions of concern. Parents often described being stressed, for emotional or financial reasons, and concerned about the wellbeing of their children. Many parents said they were relatively isolated socially and had few friends or relatives to turn to for help. All of these factors are indicators that many DR families have problems or conditions associated with poverty, whatever its cause. Similarly, case workers identified numerous conditions related to family functioning that represented risks or threats to the wellbeing of children.

Chapter 5. Differential Response Practice, Part 1: Family Engagement

As described in the introductory chapter, the differential response model of child protection implemented in Nevada has two basic components. The first involves the manner in which families are approached, the second involves how children and their families are helped. The objective of the first component, examined in this chapter, is to learn enough about the family's situation, problems, strengths, and needs that effective intervention can occur and children made safer now and over the longer-term. The nature of the intervention, the model's second component, is the focus of the following chapter, while the effects and effectiveness of the Nevada DR program are examined in succeeding chapters.

Family Survey Data

In this evaluation, as in former ones of differential response programs conducted by IAR, the family survey instrument was a crucial source of data on whether the family assessment approach was implemented in a manner consistent with the model. A specific set of items were included in the survey specifically for this purpose. These questions were:

1) Overall, were you treated in a manner that you would say was friendly?
2) Were you involved in the decisions that were made about your family and children?
3) Did the worker who met with you listen to what you and other family members had to say?
4) Did the worker who met with you try to understand your family situation and needs?
5) Were there any matters that were important to you that were not discussed?
6) Who was present during the family assessment?

The first five questions in this list asked families to give their judgment or assessment about aspects of their encounter with an FRC case worker during a DR family assessment. The items were constructed as measures of specific aspects of the model (as presented in the Introduction). The same is true for the sixth question, which asks who was present during the meeting with the case worker. When coupled with the information on the composition of the household, this allows a relative measure to be made of whether the worker met with the entire family as a unit. Finally, the survey asked respondents to describe their emotional response to the first meeting with the case worker. This item is important in its own right but also provides a validity check on responses to the specific items about the DR protocol.

Friendliness. A key part of the family assessment approach is approaching families in a friendly, non- accusatory manner from the very first encounter. A very high percentage (98 percent) of

family respondents said they were treated in a manner that was friendly and three out of four (77 percent) described their treatment as "very friendly." Only a few of those completing the surveys said the worker had been unfriendly and none said a worker had been "very unfriendly." This response pattern was found across the state among all families who received a family assessment; no differences were found among families in Clark, Washoe, and the other, rural counties. (See **Figure 5.1**.)

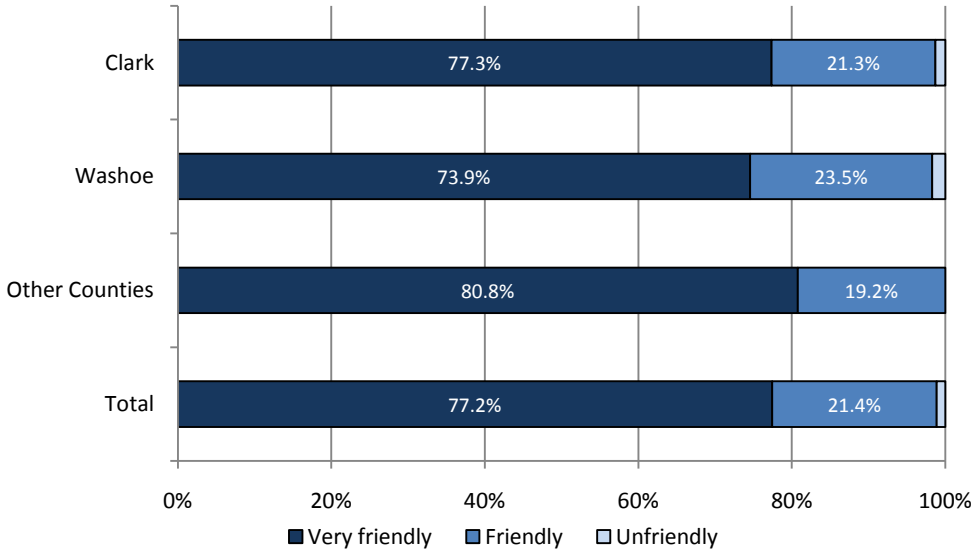


Figure 5.1. Question: Overall were you treated in a manner that you would say was friendly or unfriendly?

In the survey instrument, families were asked to provide any comments they may have about their experiences with the FRC DR worker. Nearly half of respondents did, and their comments generally reflect largely positive tone of the data in the previous figures, although with a more personal touch. Many commented specifically on the friendliness of the worker. Often these were very brief remarks, such as "[the worker] was kind and friendly, very easy to talk to and helpful." Or, "She was very kind, an unexpected experience." Another example: "The social worker was very kind and compassionate and made my children feel comfortable." Many respondents had positive things to say about the FRC case workers who came to their house and named the worker: "[_____] was wonderful. She was supportive and caring yet informative as well. She was very helpful." Case workers were frequently said to be "respectful," "polite," "pleasant," "nice and professional," "courteous," and "not insulting." A small number of family survey respondents had negative reactions, such as those who wrote that their case worker was a "very poor communicator" or "called late on a work night." But, although one commented the worker made her "irritated," more were impressed by the workers who they described as "one outstanding person" or "a good person."

As was done in the previous chapter, it is possible to add some perspective to interpreting the survey answers of families by comparing their responses to families in other states. As before, **Figure 5.2** provides the responses of families in three states in addition to Nevada who have received the family assessment approach to the question about the relative friendliness of their treatment. And again, as can be seen, the reaction of Nevada families has been as positive, if not more positive, than families surveyed in other studies.

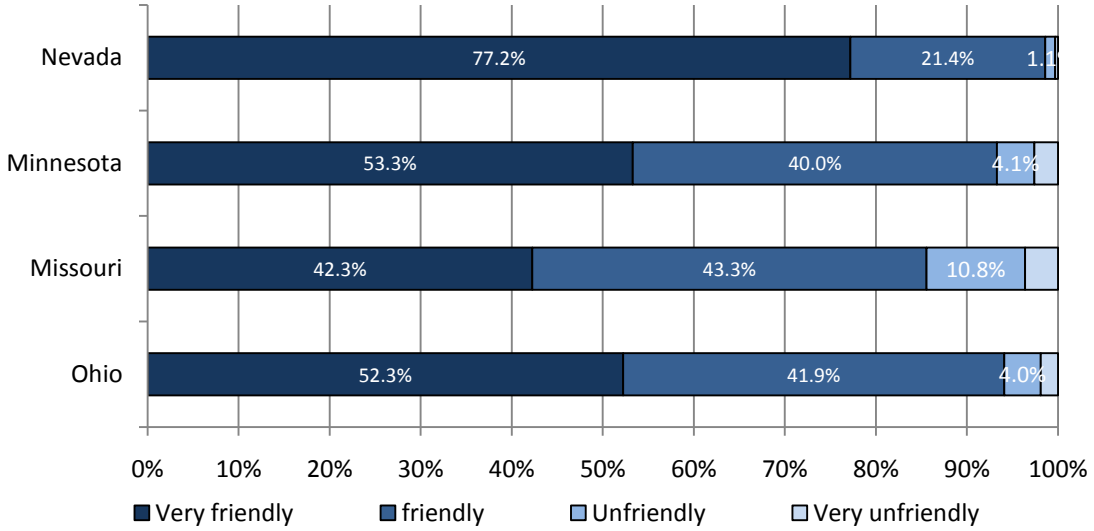


Figure 5.2. Question: Overall were you treated in a manner that you would say was friendly or unfriendly?

Approaching families in a friendly manner became a part of the original differential response model in Missouri where the Division of Family Services was being criticized as often being unnecessarily heavy handed and authoritarian in its treatment of families. Picking up this model component, CPS agencies in other states began talking about treating people as you would want to be treated. A state administrator who coordinated the Minnesota DR pilot project argued, "If you can achieve the same results by being friendly as you can by being threatening, why wouldn't you want your social workers to be friendly to people." But, as the Minnesota and other DR pilot projects have demonstrated, you can often accomplish better results by being friendly.

One of the reasons for approaching families in a friendly manner is to gain their cooperation and participation in the assessment process. One of the frequent effects of an investigation is to place families on the back heel, and the natural reaction of many people in such circumstances is to become defensive and, as one mobster said to another when arrested, "clam up." In most instances, real improvement in the situation of families and the welfare of children is unlikely to happen without their willing involvement. A Minnesota family assessment worker commented: "A

family assessment takes pressure off of families and lets them take more responsibility for their actions so they work with us in fixing a problem without getting defensive from the start and being court-ordered." Another said, "Unless you can build an atmosphere of trust, nothing's going to change….Family-driven goals are more effective than the agency deciding what should happen."

Listening and Understanding. Beyond being friendly, the possibility of effective intervention requires the worker to have full and accurate knowledge of the family's situation and of the family's strengths and needs. Building trust and providing help that is needed requires listening. In the family survey we asked if the worker who met with them listened to what family members had to say. Most (91 percent) of the family respondents said the worker listened to them "very much." And 88 percent said the worker tried to understand their family's situation and needs. Very few criticized workers about this. (See **Figure 5.3**.) Most (92 percent) respondents said that all matters important to them were discussed. There were no differences of consequence in these responses among families from different parts of the state.

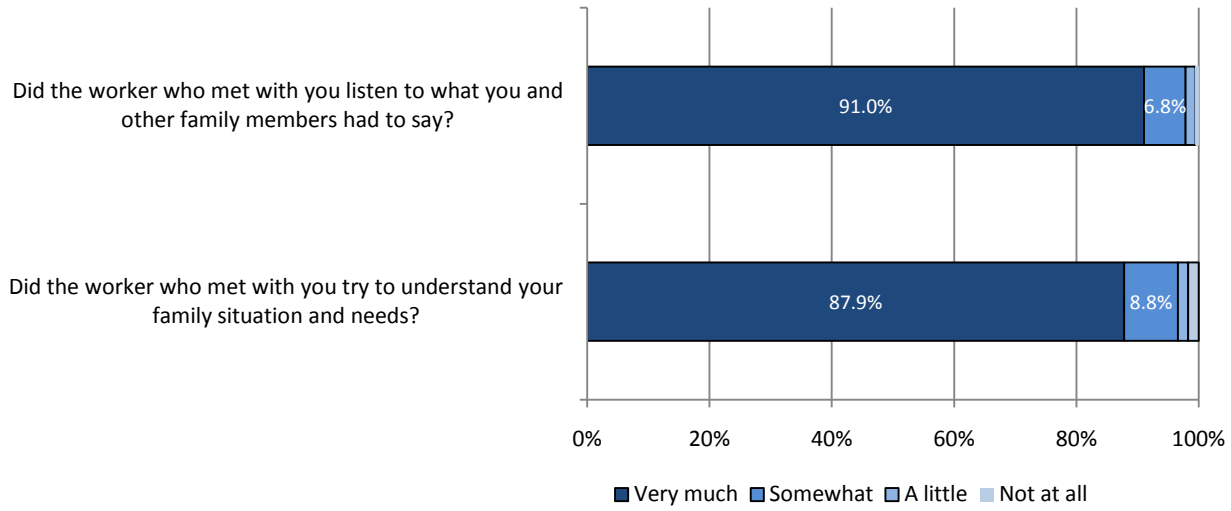


Figure 5.3. Percent of families who said their worker "listened" to them and tried to "understand" their situation and needs

Comments of respondents indicated they appreciated workers who listened to them and tried to understand their point of view and situation. One wrote that the family assessment was "a pleasant experience. I did not feel like I was judged before they knew me or my family or the situation." Another said the worker was "very caring, understanding and helpful. She listened and understood our situation." Still another said the case worker "listens, explains, is very knowledgeable and doesn't jump to conclusions." One case worker was described as "a credit to his profession…upbeat, concerned, and demonstrates a willingness to listen and help families." Finally,

one respondent wrote the case worker "would let you vent and then give advice. [She was an] irreplaceable lady."

Decision Making. Two-thirds (67 percent) of DR families said they were involved in the decisions that were made about their family and children. Another 16 percent said they were "somewhat" involved in such decisions. A small number (3.5 percent) said they were only involved a little or not at all in decisions that were made. A little more than 1 in 10 (13 percent) said no decisions were made. (See **Figure 5.4**.) The participation of family members in the assessment process, especially taking responsibility and being involved in decisions that are made about what to do next, is a critical component of the family assessment model. It is an iron law of group dynamics that people who are involved in making a decision become more vested in its enactment, especially if it affects them personally. The results regarding decision making are positive in themselves. And, again they are very similar to findings from evaluations of DR in other states.

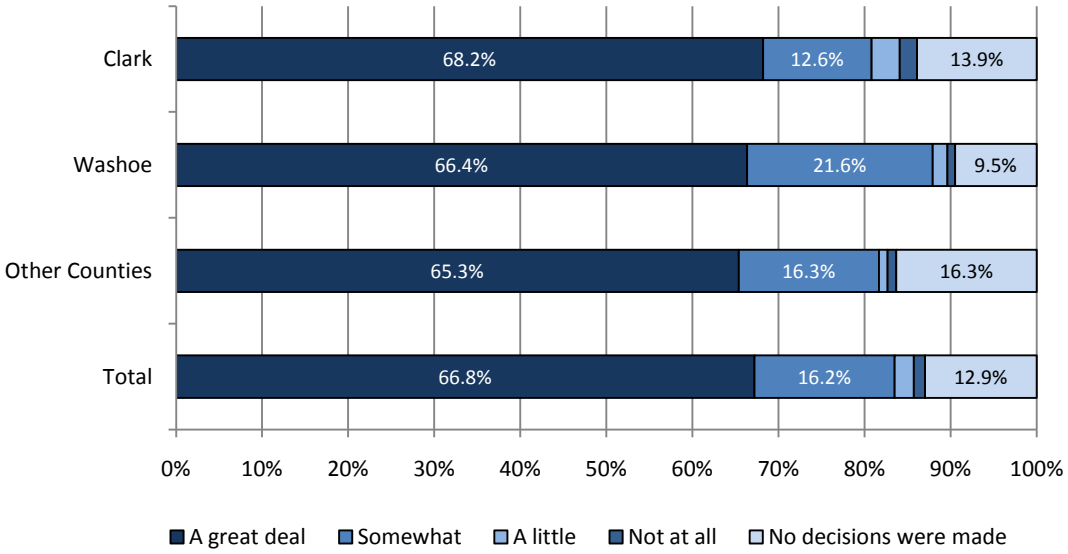


Figure 5.4. Question: Were you involved in decisions made about your family or children?

Family Members Present during Family Assessment. Part of the DR model as developed in Missouri and Minnesota involves treating the family as a unit, and this includes attempting to meet with all household members together at the first visit. There will be situations in which, given the allegations in a report, a worker may be concerned about the safety of children or of a spouse, and exceptions may be made. This does not appear to be a high priority in the Nevada approach. **Figure 5.5** shows the difference between household members and participants in family assessments. Thirty-six percent of DR households included two parents and 28 percent of family assessments were conducted with two parents present; this means that in 8 percent of the households there were two parents but only one met with the DR worker on her/his initial visit. If

other relatives lived in the households (most often grandparents), they participated in the family assessments most of the time (16 percent vs. 18 percent). Similarly, nonrelative household members (such as boyfriends or other friends of the parents) generally participated in these meetings. Children were present in 70 percent of family assessments. Fourteen percent of the time the only member of the household present was one parent, usually the mother of the children. Thirty percent of the time family participants consisted of one parent and her/his children.

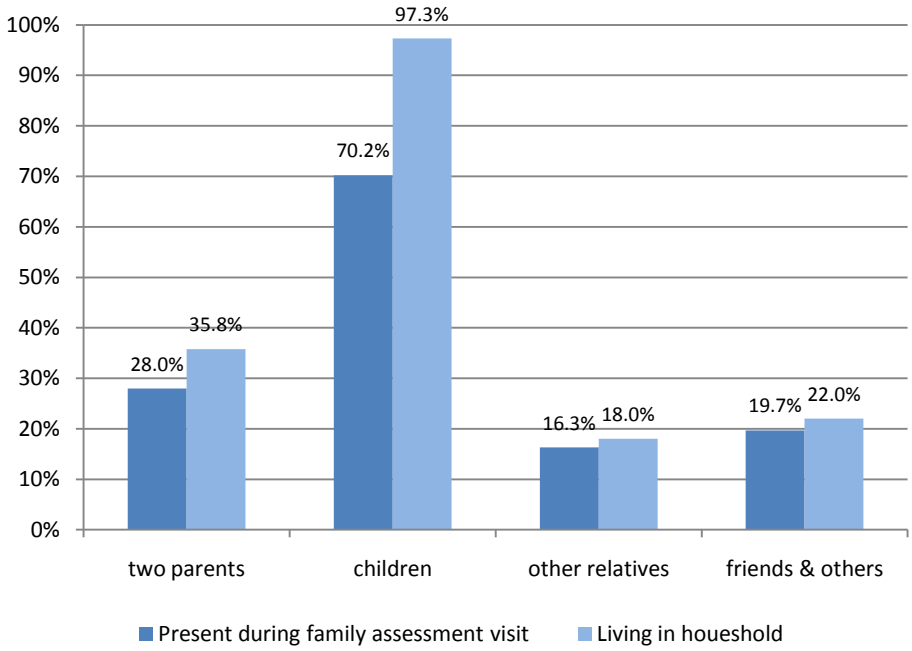


Figure 5.5. Types of householders and participants in initial family assessment meetings

Emotional Response. One of the ways we measured the approach of workers in the family assessment was through the emotional reaction of families to what can be a difficult experience for them. We asked family respondents to describe their feelings at the end of the first visit from the worker. We ask them to do this by selecting from a set of descriptive words, half positive and half negative, that reflect their feelings at the time. In the instrument, the positive and negative descriptors are interspersed.

The list of descriptive words from the family survey instrument, grouped by those that are positive and those negative, can be seen in **Figure 5.6**. This figure shows the percent of family respondents that selected each descriptor. As can be seen, reports of positive feelings outnumbered those of negative feelings by a large margin. Families most frequently reported feeling thankful (about 4 in 10). One in three reported feeling positive, helped, grateful, hopeful and relieved. The most frequently selected negative feelings were stressed and worried. However, these negative descriptors were selected by fewer families than reported any specific positive feeling. Differences

among respondents from different parts of the state were generally minor. Coupled with other family responses, described earlier in this chapter and in Chapter 5, this suggests there is a great deal of similarity in the manner in which family assessments are being conducted by Family Resource Centers across the state.

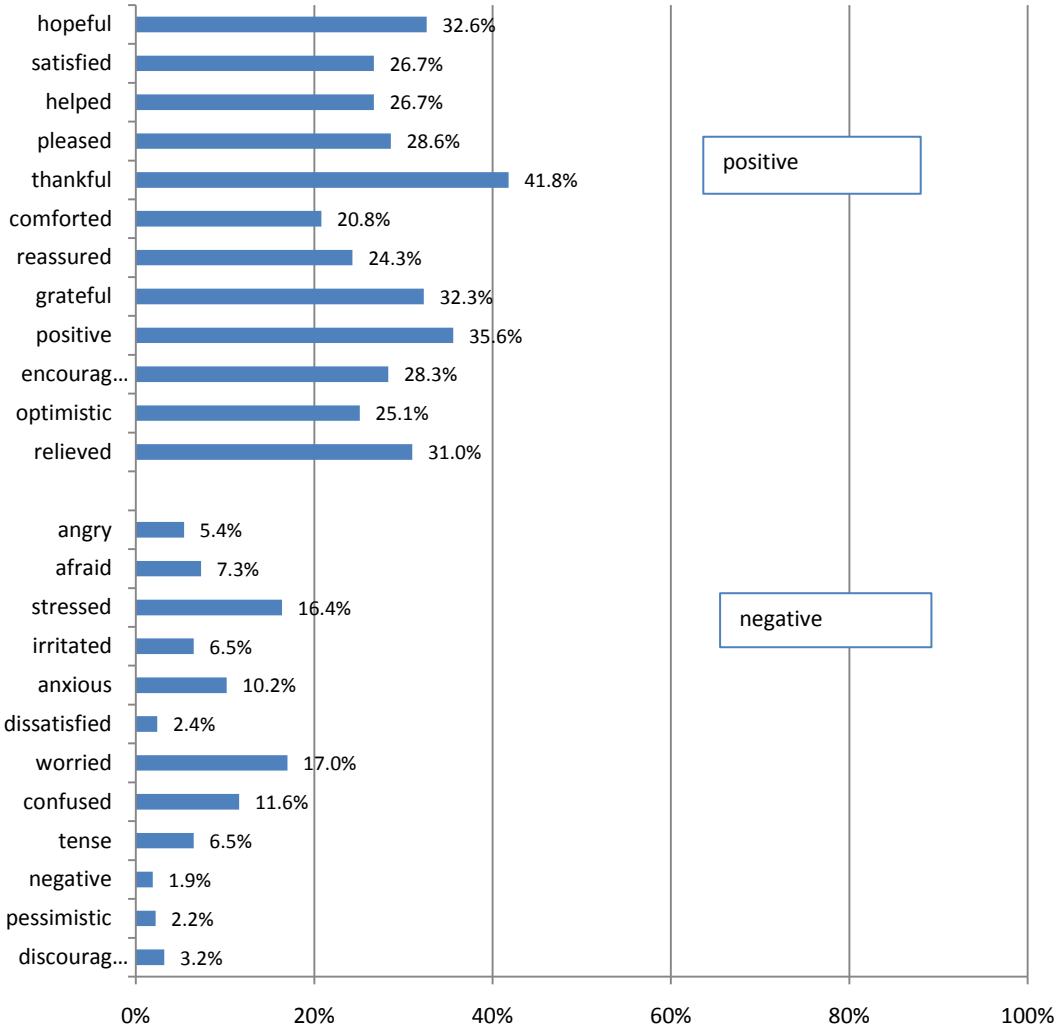


Figure 5.6. How family respondents described their emotions Following the initial family assessment visit

The results on the emotional response scale among Nevada DR families are similar to findings from our evaluations of the Minnesota and Ohio differential response pilot programs. (See **Figure 5.7**.) In those studies, we found families who received a family assessment to be significantly more likely to report positive reactions and less likely to report negative reactions than those receiving traditional investigation. ($p<.05$) In the Minnesota evaluation, for example, DR families were significantly more likely to feel relieved, hopeful, helped, pleased, reassured, and encouraged.

Control families who received traditional investigations were significantly more likely to report that they felt angry, afraid, irritated, dissatisfied, worried, negative, pessimistic and discouraged.

In fact, as can be seen in Figure 5.7, the response of Nevada DR families tend to be even more positive and less negative than families in the other two states. Again we can ask: Why is this? And the two possible reasons suggested in the previous chapter would seem to apply: 1) Nevada's criteria are more conservative than what is used by the other two states and tend to screen in a higher percentage of less severe reports overall. And, 2) Nevada relies on community organizations to conduct family assessments and FRC workers bring a fresh, social worker perspective to their encounters with families.

The comments of a number of families described a situation that was initially difficult for them but that was transformed by the case worker. One wrote:

> "This was a hard situation to have someone from any office show up to discuss the care of your children. It's nerve racking, but the worker was very good at explaining why she was there, how the process worked, and she listened to me. Overall this experience was supposed to be very uncomfortable and high stress but she made it the complete opposite. I am thankful for that."

Others made similar comments.

> "I was angry at first but was happy at the end that [_____] was able to help. I am glad she came into our lives."

> "I was so scared about this situation. An experience like this is very stressful. [_____] made me feel comfortable and relaxed and was very respectful."

> "The visit I received was unexpected and shocking. But overall, it worked out to be a benefit and even a blessing to meet my caseworker."

One respondent seemed to pick up on the survey question that asked families to select adjectives to apply to themselves when visited by a worker. She created her own list about her case worker:

> "[_____] is wonderful, compassionate, responsible, trustworthy, concerned, hardworking, honest, kind, resourceful, available and full of knowledge. He's been a blessing to me and our family during this difficult past year. He kept trying until we got help for [our daughter]."

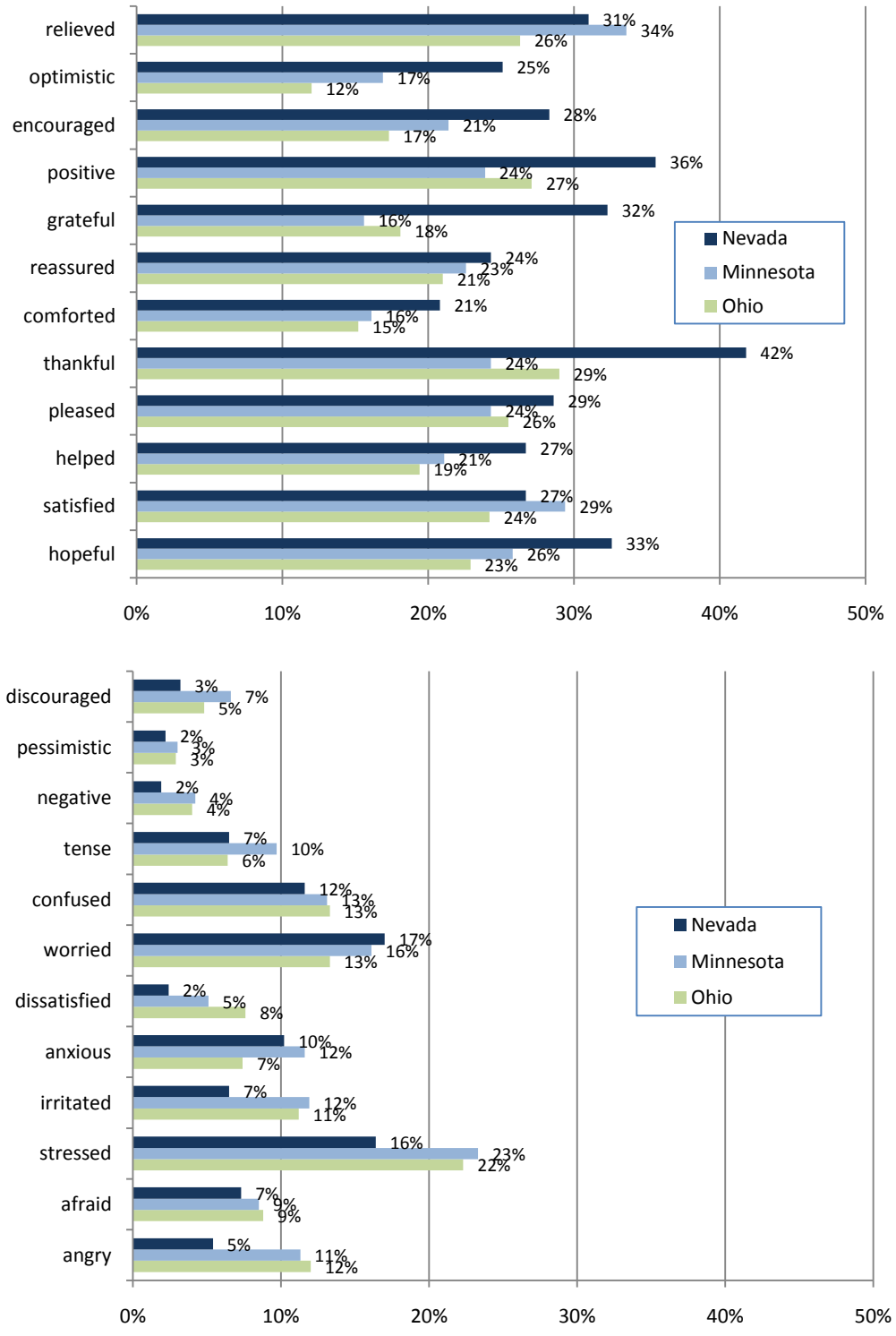


Figure 5.7. Emotional response of families in three states to family assessments

Family Engagement from the Perspective of Workers

During site visits, case workers and supervisors were interviewed about their approach to family assessments and the process of engaging families. DR case managers across sites expressed confidence in their ability to work productively and meaningfully with the families they served. As the program continued and workers became more familiar with the types of situations encountered in child protection, this confidence grew.

Consistent with statewide DR policy, workers said that first contact with the family was made within three working days of receipt of the referral. This contact was typically made by phone call or by a visit to the home. If phone or face-to-face contact could not be made within 72 hours, a letter was sent to the family, or a note left at the residence, requesting a call back. According to a DR worker in Washoe County, "People are pretty good about calling back. Once they know our affiliation and partners, they generally want to know what is going on." Workers in most DR sites typically did call the family first and try to set an appointment before making an unannounced visit to the home. However, all workers had the discretion to go out to a family home unannounced depending on the content of the report. Certain DR workers in Clark County determined that, for them, dropping by the home was a better method for communicating with families:

> "When we first started DR, there was a lot of discussion about whether we should be doing 'cold calls,' but the workers are so experienced now, they know exactly what they need to do, for which family. The first visit, we just go out first without calling. I feel that meeting someone for the first time with the report information is much better in person. They can see your body language. You can explain it to them." (Clark DR worker)

At the Children's Cabinet in Washoe County, the DR supervisor made all initial phone calls to the family and set up the first home visit on behalf of the worker. This practice was established to utilize the strong engagement skills of the supervisor to reduce the number of families that might have been hesitant to meet with the case worker.

Creating a positive exchange with the family at the outset was viewed as especially important since it was up to the DR worker to convince the family to consent to an assessment and then, if appropriate, to agree voluntarily to case management. During the first home visit, the family was required to sign a consent form granting the worker permission to proceed with the assessment. Only after the form was signed could the worker begin to gather information about the family or meet with the child. Case managers could not interview the child without completion of this form, nor call any institution that might have known about a family's whereabouts or situation. Because

the county had legal authority to call schools directly and access databases in order to locate families, DR workers often consulted with CPS for this information. Typically these searches were performed easily and quickly by CPS supervisors to assist DR family assessment workers.

As part of the first visit, DR workers completed a safety assessment on each family, using the same instrument that was a part of CPS investigations. Only if no safety threats were discovered would they proceed to work with the family. Depending on content of the report, children might have been seen alone at school first or with their families, but they were generally included in the assessment interview when possible.

> "We may see the children with the parents or separately, depending on what the report says. Sometimes you really have to see the children alone. If it is educational neglect, then it makes sense to talk with them together, if it is minor abuse, it is tricky. Or custody cases." (urban DR worker)

Once the children were determined to be safe, the general needs of the family would be explored and addressed. The North Carolina Family Assessment Scale version G was used for this. The NCFAS-G was an instrument intended to identify the level of family functioning and to assist with the development of the case plan. The NCFAS-G was designed to be completed at the start and end of the worker's involvement with the family.

If a family was uncooperative with the initial assessment, the worker might have informed them that CPS could potentially become involved. CPS was consulted for advice when needed, and, in certain circumstances, a CPS investigator accompanied the DR case manager on a home visit to support them in their attempts to get in the door. However, workers typically did not need to invoke the possibility of CPS involvement, and learned better techniques for talking with families as the project continued.

> "I think we used to say 'you need to get that kid in school, or all these things could happen to you.' I don't say that stuff anymore. I say 'why is he not going to school?' We never use the 'boogie man' of CPS anymore, saying that if they don't work with us, that we will call CPS, to scare them straight. Now we work it out. The reality is that if we called CPS, chances are they wouldn't follow up anyway." (urban DR worker)

Any other questions or concerns about cases were discussed in phone calls between DR workers and CPS supervisors or during monthly DR meetings where cases were reviewed. In general, DR workers viewed CPS as being supportive and positive.

Most DR workers statewide did not have a background in CPS, although four DR workers were exceptions to this. When asked to describe how a first meeting might be different in DR than in a CPS investigation, workers stated that it was the wording, the tone, and the offer of assistance that made a difference in their approach. The allegations were still addressed, and a full safety assessment was completed, including visual inspection of the children and the home environment, but family assessment workers tried to de-emphasize the specific incident of the report in order to obtain a full picture of families' needs.

> "(You) need to be both strong and a partner. Introduce yourself as a Family Advocate. 'I'm not here to place blame. I'm not here to say whether or not abuse happened, I'm here to help you. I'm here to work with you and be your partner in this.' This approach works really, really well for the vast majority of people." (urban DR worker)

> "I just go in and am truthful. I tell them that we have received a report, but that I want to hear their side of the story. What is going on? And what can I do to help you? It's a softer approach." (urban DR worker)

> "The allegation is not the reason for services. It is the reason we are coming to the home, but it's more about what we can do to help. Sometimes the allegation isn't real, but we can still offer services. Sometimes I will tell them, 'we don't really have to talk about that (the allegation). What can I do to help you?' And it really changes the tone." (urban DR worker)

> "We are not just specific to that one issue, whatever that issue might be. We are asking questions as a whole. And we can get a better sense of what things can happen in the future." (rural DR worker)

One former investigator who was interviewed said she saw DR family assessments as "not that different from an investigation, except there is no substantiation." Nonetheless, she viewed DR as the better approach because of the focus on prevention. "CPS is not comfortable for people; there is always a fear that something else will happen and that children might be removed." For the family assessment case worker, coming from an FRC, there was not as much of this "stigma" in the background. They were a person from a community organization who was there to help, and they believed it fostered a different relationship.

Trust between the family and DR worker was viewed as something that developed over time and improved throughout the course of the case. Though the response of the family was usually positive, making real progress with a family required motivation on the part of both the family and the worker. Being available for the family was the best indicator of a worker's commitment to help, and that commitment was part of what encouraged a family to share more about their needs and barriers.

> "We don't just treat the identified victim, we treat the whole family. ….We also have a relationship, by showing up, by being there for them…. they understand that we are there to help. We really want to see them achieve their goals. We are not so threatening. It's not an adversarial relationship, it's supportive." (urban DR worker)

> "We get to be part of their stories for a time. We need to meet them where they are at. Not where the report says they are at and not where we think they should be at. That really helps us to create a bond that it is positive." (urban DR worker)

A number of CPS and FRC-DR staff interviewed spoke about the potential for a close, supportive relationship that can develop in family assessments that are very rare in investigations. And they spoke more broadly about the differences between the two approaches. A DCFS supervisor observed:

> "People react differently with DR because DR won't take the child from the family and, therefore, the trust is higher….I see DR as family-centered practice – without a record and the potential complications that can rise out of a CPS investigation. Normal investigations are, or they should be, family-centered, but….[leaving unspoken the implication that they are not] If DR-like cases are investigated, serious complications are possible. In investigations, without funding, CPS is not able to do much…If not for DR, nothing would have happened in many of these cases."

DR workers were able to have more frequent contact with families than their CPS counterparts and tend to spend more time giving one-on-one assistance. Cases that may be closed quickly in CPS are, instead, afforded as much time as necessary to improve the family's condition in DR. Reports of lower-risk concerns (such as educational neglect) are often unsubstantiated and closed without support services in CPS:

> "What seems different with DR is that we are really involved right from the beginning to the very end. DR workers have more time to spend with the family.

[We] do more direct, hands-on help with the family. At the time of the first phone call, it may not seem that different to families, but the workers are really trying to listen to the family." (Washoe DR supervisor)

"We can address why (they were reported) and actually help them. They'll say 'I know I need to send my child to school, but I need to take care of this, I need to take care of that,' so…DR is definitely needed. Families may even say that it was a good thing that they got reported." (Clark DR worker)

"There's less red tape for DR; they can take a less adversarial approach, get through to the family on a different level. They have the option to say they are not from CPS, not here to remove child. They also may have different contacts and relationships (in the community). May have different access to programs, or know about things we don't know about." (Clark CPS supervisor)

Summary

The responses of family members and views of FRC DR workers indicated that families were being engaged during family assessments in a manner consistent with the differential response model and as intended by project managers. Although there was no control group responses to the family survey who received the traditional investigative approach and to whom DR family responses could be compared, results in Nevada were consistent with what has been found in other states. Importantly, on every measure of the DR model, the evidence indicates that FRC DR workers have been doing what they were expected to do when they met with families. Families described workers as friendly and supportive, as listeners who tried to understand the situation and needs of families, and as creating a positive atmosphere conducive to creating cooperation among families and their involvement in case planning and decision making.

Chapter 6. Differential Response Practice, Part 2: Services

This chapter examines the second core element of the DR-family assessment approach, the provision of assistance to families that matches the needs and problematic conditions related to family and child welfare that were uncovered in the assessment process. This assistance may take the form of informal help from the worker, helping the family organize its own resources, linking the family to community resources, or arranging for the delivery of specific, formal services. Just as family assessments are designed to be comprehensive and holistic and examine underlying conditions that may threaten the welfare of children, now or in the future, the service response is also meant to be broad in scope. Just as the family assessment is meant to identify particular strengths and problems within a family, the service response is intended to be a targeted response that utilizes and builds on the strengths and natural support system of a family and focuses help where help is needed. Just as the assessment process is meant to be driven by the family with the facilitation and judgment of the worker, the service response will frequently involve the delivery of practical, basic services needed by DR families who often lack basic needs and often live in poverty.

Family Reports of Services Received

Two out of three (67 percent) families who received a family assessment reported in the family survey that a DR worker helped them obtain a service they needed; this figure was somewhat higher in Washoe County and the rural counties (71 percent) than in Clark County (62 percent).

According to the families, workers themselves sometimes (37 percent) helped the family directly; that is, the worker herself/himself was the source of assistance. Across the state, 67 percent of family respondents said the DR worker had given them the names of service agencies where they could obtain assistance; nearly half of these said the worker had contacted another agency or community resource on the family's behalf. Less than one in five (19 percent), said there was help of some kind that they needed but did not receive, and 13 percent said they were offered services that they turned down. (See **Figure 6.1**.)

Families in rural counties were somewhat more likely to report that workers gave them information about where they could get specific help and were somewhat less likely to say they turned down any assistance they were offered. Interviews with DR workers suggested this might have to do with the large geographical area of rural counties, the relative isolation of some rural families and their lack of awareness of where various service resources may be located.

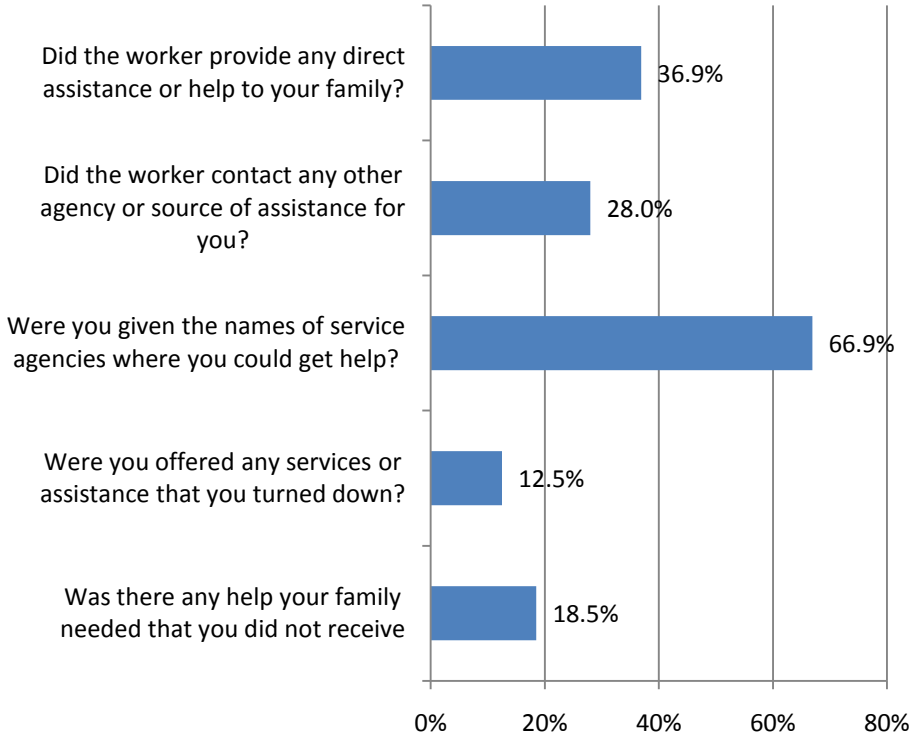


Figure 6.1. Reports of families about services offered and received.

Types of Services Provided. The specific types of services and assistance that families reported receiving are shown in **Figure 6.2**. The services were varied and often involved some type of practical assistance. In the figure, the services are ranked in order most often provided. About one in three (32 percent) families reported receiving very basic assistance with food or clothing. This was followed by counseling services (18 percent). Approximately 1 in 10 said they received help paying utilities, obtaining medical or dental assistance, finding or changing jobs, or some type of financial assistance not listed. Slightly smaller percentages said they received help obtaining public assistance, mental health services, parenting education, and transportation assistance including car repairs, as well as assistance with housing, education, home repair or the purchases of furnishings and appliances.

Some respondents described more specific assistance or services they received, such as “anger management classes for my children” and “copies of important documents” and “enrolling my son in school.” Respondents also mentioned specific types of financial assistance, such as pre-paid Wal-Mart cards for household needs and Christmas presents for children through donation programs. These types of help were often described as having been provided directly by the DR worker. Other such “direct” help mentioned by families included gas vouchers, bus passes, transportation to appointments, and food and clothing.

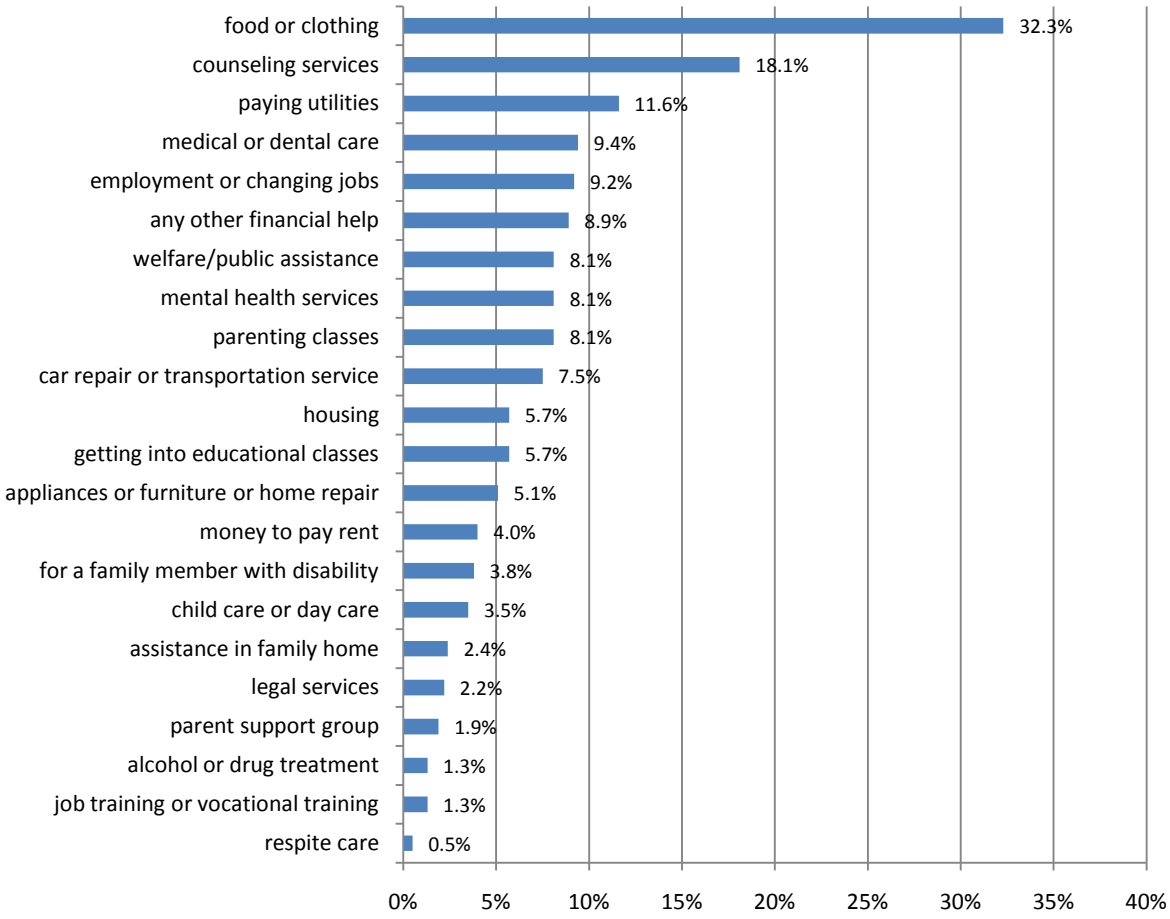


Figure 6.2. Percent of DR families who reported receiving specific services.

There were similarities and differences in services provided to families in the three service areas. (See **Figure 6.3**.) Much of this can be explained by the array of services available through Family Resource Centers. There is a great deal of similarity in how these agencies operate and in the help they provide to families. The types of families these agencies were set up to assist fit the profile of many DR families, those who are economically less advantaged and lack basic needs. It is not surprising, therefore, that many DR families reported receiving food and clothing assistance since these needs can often be met through the FRC itself or through an agency with which the FRC works closely. Some of the notable differences in Figure 6.3 are also attributable to differences in services available through these community agencies. The Children's Cabinet in Washoe County, for example, is particularly equipped to provide counseling services, parenting classes and provide transportation assistance, and this is reflected in the greater proportion of families from Washoe County who reported these services.

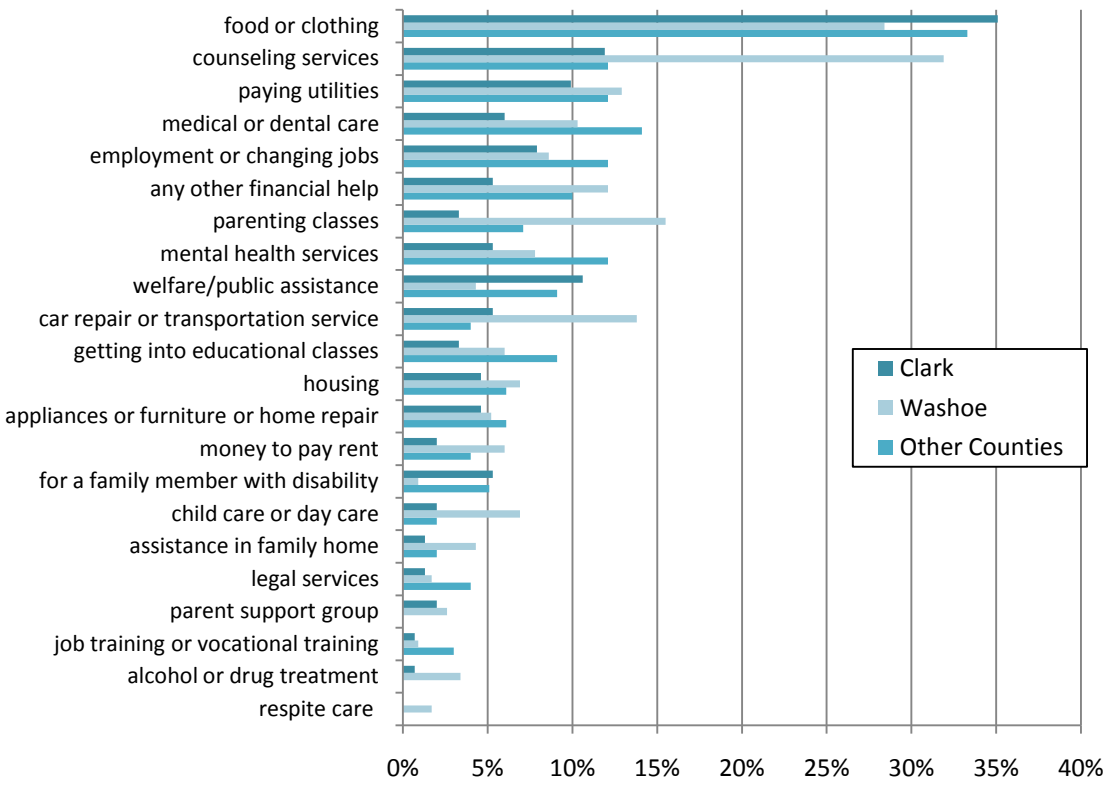


Figure 6.3. Percent of DR families in different areas who reported receiving specific services.

Overall, the pattern of services provided to DR families in Nevada is not dissimilar to what was found in evaluations of DR programs in Minnesota and Ohio. (See **Figure 6.4**.) In these other studies, statistically significant differences between services provided to experimental (DR) families and control (investigation) families often involved an increase in poverty-related services. This included the provision of food and clothing, help paying utility bills, home repairs or furnishings, transportation assistance, and other financial assistance. Other service areas where differences between DR and investigation families were found in the other studies included public assistance, medical and dental services, child care, and counseling services. The increase in the provision of services provided to DR families found in the other studies, the breadth of services provided, and the increased frequency of services that address basic needs were all factors consistent with the social work model of the DR approach. The similarity in the service pattern among Nevada DR families and those in the other two states indicates the model at work in Nevada as well.

As was seen earlier, a relatively small number of families said they needed a service they did not receive. A majority of those who commented about this said they needed more help with utility bills or rent they were unable to pay. Others who said unmet needs remained described legal

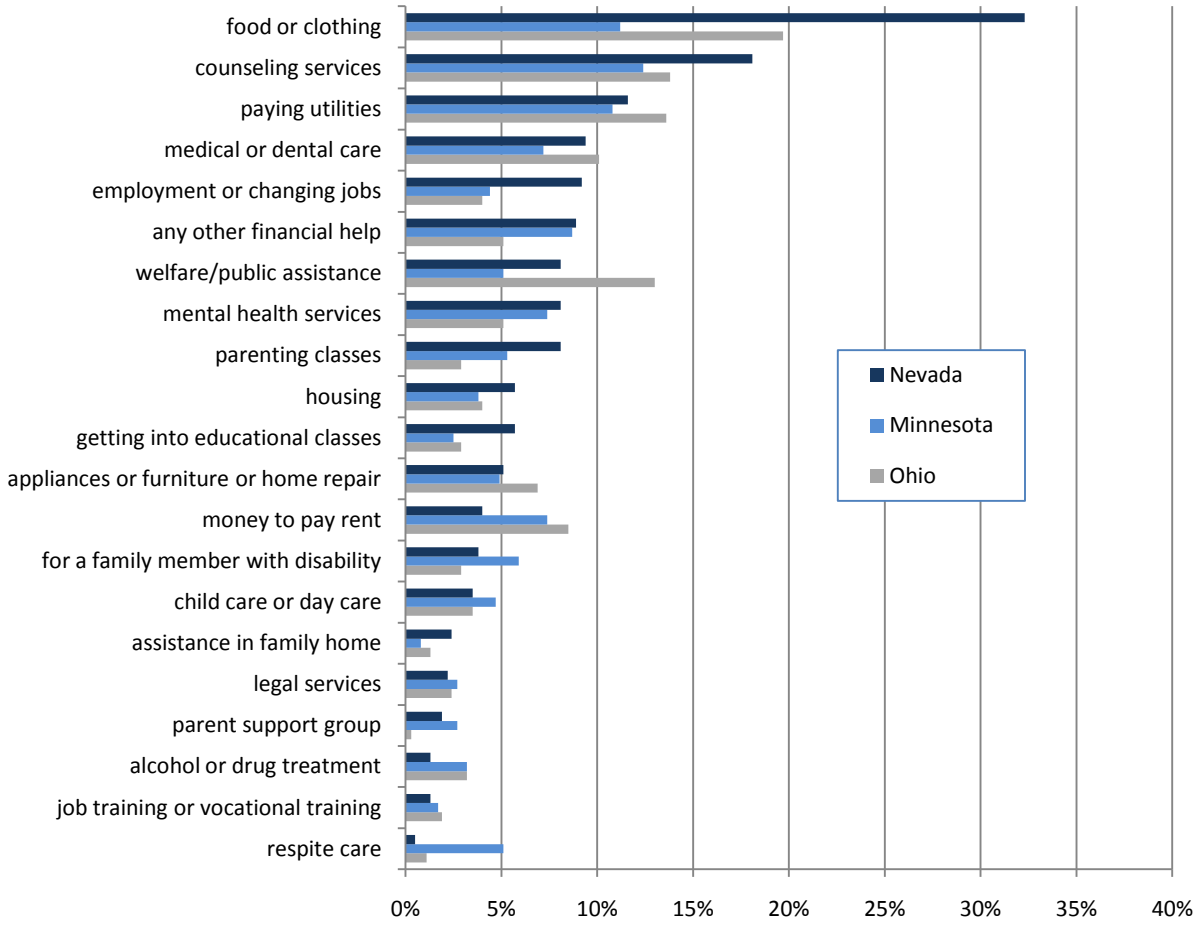


Figure 6.3. Percent of DR families in different states who reported receiving specific services.

problems, the disability of a family member, chronic unemployment or counseling, and health care. A small number said they had additional family needs but had not told the worker about them.

A small number of families reported turning down services that were offered to them. Most often turned down were counseling and parenting classes. A few said they had declined financial assistance or food and clothing. And a few also said turned down "everything offered."

Appropriateness and Sufficiency of Services. Nearly three out of four families said the services or assistance they received were what they needed. Most of the rest said they had not received any services, whether through the worker's assistance directly or indirectly through a service referral. A small number of respondents, about 1 in 20, said the assistance they got was not what they needed. Similarly, a high percentage (71 percent) said the services they received were sufficient for the needs of their family. Again, most of the others were families who said they had received no services (22 percent), but a small number said the services they received were not enough to help

them (7 percent). (**See Figure 6.4**.) Families from rural counties and Washoe County were somewhat more likely than families from Clark County to respond positively when asked about the appropriateness and sufficiency of services; this was a strong statistical trend, but not statistically significant (p<.08). Overall, among families who received any assistance, families in Washoe County reported receiving a greater number of services.

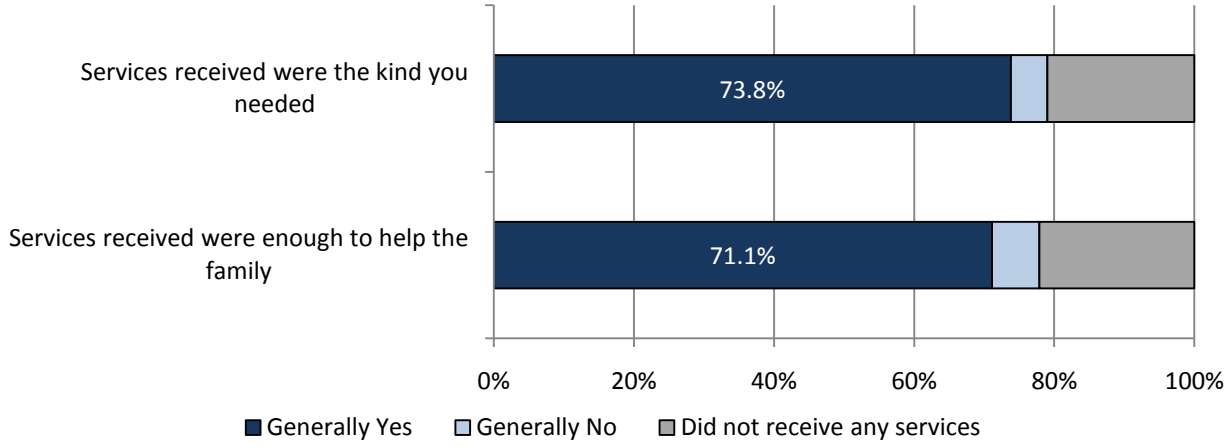


Figure 6.4. Percent of DR families who said the services they received were sufficient and what they needed.

Family Comments. In the survey instrument, families were asked to provide any comments they may have about their experiences with the FRC DR worker. Respondents from all counties often wrote about the services and help they received. Typically, families simply wanted to express gratitude for and satisfaction with the resources provided. Specific types of help were sometimes mentioned, demonstrating the variety of service connections made through DR, as in the following:

> "I'm very grateful for the help with the parenting classes since they've helped us along with the kids and we learned how to better support our kids and their needs thank you very much!"

> "My little girl needed glasses. And we are grateful for the help we got. Thank you. My little girl can see now, and the school is happy."

> "I just want to thank you for everything they did for us. I am especially grateful for the holiday party. The gifts my grandchildren received were unbelievable and I had no money to get them anything so I was truly happy they were able to help me. Thank you once again."

> "She helped provide us with the counseling we so desperately needed. She is terrific."

> "[The worker] talked with us and gave us options and helped get my son on board. It was great to see my son no longer missing school. I was recently laid-off so it's been an adjustment. The information [the worker] gave got me set up for food stamps and Medicaid."

A very few comments were negative in tone, with respondents expressing dissatisfaction with the assistance they received or did not receive.

> "It's great they are concerned about welfare of children and families. But I thought they would help with rent, utility and clothes for child. But they did not help me apply for welfare, food stamps, or Medicaid."

> "I really needed more help with transportation. Especially since daily bus passes went up to $4.00, I can't go anywhere. And my son will be unable to attend school after Jan. 26th when my bus pass expires, and I can't even take my son for his immunizations."

> "I needed more assistance with general needs, which I didn't get. It was difficult to contact the worker or for her to contact me."

Other comments highlighted the breadth of help that was provided and implied that what was received was often more than what was expected:

> "I had no idea there were so many different services and that I qualified for them. It is great knowing I can get help if I need it. Thank you for having this program."

> "She came into our home to help with one problem and ended up helping us with so much more than we were willing to ask assistance for on our own. "

In general, families mostly wanted to convey that the offer of assistance was appreciated and needed. As shown in the following comment, families valued the connections made with resource providers that they can now rely on in the future:

> "Just wanted to say it feels nice to get some help from someone and knowing it's out there. I really need all the help I can get, and again thank you."

Worker Reports: Take 1, Case Reviews

In the case reviews of sample families completed by workers, DR and CPS workers were asked whether any services, support or assistance was provided to families on whom a report of child maltreatment had been received. Slightly more DR workers than CPS workers answered affirmatively (63 percent to 58 percent), a difference that was not significant. When asked what specific services had been provided, however, 47 percent of DR workers compared with 26 percent of CPS workers identified one or more services, a difference that was significant ($p<.008$). The percent of DR workers who reported providing specific services is lower than the percentage of DR families who reported receiving a service. However, families included services received through referrals facilitated by workers. Workers were asked separately about information and referrals they provided to families about specific services. Both DR and CPS workers reported doing this, with DR workers saying they did it somewhat more frequently (71 percent to 65 percent). However, DR workers were significantly more likely to know whether the family followed through with the referral and actually received the service, suggesting more sustained contact and assistance regarding such referrals. Further, DR workers knew more about the relative effectiveness of services provided to the families they worked with compared with CPS workers. DR and CPS workers were equally aware of specific services that families were already receiving.

Types of Services. The case reviews completed by workers provided a glimpse into the nature of their work with families and the types of assistance the workers provided. Workers were asked to indicate the specific services that had been provided to the families in the sample. **Figure 6.5** shows the responses of DR workers regarding families who received a family assessment. The graph shows the percent of DR families who were provided specific services, according to the worker, and the percent given an informational referral for the services. As in the case of the responses of families, many of the services can be seen as addressing poverty-related conditions: emergency food; help with basic household needs; public assistance and food stamps; help with transportation, employment and housing. Many other services provided represent typical service responses to reports of child maltreatment, such as therapeutic interventions, counseling, and parenting training. A variety of other assistance was also provided, including help with educational needs, child care, and household management assistance.

Figure 6.6 compares the types of services provided to the sample of DR and CPS families, that is, families who received a family assessment and families who received an investigation. The figure gives the percent of both sets of families reported to have received particular services according to DR and CPS workers. Significant differences in service provision are obvious. Treatment for substance abuse was the only service reported more often by CPS workers. And, it should be noted

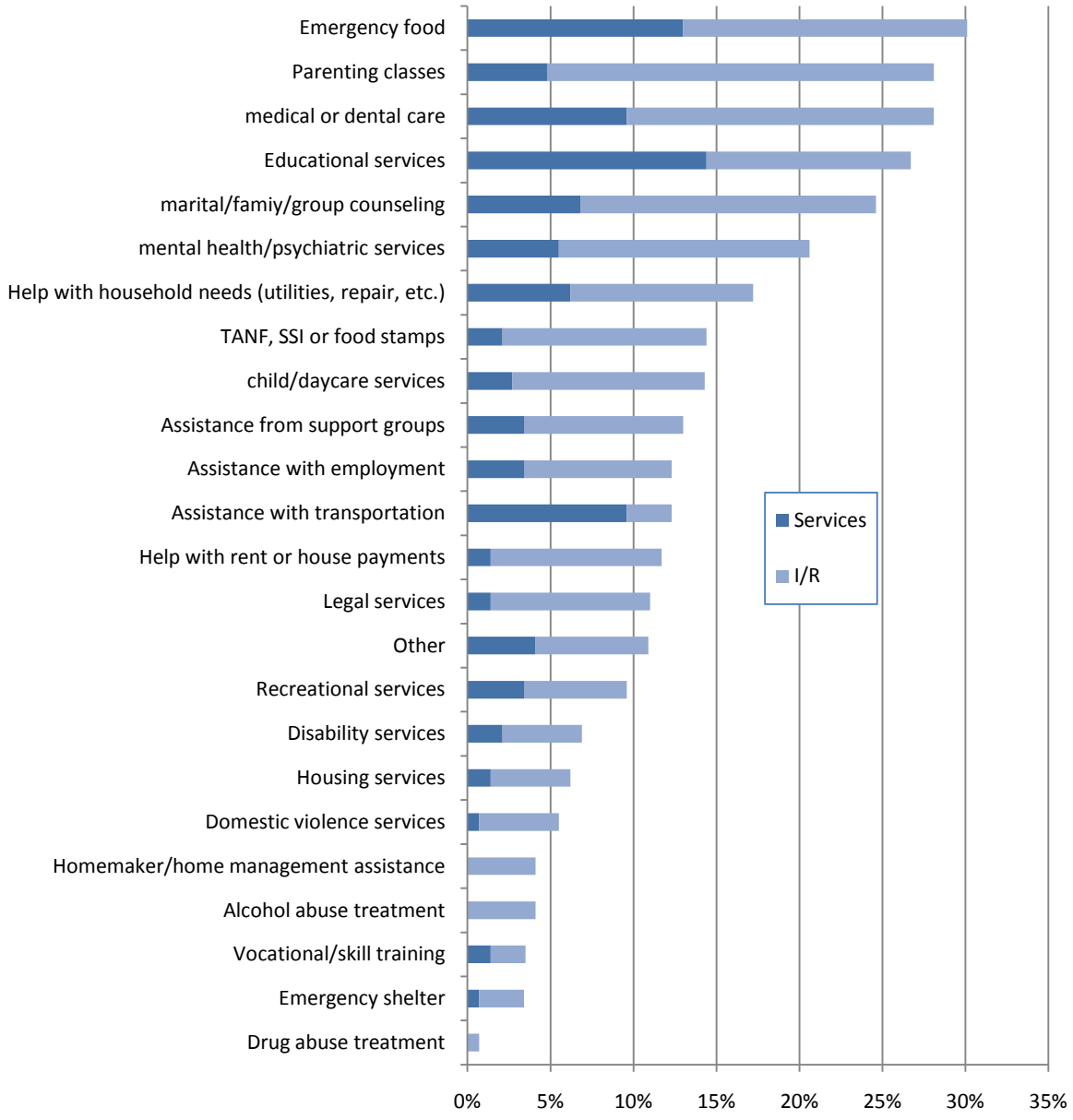


Figure 6.5. Percent of families provided specific services and service referrals according to DR worker case reviews

that Nevada families found to have significant problems with drugs or alcohol are routinely referred by the DR worker back to CPS and the track changed from family assessment to investigation DR workers were somewhat more positive than CPS workers in their assessment of the appropriateness and effectiveness of services provided. Slightly more than half (56 percent) of DR workers thought that services provided to families were well matched to their service needs, while in other cases the workers judged the appropriateness of services provided to be adequate.

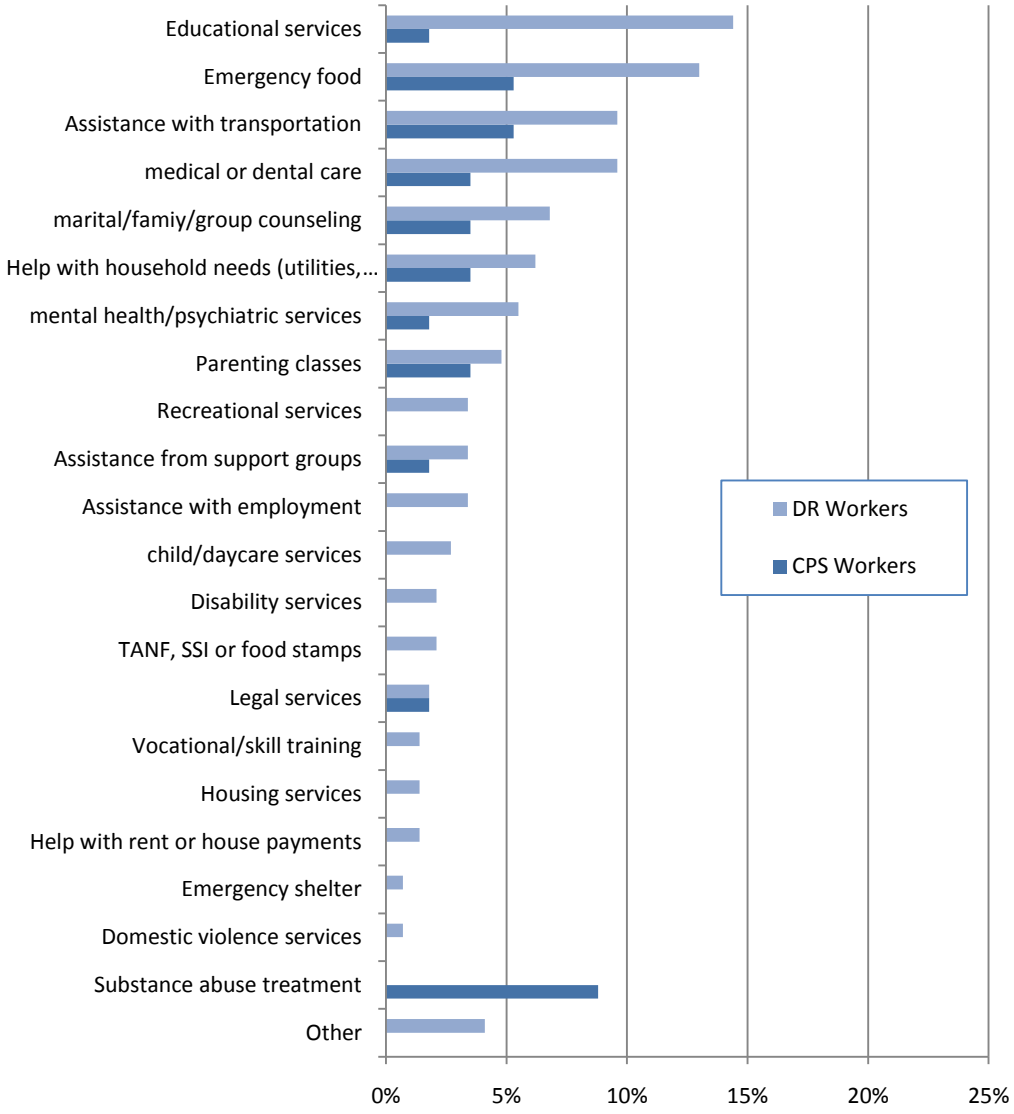


Figure 6.6. Percent of families provided specific services according to DR and CPS workers.

Similarly, DR workers said they considered services provided to be very effective in fully addressing the problems experienced by about half (53 percent) of the families; 29 percent thought the services were somewhat but not completely effective; 18 percent thought the services were ineffective.

Use of Community Resources. In the case reviews workers were asked whether they helped members of the families obtain services or assistance from specific, local service resources. The most frequent resource noted by DR workers, was schools (noted in 40 percent of the cases). This was followed by community service agencies (21 percent), most often the Family Resource Center itself. Other frequent resources to which families were connected were MR/DD service providers

(19 percent), legal services (18 percent), emergency food provider (11 percent), and the family's extended families and friends (10 percent). Smaller numbers of DR families were put in touch with a variety of other community resources. **Figure 6.7** shows the percent of DR families in the three service areas linked to various community resources by DR workers.

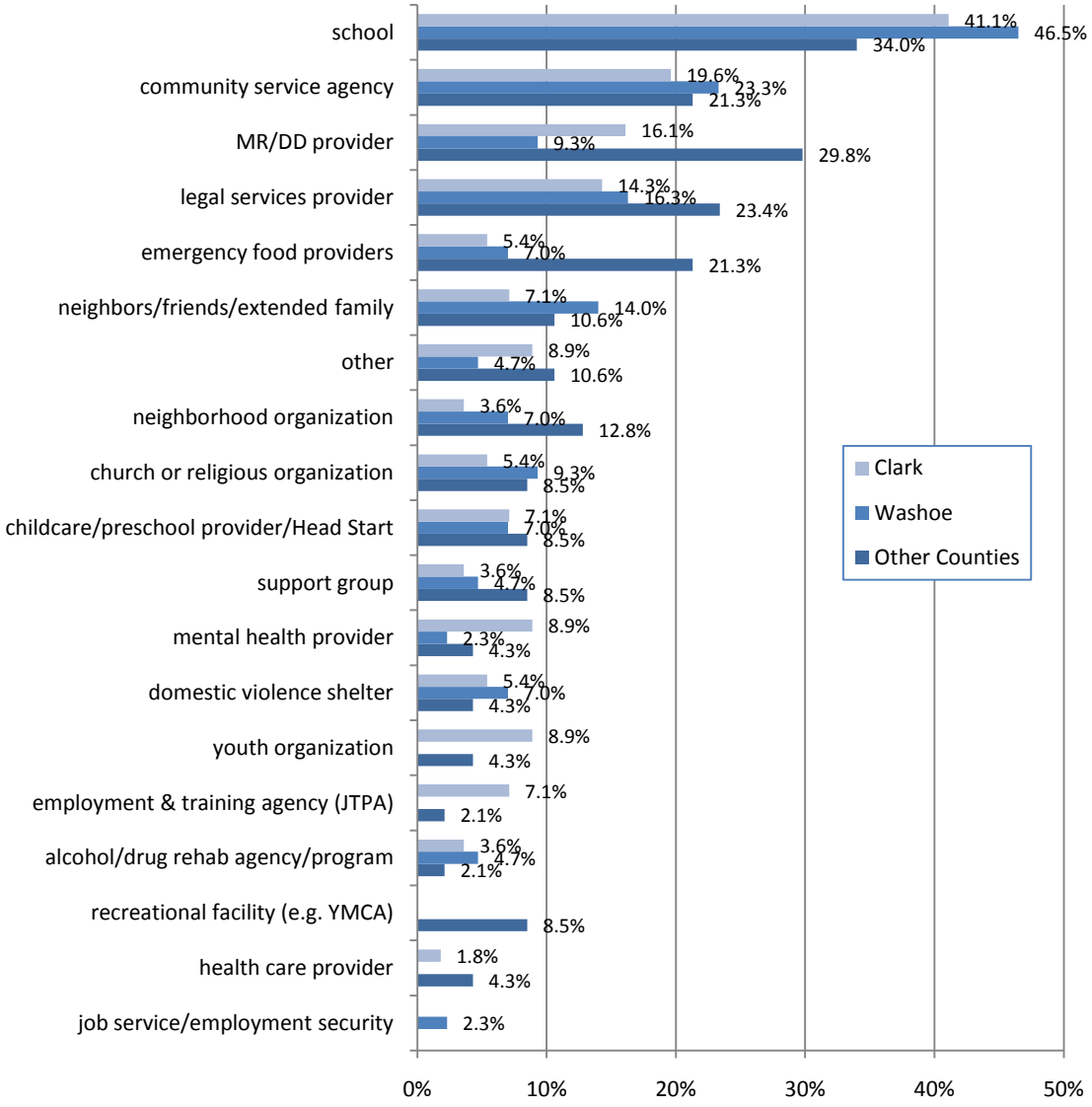


Figure 6.7. Percent of DR families connected to community resources in the three service areas.

For the sake of perspective, **Figure 6.8** shows the percentage of families reported connected to community resources by DR workers in Nevada and Minnesota. There are some interesting differences between the states. The greater use of community service agencies in Nevada is the result of the state's reliance on Family Resource Centers. Additionally, however, more Nevada DR

families were referred to MR/DD providers and legal services providers, while less use was made of mental health providers in Nevada than in Minnesota. It is certainly the case that differences between the states in the types of cases screened for a family assessments would be expected to have an effect on the types of services provided and resources utilized.

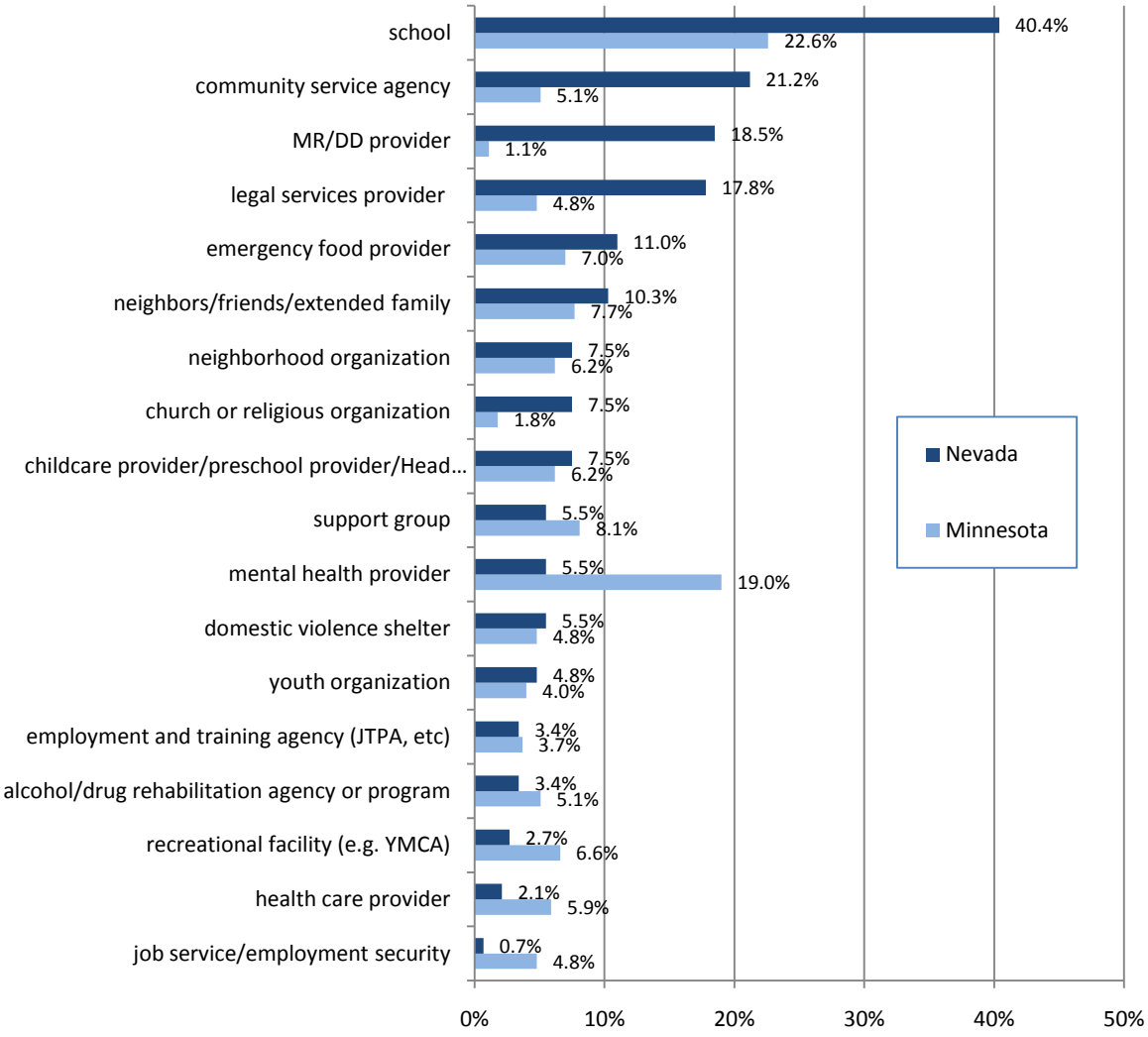


Figure 6.8. Percent of DR families connected to community resources in Nevada and Minnesota.

Worker Reports of Services: Take 2, General Worker Survey

The worker-reported data above came from the case-specific sample. There was also information about service provision from the General Worker Survey that was conducted at the end of the

project. In this survey, DR and CPS workers were asked to indicate whether any of their client families had received or been referred to a service provider for various services during the last thirty days. There were some services that every DR worker said had been provided to at least one family on their current caseload: emergency food; assistance with utilities, rent, or home repairs; assistance with other basic needs; and mental health services. While 70 percent of CPS workers said they had referred at least one client in the last 30 days for mental health services, less than half said the same about emergency food or basic home-related assistance. As was seen in the previous section, only services related to substance abuse treatment were much more likely to be provided by CPS workers.

The types of assistance provided to client families might be broken into five distinct groups: 1) help with basic needs; 2) mental health, therapy or counseling services; 3) health services, including dental; 4) practical assistance, such as transportation assistance or home management help; and 5) services to enable the family to help itself more in the future: employment, vocational training or adult education. Services in each of these categories were more likely to be provided through DR workers than CPS workers. The difference between the two groups was statistically significant with respect to the following types of assistance:

- assistance with other basic needs
- assistance with utilities, rent, home repairs
- emergency food services/ food pantry
- housing assistance

- mental health services
- child counseling or therapy

- medical services
- dental services that accept Medicaid

- transportation services
- homemaker/home management assistance
- assistance with physical disabilities

- adult education services
- adult vocational/job training

In the General Worker Survey, DR and CPS workers were asked how often they referred client families to ten types of community resources. For one type listed, early childhood services, CPS workers more often reported referrals than DR workers ($p=.006$). For three types of resources, support groups, community action agencies and referrals to the Division of Welfare and Supportive Services for food stamps and other public assistance, there was no difference in reported referrals.

For the other six, DR workers were more likely to report making more frequent referrals ($p<.03$). These were:

- Job Seeker Service or JobConnect
- Workforce Investment Act (WIA) services
- Youth organizations (such as, Boy Scouts)
- Recreational services (such as, YMCA)
- Neighborhood organizations
- Churches and other religious organizations

Qualitative Analysis of a Service Shift with DR

Analysis of quantitative data from surveys of families and case workers indicate a new approach to services developed with the introduction of differential response and the involvement of FRCs more directly and fully in CPS cases. The following section summarizes the qualitative evidence for this obtained in interviews with DR and CPS workers during site visits.

Case Management and Intervention. Once the initial safety and family assessment was completed by a DR worker, families that agreed to case management participated in ongoing services in order to address any risks or needs present. If the family was amenable to receiving continued visits from the DR worker, the case proceeded until the goals of the family were met. Workers across the state saw their role as service brokers, to assist families in remediating presenting problems as well as to preventing future child protection involvement. Frequent contact was made with CPS supervisors to consult on cases when questions arose.

The amount of interaction the worker had with the family depended on the level of need. While the allegations for DR reports tended not to reflect high risk, the actual circumstances of families varied widely, from "open and shut" cases with families that were essentially healthy and safe, to complex cases of families with multiple, intense and chronic needs that might have required support for a considerable period. Families might not have required more than one or two visits, or they might have needed attention for a year or more. Workers made decisions about the time they chose to invest based on the working relationship, the motivation of the family, and the potential for progress to be made.

> "Lots of cases close in less than a month. There are some that close in a week…the family takes care of everything before we even get out there. Some are minor, they just need benefits applications (food stamps, Medicaid), immediate things they need, and then we refer them over to the FRC, because their needs are really not

> what was on the report. But maybe only 5% of families need nothing at all." (urban DR worker)
>
> "You have to spend the time getting to know your families. Because a lot of time in the first couple visits, they don't have any needs—they're fine—but after you ask them some different questions, they have things that come up. New glasses, things like that." (rural DR worker)

Families often had at least weekly contact with the DR worker, either in person or by phone. A few DR sites had specific policies that outlined the frequency of contacts, and others left it up to the worker's discretion. Elko's DR program made it a goal to see their children at school or in their homes at least once a week, though high need families might have been seen three to four times a week. Likewise, weekly visits were also required in the Children's Cabinet in Washoe and Olive Crest in North Clark. In Lyon, new cases were typically seen once a week, while ongoing, maintenance cases were seen every other week.

If short or long term case management was warranted, DR workers could usually accommodate a family on their caseload. But workers also tried to solve issues quickly for families and avoid involvement when this was possible. As one worker in Clark commented:

> "I don't know that there is a direct correlation between more time and more success. I think it is the quality of time. If you can fix it in two weeks then I am just as happy with that family, than one that it took six months to get any kind of progress. High maintenance doesn't always correlate with stability." (urban DR worker)

DR workers adapted their practice to what was seen in the field. Local programs did not always start out with such an intensive model in mind. Experience with the program changed the expectations that some workers had for families and also changed their approach. Two workers that had been with DR for some time explained what they had learned:

> "I engage them a lot differently that I did in the beginning. …I think I'm little more firm. (Now) I have a set appointment with my families every other week, regardless of service need. This has cut down on families making and breaking appointments, which takes away time from other families. I like to touch base. And usually something will happen, it's not an unnecessary visit." (urban DR worker)
>
> "Our goal is to try to keep these cases from coming across our desk again. What I was doing when I first started, was go in, assess the case, refer them out and go on to the next case. And I didn't find myself successful. These cases were just coming

> back and coming back, and so based on caseload, I would rather keep a case for a little bit longer until we feel we can cut it loose, rather than close it too soon and have it be another referral." (rural DR worker)[9]

Because of the flexibility of the DR program, and the smaller caseloads, DR workers were typically able to form intensive, supportive relationships with families needing services. Families were not simply told which resources to call. Referrals and resources were provided within the context of dialogue with the family. By helping a mother read and complete applications for benefits, or by facilitating a conversation with a service provider, for example, workers made sure that families actually connected to and followed through with services in the community. Direct guidance and advice from the worker was often coupled with service brokering. Issues such as home management and organization, how to shop on a budget, or even family conflict, might have been dealt with directly by the worker at appointments. Families responded very positively to being helped in small ways even when larger issues could not be immediately resolved. Workers gave examples of support and assistance they provided:

> "There is no one like us that can tell a family how to shop at thrift stores, how to pack a bag for five dollars." (rural DR worker)

> "Being (community agency) employees really helps. Communication between the parents and the schools is sometimes shaky, so if that is an issue we can be that mediator." (urban DR worker)

> "The vast majority of the cases we are doing that. (We are) helping tackle family problems. Discipline problems. Getting the parents and children on the same page. Getting children to take ownership for their behavior. We do that coaching. Helping them fill out forms, making appointments. I am there with them." (urban DR worker)

In the rural area of Fallon, parenting instruction was provided by the DR worker as part of her support of families. She learned the curriculum for the parenting class provided at the FRC and provided this parenting instruction directly to families, in the office or in-home. Because some families did not want to attend the classes at the FRC, she was able to teach them the same material at home, surreptitiously, and they "didn't really know they were getting the information."

The increased intensity of the support available from DR allowed the worker and parent to work more closely together to ensure progress was made and risks to the child and family reduced. A

[9] New referrals of DR families to DR are considered in Chapter 9. A substantial minority of DR families were subsequently re-reported and referred again to the FRC.

rural DR worker summarized her work this way: "Families don't believe you are actually going to help them. And when you do, they are flabbergasted."

Services. Children and families assessed through DR had a wide range of needs. Some had long histories with CPS and some had no prior reports. Some were already participating in several programs or benefits while others had no familiarity with community resources. Cases of minor neglect were the primary referrals to DR, but often these families had deeper issues. Discovering these other issues and dealing with them proactively was the goal of case management. Ideally, when a DR case closed, the family was adequately connected to those supports that would help maintain their well-being.

During the course of the project, workers in all areas encountered parents that had recently lost employment due to the recession and were new to the social service sector. These families had no experience with how to find help or benefits, because until recently, they had been receiving a regular income. Families like this stood out in the minds of workers, since they were in particular need of help navigating the web of community resources.

> "Those people that aren't used to having to request services, they have no idea. They have never had to ask for services before. They don't even know there is an energy assistance program. Those that are getting laid off….we see a lot of medical necessity, because they no longer have insurance. I have one kid now, who has no dental and has cavities everywhere, so he's in pain when he goes to sleep….He's not in immediate danger, but it could result in septic or something if he's not treated. So we get them a check up or Medicaid. And they are grateful." (urban DR worker)

> "Most families want the assistance, they just don't know how to ask for the assistance. Us being there is a safe way and an easier way to get the help. Parents don't want to stand in the social service line all day. Especially with the link to the FRC, if they see we can get something for them, they become motivated." (urban DR worker)

Proximity to the FRC allowed DR workers to quickly and easily facilitate certain services and resources for families. FRCs in each location had slightly different services, but most had the ability to connect families to parenting classes, emergency food and clothing, utility assistance, medical and dental providers, and housing and job assistance. Since many of the biggest needs in families were in these areas, families were often connected with these services during the open case or transferred to the FRC case management with a 'warm hand-off' when the DR case closed. Co-location of services also eased the burden on families, freeing them from having to set multiple

appointments and travel to multiple agencies. "That's the beauty of being in an FRC," a worker in Washoe said, "because we can just refer our families." Other workers said similar things:

> "We're connecting families to the FRC all the time. Parenting classes, utilizing baby services, Hispanic services, it's amazing how many times we connect. We are also able to utilize just the brain power around here, to find resources for our families. It is a huge attribute to our program to be able to access the resources here." (Elko DR worker)

> "Many things go to the FRC. If they (families) needed birth certificates or something, they would go to the FRC. And bus passes. We have access to food here, a USDA program. And a grandparent program, for respite for guardian grandparents." (Clark DR worker)

> "Our worker went to a home and saw kids come out of a van without their car seats attached properly. The FRC has two nationally certified car seat technicians, so she came back and got one of them and went out to the home and made them safe right there. We have a lot more tools in our tool box." (Rural DR supervisor)

In rural areas, resources are scarce and those that are found are often within the FRC itself or they are not found at all. A rural area FRC supervisor said:

> "We do have resources we can offer. We help with public utilities and provide parenting classes. We can refer to Family Court as an alternative to someone going to jail--another kind of DR. We have a food bank, emergency clothes, a domestic violence program, and a program for kids funded through the DV program. But outside of us there isn't much. There are some other resources available in the community, but not many. Nothing is available through churches or the schools. The Boys and Girls Club has a good program, but it isn't easily available and children have a hard time getting from school to their facility."

Outside of the resources common to all FRCs, some of the DR agencies had special programs or expertise in certain areas that allowed them to serve particular needs of families. The Children's Cabinet in Washoe arranged for all DR families to be eligible for 10 free counseling sessions through the agency's counseling department. Money that was originally allocated for a fourth DR worker was transferred to pay for a therapist to provide counseling, which became "an invaluable expense." Other programs at The Children's Cabinet also benefitted DR families, including a Truancy Intervention Program and a tutoring program. Likewise, Olive Crest in Clark County specializes in therapeutic treatment for children with mental health diagnoses, Washoe FRCs are

connected to the school district, and Lyon County Human Services provided Housing and Recreation programs.

Services that cannot be found in the FRC were sought in the greater community. DR workers appeared to do everything they could to meet a family's most pressing needs. As one Clark supervisor explained, "Workers are tenacious in what they try to get done." Frequently utilized services include counseling, psychosocial rehabilitation, parenting support, special education advocacy, and medical referrals.

When families needed basic concrete items, DR workers used Wal-Mart gift cards which were obtained for all sites with one-time DR funding. Purchases made with this resource were invaluable. As workers commented:

> "Aid in the form of dollars is pretty light, but the Wal-Mart cards have been a great benefit. They have saved the day. There is a lot of stuff you can get there: food, medications, glasses, clothes, diapers."
>
> "These have been the best resource. To go shopping with the family---they are so appreciative, because they can get what they need and want. They are not restricted."

Flexible dollars like those were limited, though, and things that could not be obtained directly from service providers presented more of a challenge for both families and workers. Mental health services, especially for children, were reported to be lacking state-wide, as were providers that accepted Medicaid. Transportation was always a problem for families that did not own vehicles, particularly in rural areas. But to fill these service gaps, workers became expert advocates for their families in the community. DR workers in Clark and Washoe counties, for example, negotiated with doctors for free or very low-cost services and medications. In Churchill, the DR worker acted as a 'middle man' to work out a deal with a seller of propane, allowing some families referred by DR to fill up their tanks for half price. The Boys and Girls Club of Las Vegas called on their board when certain services could not be found and discovered new resources this way. And in Elko, staff members worked on a project with the transit coalition to try to get new transportation resources established.

Ensuring that families get what they needed was an ongoing battle. However, when service connections were made for families that really needed them, it often resulted in big positive changes for families. As a rural DR worker says, "You just find creative ways of getting it done."

Limitations and Possibilities. In the traditional child protection system, an investigator's primary goal has been to look for a safety risks, make a determination about the allegation, and either close or transfer the case. Reports of lower-risk concerns (such as educational neglect or inadequate

supervision) are often unsubstantiated and closed without support services in CPS. Balancing case volume with case severity is an important consideration for CPS workers and supervisors, and a CPS investigator's ability to work with families and connect them to resources is highly dependent on the size and intensity of their caseloads. "If CPS has a lot of court cases or removals," said a rural supervisor, "then it is hard to work with those families that are doing okay but need some extra support. Those families tend to get neglected."

Traditionally it has not been the job of investigators to have in depth knowledge of community resources and follow up with lower risk cases. Information and referrals that are given to cases that close during the 30 to 45 day investigation period may therefore be superficial. Though these families may have needs, only cases that formally opened are addressed with service planning and case management. But providing adequate services for families with open cases can be a significant challenge too. This has been an issue for Nevada's child welfare system, particularly in the Las Vegas urban area. Barriers like high case loads, incomplete training, and a deficient community service array can impair the ability of ongoing workers to keep families intact or move children to permanency. Though many improvements to the system have been made in recent years, the county is still working to reduce unnecessary removals, serve more children in-home, and increase appropriate services. As the CCDFS director stated, "We have a residual allegation, injury driven way of thinking, and I think it's a struggle around the issue of engaging families. It's get in, get out, rather than getting to know the family."

An urban area DR supervisor commented:

> "My perception is that the children that do not have permanency cases (in CPS) do not have very in-depth referrals, resources, and support. So the ones that are unsubstantiated, and that still have needs, are even less likely to get referrals that are given in a way that the family will access them. It is one thing to hand them a list and say call these people, and it is another thing to explain, these are the things you need to have before you call this person, this is the timeframe you need to call in, and do you have transportation? So I think that is the primary difference. In DR, we can hit the ground running with that kind of approach. It's the depth and intensity and detail that the CPS workers don't have time to provide." (urban DR supervisor)

The success of any family intervention depends on the worker's ability to match resources with needs and the family's motivation to make changes. Because DR workers must work with families voluntarily, they must rely on their own ability to encourage the family to participate. It often does not affect the family to have the threat of CPS involvement, as many have had prior interactions

with CPS but have never had problems significant enough to require the CPS worker to remain involved.

> "We try to motivate on the positive side, with carrots instead of sticks, but some people don't respond to carrots, only sticks. Our literature says that the case may be staffed with CPS. But the families know better. Especially those that do have pages and pages of prior reports, they say 'So what? They'll come, they'll look, they'll leave.' And DR is likely to stick around for awhile." (DR supervisor, Clark)

A Clark County DR worker described in detail a referral the FRC was given. The case involved a family that had been cited on numerous prior occasions for a dirty house. On arrival, the DR worker found more than she expected: many dogs in the house, the floors of every room covered with dog feces, and roaches everywhere she looked. (To her disbelief, the worker was asked to remove her shoes before entering the home.) But she persevered and insisted on the house being thoroughly cleaned and had repeated house-wide roach bombings. Due to the relentlessness of the DR worker (and to the surprise of the homemaker), the house was eventually cleaned. The homemaker told the DR worker that she had spent much more time and been much more persistent than CPS ever had. "The last two times they just said 'clean your rug' and closed the case."

A CPS worker commenting on this story said: "We would have given them two weeks and walked away."

Summary

Providing services and assistance to families based on the needs and situations discovered in the assessment process is the second core component of the differential response model. Evidence from feedback from families and from quantitative and qualitative data obtained from DR and CPS case workers indicates that this element of the model is in place. DR families are more likely to receive assistance and services and what they receive is likely to be viewed by them as what they need. The assistance in most instances addresses imminent and potential safety risks to the wellbeing of children. Services often address basic needs arising from the low economic conditions of the families. DR families are more likely to be put in touch with other community resources from which they can receive additional assistance.

Chapter 7. Response of Families to Differential Response

The response of families to the family assessment approach is important as an outcome in itself and as an intermediate facilitator of other positive outcomes. Families who are satisfied with how they were treated and with the assistance they have received from a human services program are more likely to be cooperative and open, and receptive to efforts to assist them address problems and conditions they are experiencing. This, in turn, is likely to contribute to program outcomes desired by both the family and the public system that is intervening in their lives. It is for this reason that the Children's Bureau has made family satisfaction a goal in all of its major national program demonstrations and as an outcome to be looked for in the evaluations of these programs.

As the shop owner knows, treating customers well is the right thing to do and good for business. Similarly, as anyone with an awareness of child development knows socialization of children through positive, loving means rather than coercive, authoritarian actions is not just proper in a cultural sense, but more effective because the locus of control for the child is more likely to become internalized and the child will learn how to control his or her own actions without having to be disciplined on every occasion. The family assessment approach is predicated on the principle that workers should treat parents in a way that is consistent with how CPS expects parents to treat their children.

In this chapter we will look at the basic response of families to the family assessment approach and examine the issue of customer satisfaction. There are three items on the family survey instrument that we have used in previous studies as a barometer of basic family reaction to the DR-family assessment approach. These questions are:

1) How satisfied are you with the way you and your family were treated?
2) How satisfied are you with the help you received or were offered?
3) Overall, is your family better off or worse off because of this experience?

Family Satisfaction

The first question, of the relative satisfaction of families with how they were treated, is perhaps the core attitudinal measure and, based on this measure, satisfaction of families with the family assessment approach was very high. Over 96 percent of the families who completed the survey said they were "satisfied" with the way they and their families were treated by the DR case worker who visited their home. Three out of four (76 percent) said they were "very satisfied." Very few

told evaluators they were "dissatisfied" and fewer still said they were "very dissatisfied." This response was found among families from all parts of the state, as can be seen in **Figure 7.1** where families have been grouped by service area.

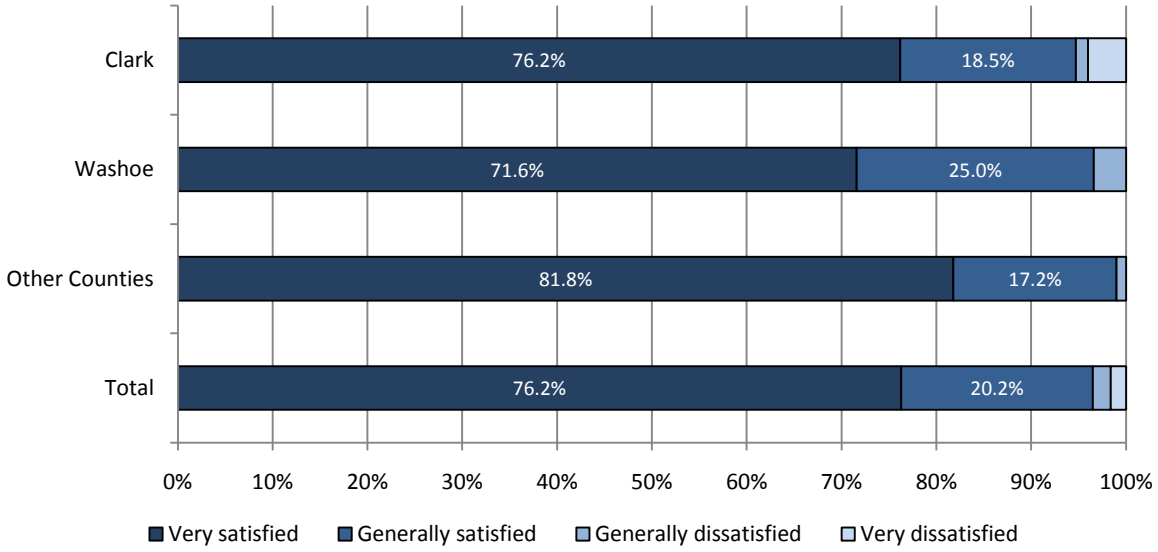


Figure 7.1. Level of satisfaction with treatment among DR families

A similarly high percentage of family respondents reported they were satisfied with the help they received or were offered. For the full sample of cases, 86 percent said they were satisfied; 76 percent said they were very satisfied. A relatively small percentage (6 percent) expressed dissatisfaction. As before differences in this response among families from different service areas were small and not statistically significant (see **Figure 7.2**). Note that a small percentage reported that "no help was offered." This was a matter taken up in Chapter 6 where the service response was described. However, it is not surprising to find some families reporting that no help was provided or offered as it is sometimes the case that no outside assistance is required by such families. And, as was seen in Chapter 4, while a majority of families who received a DR family assessment were near or below the poverty line, there were also some with the means to provide for themselves anything that might have been viewed as necessary by the case worker. It should also be remembered that the acceptance of services by DR families is voluntary unless the worker believes it is in the safety interest of the child; in such cases, were a family to refuse services the course of action required of the worker would be to refer the case back to CPS for a formal investigation.

The last question in this series asked whether families saw themselves as better off or worse off because of this experience. Three out of four (76 percent) respondents said they thought they were better off. A very few (4 percent) said they were worse off. Most of the rest (20 percent) said it had made no difference; whether this was due to the extent of their needs, the availability or

accessibility of services, or disagreement between the family and the worker of what was needed cannot be known from this question, but is a matter that will be part of the discussion of services in Chapter 6. Differences among families from different parts of the state on this question were not significant. (See **Figure 7.3**.)

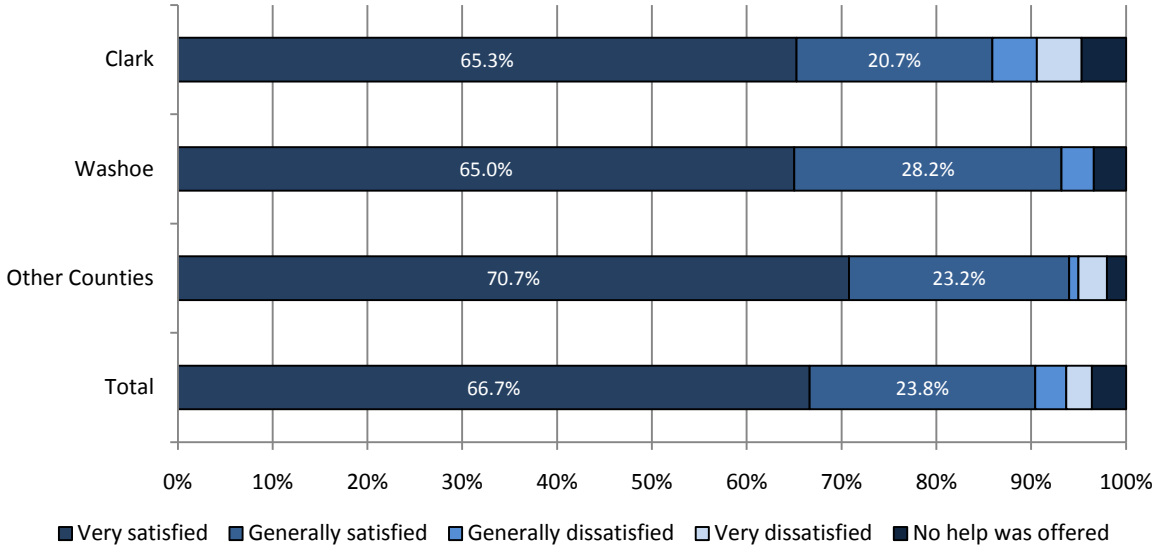


Figure 7.2. Level of satisfaction with help received or offered.

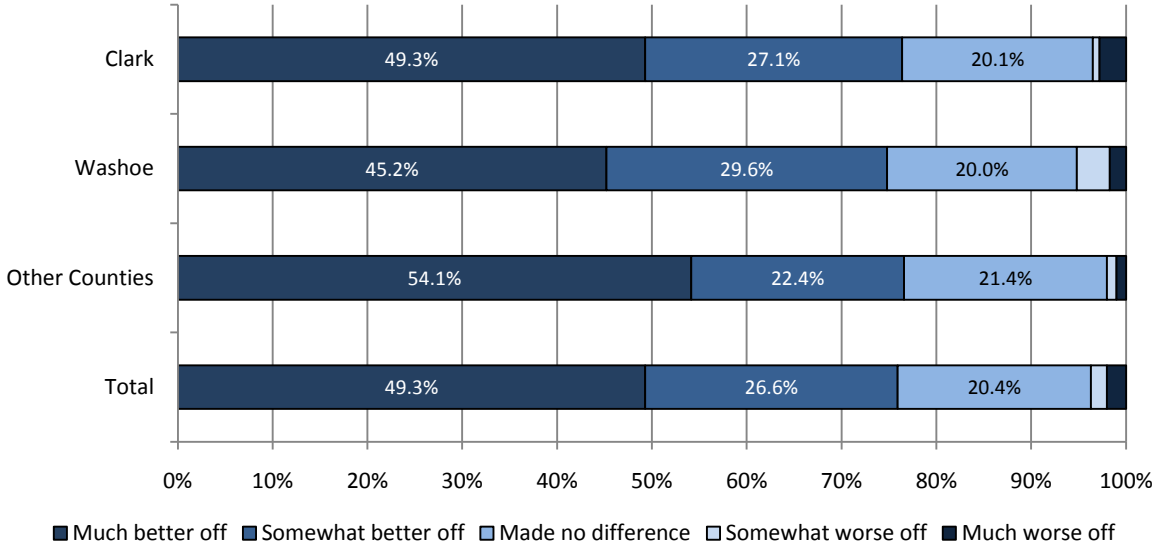


Figure 7.3. Respondent sees family as better off or worse off

Family Comments

Written comments provided by caregivers on the survey reflect the general satisfaction with treatment and help from the DR worker shown in the figures above. The large majority of comments were positive and expressed an appreciation for the attitude and emotional support of the worker. Many families wanted to thank their caseworker directly, and often did so by name.

> "[DR worker] was absolutely amazing with our family. I would turn to her in any time of need."

> "Our experience with [DR workers] was wonderful! They both went out of their way to help me and my family in every possible way they could. We appreciate everything they've done for us! They are great people!"

Some of these comments stressed in particular the worker's ability to listen and provide advice. The following remarks demonstrate the trust and communication that developed between some families and their DR workers:

> "You guys do a lot of extraordinary work to help people like me who need family advice. It was the best advice you all could've given me."

> "The way [the DR worker] listened to me and gave me advice on how to get out of my dilemma was amazing; she gave me lots of assurance that what I'm doing with my family is good…"

Several families described specific problems that the worker helped to resolve. Caregivers commented on the determination and dedicated of the worker to find real solutions:

> "He kept trying until we got help for our child."

> "[The DR worker] is truly interested in helping families. Thank you personally to have her and for her aptitude and capacity to solve problems."

For some, the intervention of the DR worker allowed them to make notable progress on an issue affecting their lives, and left them in a visibly better place. These changes were described in their comments:

"I would like to thank [the DR worker], for all of her help, support and kind words in this most difficult time in my daughter's life. She has helped me to understand what is happening in our lives, supported my daughter by visiting her school and working with the school counselor, and by giving me words of encouragement. I'm not happy about her closing out this case but I understand she will be helping other families in need of assistance."

"I'm glad she came into my life with my son. He is now doing better and his outlook on things are much better."

"I was overwhelmed as a divorced mother of 5. I have kidney failure and am sick a lot. My kids hated school, their teachers. The case worker helped us. We enrolled the kids in a new school. They don't miss any days now. They like it. My son has PTSD, ADHD, and ODD. He is doing so much better. He's calmer before he gets angry. It has helped us out so much. Their dad abused us all. We are so much happier now."

"Social worker helped our family a lot. We are not stressed anymore about our kids' attitudes and the kids learned a lot too. She guided us and was patient and listened to our needs. Without her we would still be struggling parents."

Comparison of Family Responses in Other States

Because there was not a control or comparison group of Nevada families who were surveyed, there is no frame of reference within the state to assess the reactions of families we have just reported. There is no doubt that the response to DR family assessments has been positive, but compared to what?

Nevada is the fourth state in which we have surveyed families as part of an evaluation of a differential response program. The three previous are completed and part of the public record.[10] These were studies of the DR programs in Minnesota, Missouri and Ohio. The studies in Minnesota and Ohio were experimental designs with randomly selected control groups. The Missouri study was a quasi-experimental study that utilized a comparison group from counties not involved in the pilot studies. The Minnesota and Missouri studies included second, extended follow-up studies of families in the study population. The results of these studies were positive, that is, the programs achieved their objectives: families responded positively to the new family assessment approach,

[10] Evaluations reports can be found at www.iarstl.org.

more services/assistance was provided to the families than would have been otherwise, and their outcomes were likewise positive, that is, there was a diminishment in their subsequent contact with the child protection system.

In each of the three other studies, families were asked the same three questions that have been used as barometers for assessing family satisfaction in this study: 1) How satisfied are you with the way you and your family were treated? 2) How satisfied are you with the help you received or were offered? 3) Overall, is your family better off or worse off because of this experience? In each of the other studies the family respondents who had received the DR-family assessment approach were significantly more positive than their control-group counterparts who received a traditional investigation. The following three bar graphs display the responses of families who received the DR-family assessment approach in the three other states, along with the responses of Nevada families.

A review of the data displayed in the three graphs (**Figures 7.4, 7.5, and 7.6**) shows that Nevada families have been at least as positive in their reaction to family assessments, and sometimes even more positive, than families in the other states. The data in Figure 7.4, for example, shows that a larger percentage of Nevada families have said they were "very satisfied" with the way they were treated and fewer have said they were dissatisfied than was the case in other states. The same is true, or nearly so, in the responses of families to the other two questions. (See Figures 7.5 and 7.6.)

While these comparative statistics should provide a measure of comfort for policy makers and practitioners in Nevada, the question they beg is: Why are the Nevada responses so positive? The evidence strongly suggests the data represents the views of DR families in the state. Additionally, there are two features of the Nevada program that are different from the DR programs in the other states. One is that DR family assessments are handled outside of state and county child protection agencies by case workers in community agencies. Few of these DR workers have had any experience with CPS (although a small number have); most, therefore, carry no baggage, positive or negative, from a child protection-investigative approach to child maltreatment reports. Secondly, however, Nevada selects a much smaller percentage of its child maltreatment reports for the family assessment response. The Nevada DR cases represent the mildest end of the child-risk spectrum. A majority of the child abuse/neglect reports that were selected for a family assessment in the Minnesota, Missouri and Ohio pilot projects would be investigated in Nevada. (See Chapter 3.)

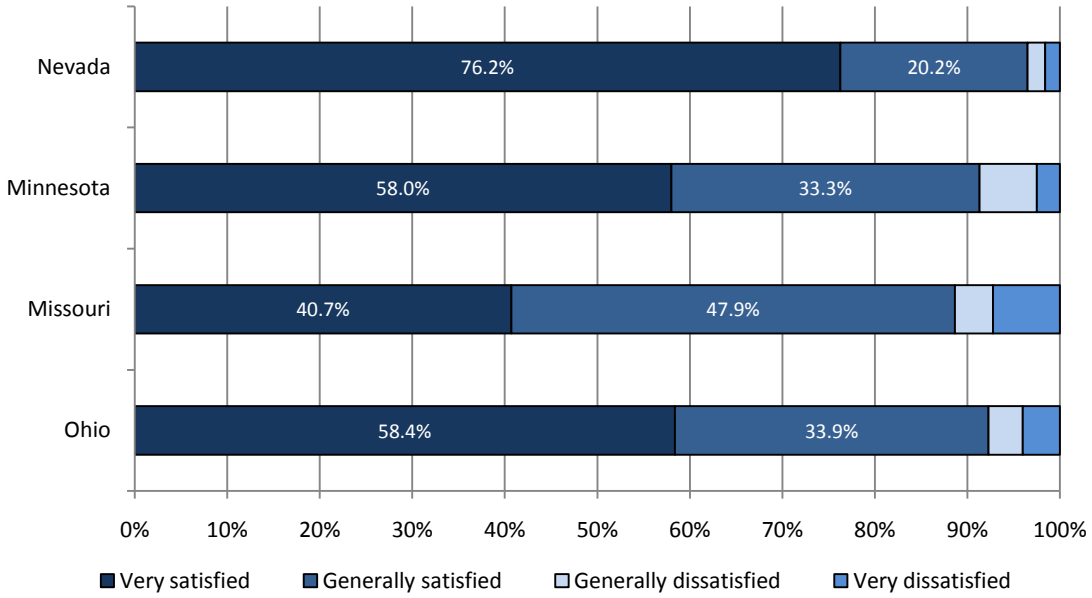


Figure 7.4. Question: How satisfied are you with the way you and your family were treated by the worker(s) who visited your home?

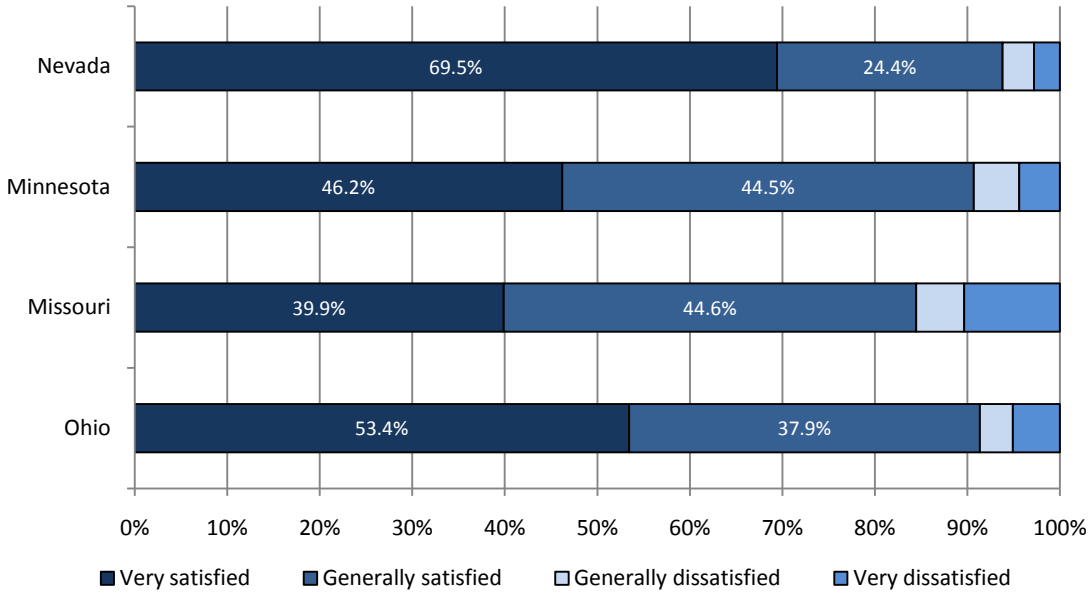


Figure 7.5. Question: How satisfied are you with the help you received or were offered?

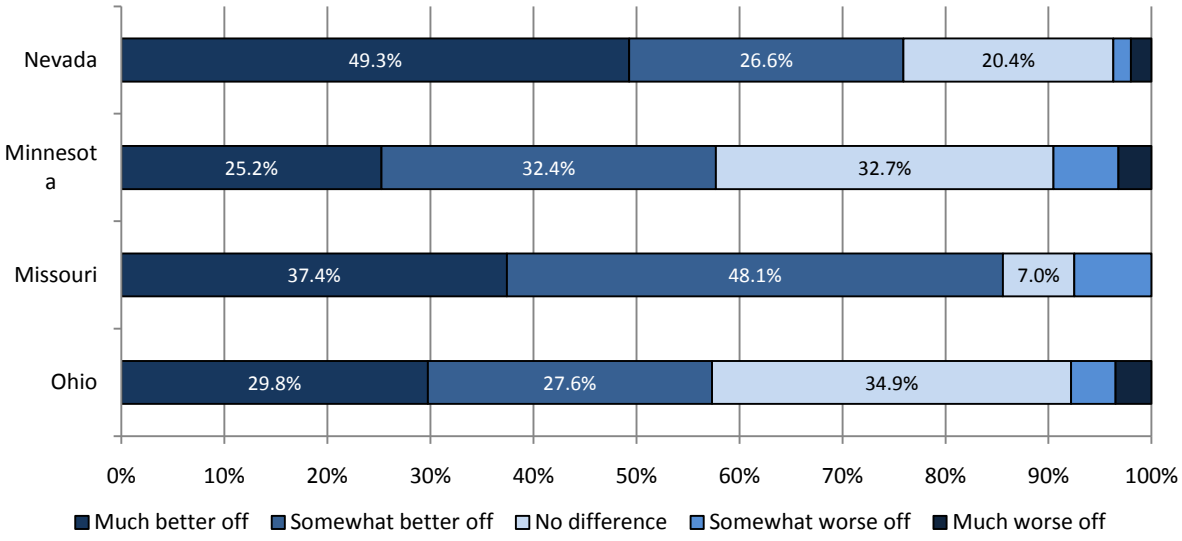


Figure 7.6. Question: Overall, is your family better off or worse off because of this experience?

The Relation between Services and Family Satisfaction

DR Families who received services as part of the differential response family assessment intervention were more likely to be satisfied with the way they and their families were treated ($p<.000$). They were also more likely to say that their family was better off because of the experience ($p<.002$). Overall, families who received multiple (two or more) services were more satisfied with the help they received from DR workers.

Families who received services were also more likely to feel that they were more able to care for their children now than a year ago ($p<.005$). These families also expressed more confidence in their ability to deal with problems and conditions in their life compared to a year ago ($p<.001$). Responses to these items were also more positive among families who received multiple services.

There was also a general correlation between the provision of services to a family and the family's view of the manner in which they were approached by the DR worker. For example, DR families who received services were more likely to report that workers treated them and all family members in a friendly manner, that the worker listened to them and tried to understand their situation and needs, and that the family was more involved in decisions that were made about themselves and their children ($p<.002$). Additionally, DR families who received services were more likely to express a positive emotional response to the family assessment ($p<.001$); specifically, they were more likely to say they were hopeful (41 percent compared with 17 percent of DR families who did not receive

services), thankful (51 percent vs. 23 percent), grateful (41 percent vs. 15 percent), encouraged (36 percent vs. 12 percent), and optimistic (28 percent vs. 19 percent).

Who Received Services?

Feedback from families through the surveys provide a picture of the kinds of DR families who were more or less likely to receive services. In general, families who reported a greater degree of distress were more likely to have received services. Parents who expressed a higher level of stress in their relationship with their children were more likely to receive services. Similarly, families who reported a variety of problems associated with their children were more likely to receive services. This included children who:

- Had a serious illness ($p<.007$)
- Had a developmental disability ($p<.033$)
- Had trouble learning in school ($p<.012$)
- Had a hard time getting along with teachers ($p<.02$)
- Had a hard time getting along with other students ($p<.01$)
- Acted out to get attention ($p<.008$)
- Were difficult for the parents to control ($p<.02$)

Families who experienced a higher level of stress regarding their financial situation, their relationships with their children and the other adults in their lives, the well-being of their children and their own general well being were more likely to receive multiple (more than one) service from DR workers.

In addition, services were more likely to be targeted to families of lesser means. Families who were poorer and had lower incomes were much more likely to receive services. Families with household incomes below $15,000 for the past 12 months were much more likely to receive; in fact, 70 percent of the families with household income from all sources of less than $15,000 received some services. In general, the poorer a family the more likely multiple services were provided by a DR worker.

This relationship between service provision and income is more understandable when one recalls how often services provided to DR families were related to basic needs, needs much more likely to be present among poor families. This relationship between services, income and need has been found consistently in our evaluations of differential response programs in states. Another indicator measure of the status of families is housing stability; and families who had moved one, two or three

times during the previous 12 months were more likely to report that they had low household and that they had received services through DR.

Summary

Nearly all families who have received a DR family assessment expressed satisfaction with the way they were treated and with the help they received or were offered. Most also felt their families were better off for the experience. The response of Nevada families was as positive as families in other states who participated in similar evaluations of differential response pilot programs. Overall, families who received services expressed a greater degree of satisfaction with the program. Importantly, families who received services tended to be those experiencing significant problems related to the wellbeing of their children and/or who lived in poverty and whose problems were sometimes acute but often chronic in nature.

Chapter 8. Perspectives of DR and CPS Workers

As important as it is to gain the views and experiences of families who have been affected by the introduction of differential response, it is equally important to learn the perspective of workers. Workers represent their agencies in the field and, in a very basic way, an agency's policies are to be found in the day-to-day actions of workers and their interactions with families. In Nevada, family assessments are the primary responsibility of DR workers in area Family Resource Centers. But the role of CPS workers should not be underestimated; they are involved in the training of DR workers, are the source of referrals and guidance, provide the broad system context within which the DR program and DR workers engage families, and could well be involved in any significant future expansion of differential response in the state.

Throughout the evaluation, the views and experiences of FRC DR workers and county and state CPS workers were solicited during on-site interviews. In addition, an internet-based survey of these workers was conducted during the final quarter of the evaluation in 2010. A similar survey was carried out in two year ago in 2008 in the early stages of the study and the results were included in the first annual report of the evaluation. Both interviews and surveys provide useful qualitative information on worker attitudes and perceptions related to the new approach. The information collected through interviews is more anecdotal in nature, while that provided in the surveys is more systematic. This chapter provides a summary of major findings from the August 2010 survey, augmented with information from interviews. Differences between DR and CPS workers are discussed as are significant changes in findings from the 2008 survey, along with similarities and differences among workers in different parts of the state.

There were 112 workers who completed the 2010 on-line survey, 91 CPS workers and 21 FRC-DR workers. Among DR respondents, 15 were engaged in conducting family assessments, while 6 were involved in program coordination and supervision. Among those who conducted family assessments, 13 did so full-time and their average DR caseload at the time of the survey was 12.8 (7 workers had 14 or more current DR cases); another DR worker conducted family assessments part-time due to insufficient referrals; in another FRC a program coordinator handled a small number of family assessments because of high demand. Among the CPS workers who responded to the survey, 75 (82 percent) conducted investigations and/or were involved in case management, while the others were involved full or part time in staff supervision, intake or had other (and frequently multiple) responsibilities. CPS workers with caseloads averaged 17 cases, of which 5.3 involved children removed from their homes.

Worker Perceptions of Assistance to Families

DR workers were more positive than CPS personnel when asked how families viewed their agencies. On a scale from 1 to 10 (1=very negative, 10=very positive), DR workers reported that the families they worked more often viewed their agency as a source of support and assistance (mean 8.7) than CPS workers (5.9, p<.001). Similarly, DR workers reported that families who received family assessments were more likely to feel they are better off because of the involvement of their agency (mean 7.9) than CPS workers (5.9, p<.001). See **Figure 8.1**.

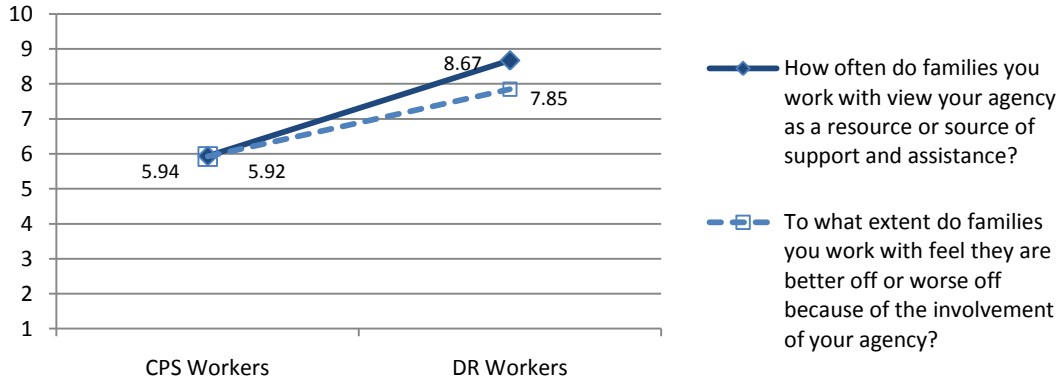


Figure 8.1. Worker perceptions of family attitudes

DR workers were also more positive than CPS staff in their assessment of how they themselves felt about the effectiveness of their work. DR workers were more likely to view the family assessment interventions with families and children as more effective than CPS workers viewed investigations and case management (p<.009). DR workers also saw themselves as more often able to help the families they worked with receive services they needed than CPS workers (p<.009). See **Figure 8.2**.

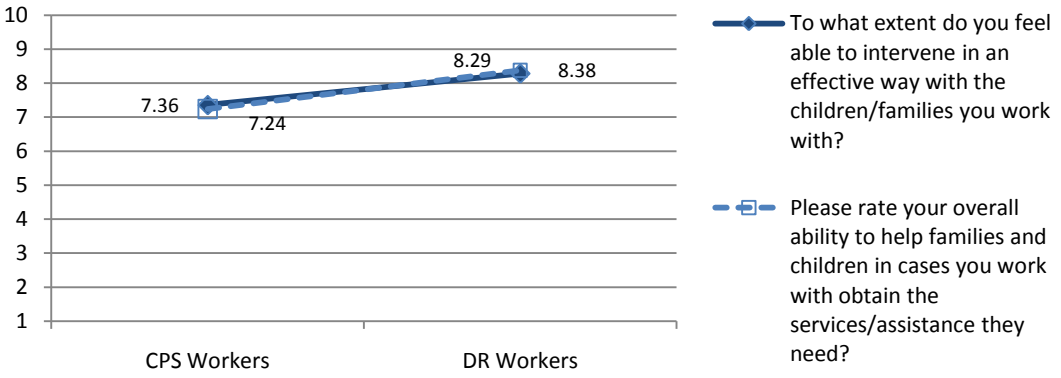


Figure 8.2. Worker perceptions of their own effectiveness

DR workers expressed more confidence in their knowledge of service resources in the community. On a 10-point scale, where 1 was "very poor" and 10 was "very good," the average self-rating among DR workers was 8.7 compared with 6.8 among CPS workers. The difference between the two groups of workers was statistically significant (p=.000) despite the fact that CPS workers were not less experienced than DR workers in the field of child welfare and protection and had been working at their present jobs longer than DR workers.

How Workers View the Child Protection System

While DR workers tended to see themselves as more effective in working with families than CPS workers, DR workers were less positive than CPS workers in their assessment of the child protection system in their county. When asked to indicate on a 10-point scale (where 1 was very dissatisfied and 10 was very satisfied) how satisfied they were with the system, the mean response of CPS workers was 7.5 and the mean response of DR workers was 6.5, a statistically significant difference (p=.03). Respondents from the rural counties tended to express a greater degree of satisfaction with the child protection system than workers in Washoe and Clark counties. Respondents in Clark expressed the lowest level of satisfaction with CPS in their county. (See **Figure 8.3**.)

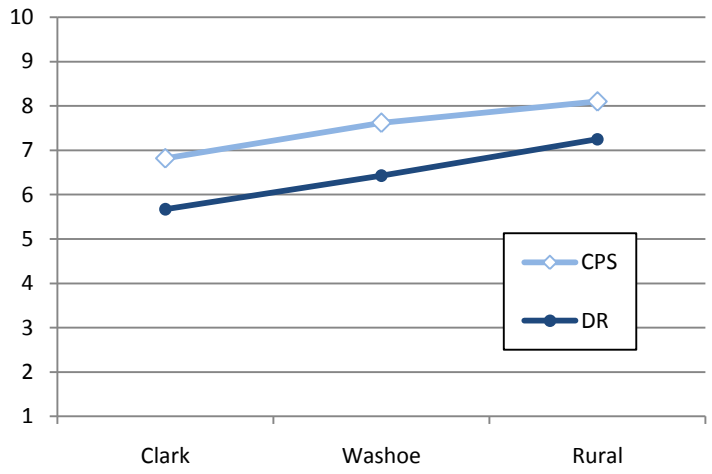


Figure 8.3. Worker satisfaction with the child protection system in their county

Workers were further asked how effective the current child protection system was in working with families with certain problems and conditions. Overall, while the responses of both groups were somewhat reserved, CPS workers were more positive in their assessments than DR workers. The mean responses of both groups can be seen in **Figure 8.4** (again on a 10-point scale, where 1=very ineffective and 10=very effective). In the figure, the problems seen as most effectively addressed are towards the right end of the chart and the problems seen as least effectively addressed are towards the left end. While the mean response on nearly all problem areas were higher among CPS

workers, the greatest differences (and statistically significant) were found related to five areas: moderate to severe physical abuse, neglect of basic needs, lack of supervision, and drug and alcohol abuse.

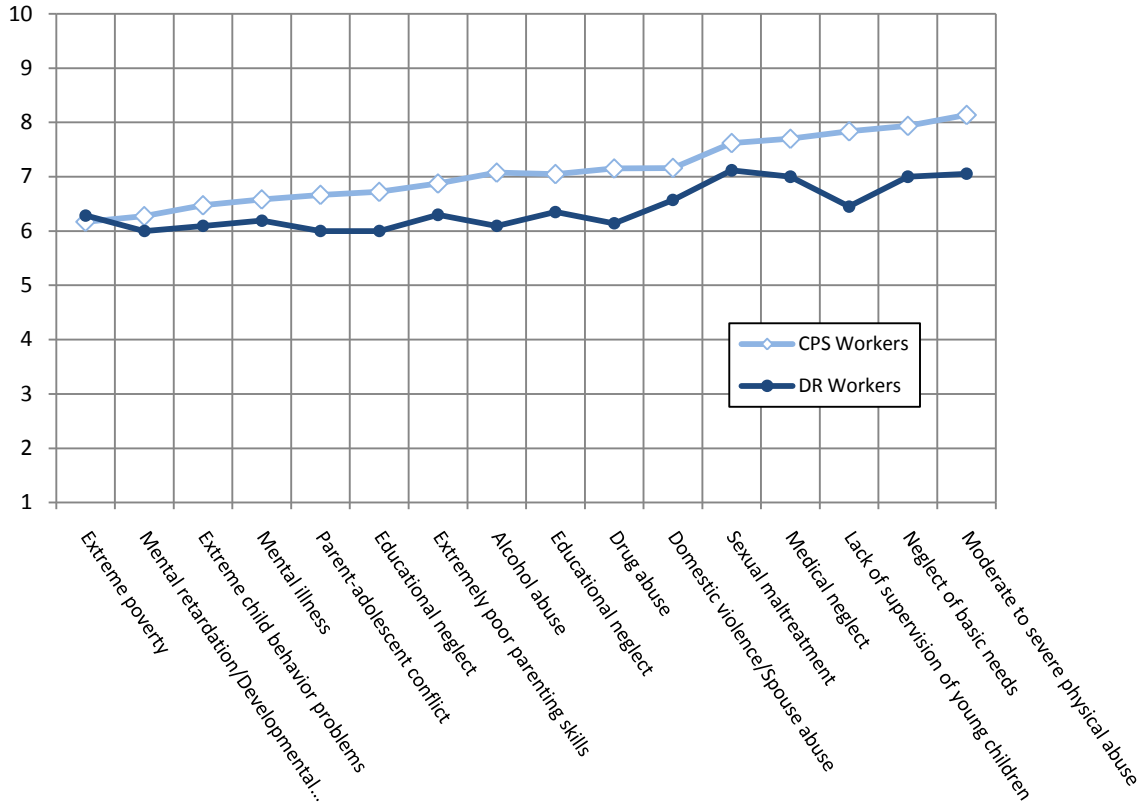


Figure 8.4. Perceived effectiveness of child protection system to address specific problem areas

Worker Job Satisfaction and Workload

CPS and DR workers were asked how satisfied they were with their jobs and their workloads. The survey included these three questions:

1. How satisfied are you with your child protection job?
2. How satisfied are you with your workload and duties?
3. To what extent do you feel "burned out" by the demands of your job?

Workers were asked to respond on a 10-point scale. For the first two questions, the scale went from "very dissatisfied" (1) to "very satisfied" (10), so a higher number indicated greater satisfaction. For the last question, the scale went from "not at all" burned out (1) to "completely"

burned out (10), so a higher number indicated greater job stress. The mean responses of CPS and DR workers can be seen in **Figure 8.5**.

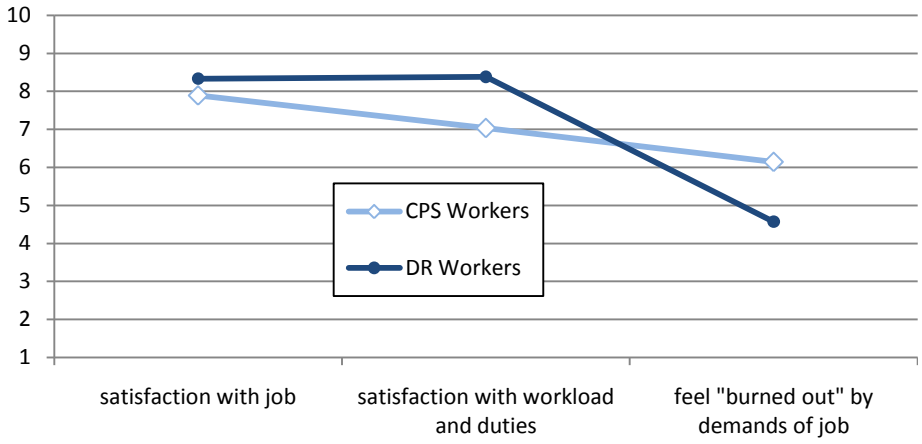


Figure 8.5. Worker ratings on job satisfaction and workload questions

Overall, CPS and DR workers' satisfaction with their jobs was relatively high. Satisfaction with workload and duties was not rated as high among CPS workers, but still remained on the positive end of the scale, although the difference between the two worker groups was statistically significant (p=.008). Responses about "burn out" were also significantly different (p=.01), with CPS workers reporting more job stress than DR workers. Among CPS workers, job stress and burn out were a more significant issue in Clark County (see **Figure 8.6**). There were no significant differences in job satisfaction or job stress among DR workers from different parts of the state.

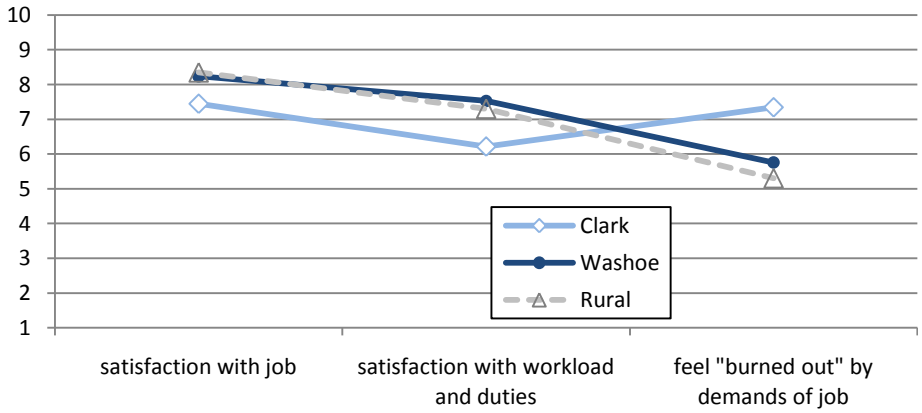


Figure 8.6. Job satisfaction and job stress among CPS workers

CPS workers were further asked how the introduction of differential response had impacted their job and workload. Most often, workers involved in investigations and case management said either that DR had had no impact on or had decreased their caseload size, workload, paperwork and job-

related stress. For example, 29.3 percent said the size of their caseload has not been affected, while 63.4 percent said it had decreased; a few (7.3 percent) reported an increase in caseload size. Similarly, 45 percent said their workload had not changed with DR and 45 percent said it had been reduced. And a majority (57 percent) reported DR had no affect on job-related stress, while a third (32 percent) said their job stress had decreased. Reductions in job stress were correlated to reductions in caseload size and overall workload. CPS supervisors reported similar essentially the same job-related affects from the implementation of differential response, with slightly higher numbers (about 1 in 6) reporting an increase in workload and job stress.

Worker Understanding of DR

It is fundamental for the correct implementation of a new program that workers have a clear grasp of its nature and purpose and why it is being introduced. In the General Worker Surveys conducted in 2008 and again in 2010, workers were asked: How well do you understand the goals and philosophy of the differential response approach to child abuse and neglect that is being implemented? Their responses can be seen in **Figure 8.7**. The first set of bars at the top of the graph shows the responses of DR and CPS workers to the most recent survey. As can be seen, DR workers have a great deal of confidence in their understanding of differential response; over 80 percent described their level of understanding as thorough, while the other 20 percent said it was adequate. Most CPS workers, on the other hand, expressed less confidence in their understanding of DR. Just 7 percent described their understanding as thorough and 40 percent said it was less than adequate or poor. These responses were quite similar to those reported in the 2008 survey, although the DR program was not up and running in as many counties then.

While it is essential that workers engaged in DR have a clear and complete understanding of the family assessment approach, there are important reasons why all CPS workers should be fully cognizant of DR as well. Beyond making the child protection system more coherent, it facilitates the referral of reports to FRCs for DR and for switching cases when necessary from one pathway to the other. Moreover, it is unlikely that many key stakeholders in the community—such as judges, prosecutors, educators, policemen, child and family advocates, and community resources of all kinds—will understand DR as might be desired while some CPS staff remain less fully informed about it. Nor can CPS itself benefit from DR, or know how or why it might benefit from it, nor understand how it is part of the state's child protection system, as long as it remains out of view and out of mind. Finally, because DR training includes the shadowing of CPS workers conducting investigations, it is essential these CPS workers have an understanding of what the DR workers are expected to do, just as the DR workers learn what and how and why CPS workers do what they are required to do.

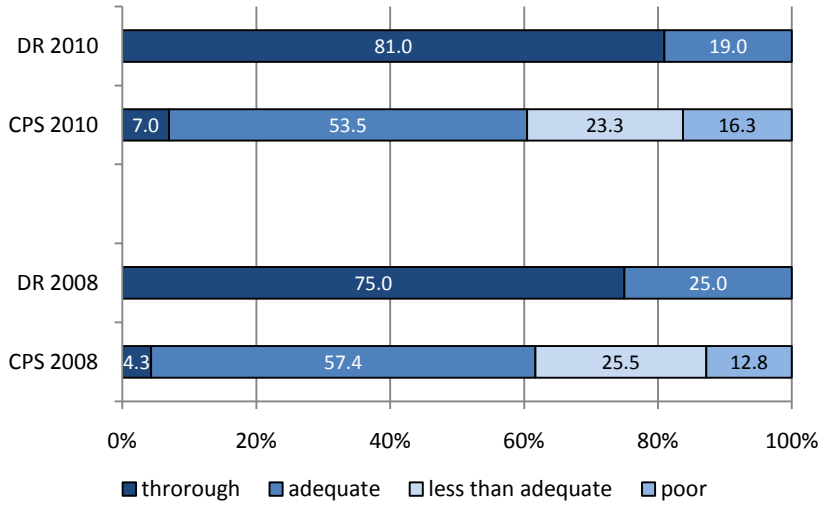


Figure 8.7. Level of understanding of DR expressed by DR and CPS workers

CPS workers in rural counties were most likely to report they had at least an adequate understanding of DR, and the program has been operating for the shortest time in most of these counties. In Clark and Washoe counties knowledge of DR is more lacking and many CPS workers expressed a less than adequate or poor understanding of the DR approach. See **Figure 8.8**.

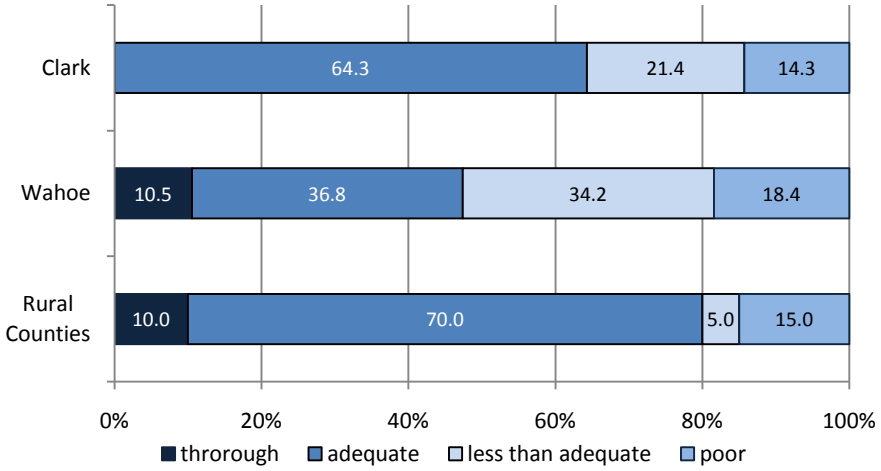


Figure 8.8. Level of understanding of DR among CPS workers in different areas

Figure 8.9 is a depiction of how CPS and DR workers view the differential response compared with traditional investigations. The figure includes a set of items that are elements of the DR model as it was described in Chapter 1. In the General Worker Survey workers were asked about these items. They were asked whether they saw any differences in them between DR family assessments and traditional investigations in their counties. Their responses, therefore, may be taken as their level

of awareness about what is taking place in each approach. As can be seen, the responses of CPS and DR workers to individual items are often quite different, with DR workers more likely to give responses that might be expected were the model implemented as intended, that is, with model fidelity. For example, we would expect to find families more often participating in decisions and case plans in DR-family assessments (last item on the right of the graph). Similarly we would also expect families to be more often approached in a friendly, non-accusatory manner (the item on the far left of the graph). As can be seen, CPS workers were more likely to respond that there was not that much difference in most of these areas whether a DR-family assessment or an investigation had taken place. At the very least, this chart represents areas in which the DR program needs more or less attention to improve or areas that should be targeted for training, especially among CPS workers. Beyond this, it represents a set of items that could be used in the periodic tracking both of DR program elements and worker knowledge of DR. In addition, some of the items—such as, whether families receive any services, services they need, services sooner, and referrals to resources in the community—are areas that can and should be tracked periodically with respect to reports that are investigated.

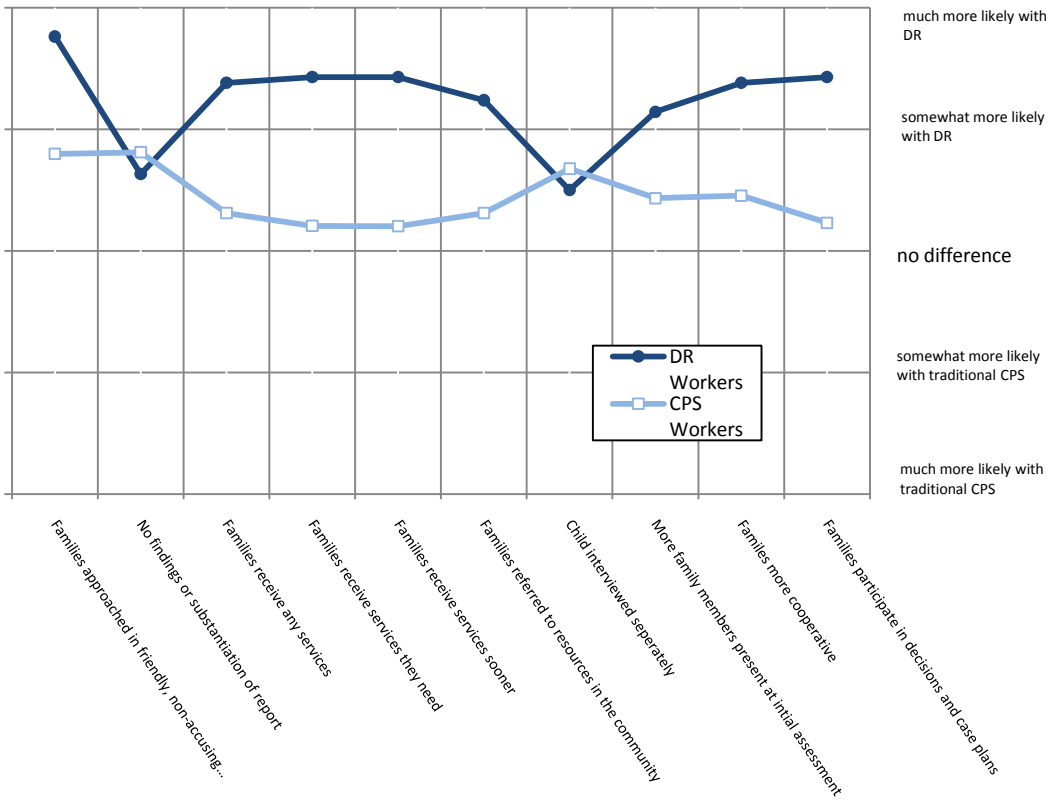


Figure 8.9. The way CPS and DR workers view DR

Training Needs

The response of CPS and DR workers to questions about the differential response program in the state underscores the need for training for both groups of workers. The workers themselves were asked if they felt the need for more training related to differential response and many said they did. Fourteen percent of DR workers and 21 percent of CPS workers said they needed "a lot" more training in DR. Many in both groups of workers said they needed "a little" more training—62 percent of DR workers and 50 percent of CPS workers. An additional 13 percent of CPS workers said they were unsure whether or not they needed more training, which generally means they probably do. Just 24 percent of DR workers and 16 percent of CPS workers said they did not feel the need for more training. See **Figure 8.10**.

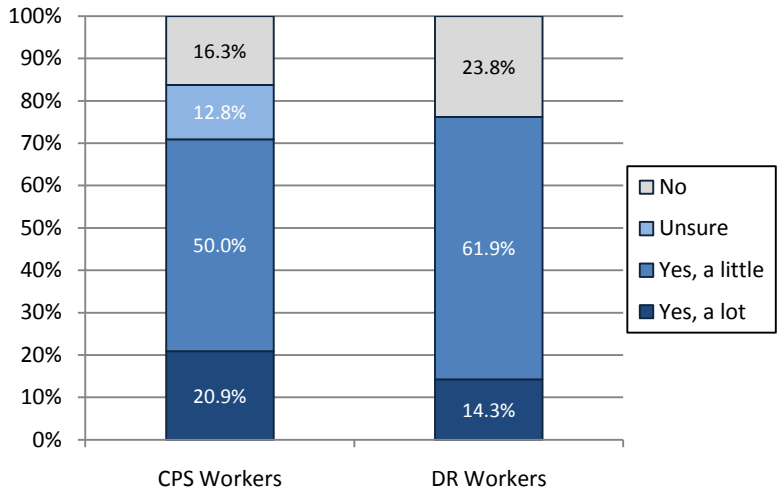


Figure 8.10. Percent of workers who said they needed more training in DR

Figure 8.11 shows the response of CPS workers in Clark, Washoe, and the rural counties when asked if they felt the need for more training related to DR. Including those who indicated "unsure" with those who expressed a need for more training, 80 percent of CPS workers in all three areas expressed a need for more training. While there are some differences in what workers say, the bottom line response was that a need for additional training exists across the state among CPS workers.

A majority of FRC-DR workers in each major service region expressed the need for at least some additional training. One-third of the workers in Clark County said they needed "a lot" more training. (See **Figure 8.12**.)

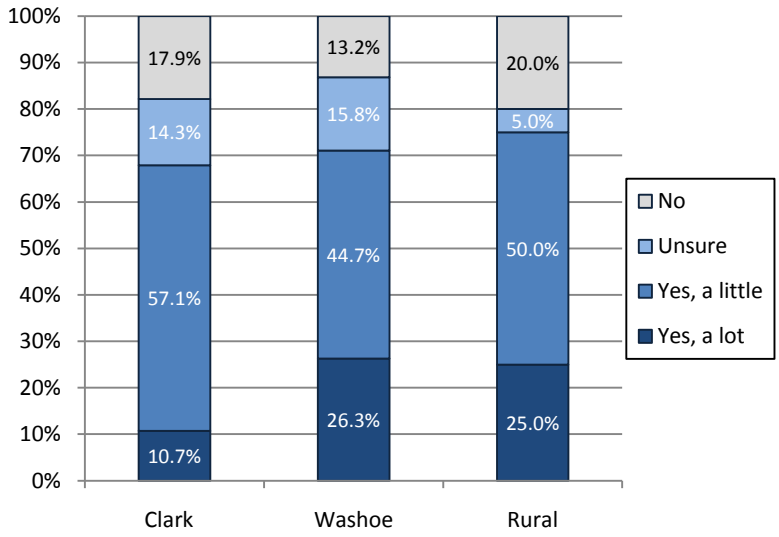


Figure. 8.11. Percent of CPS workers in different areas who said they needed more training

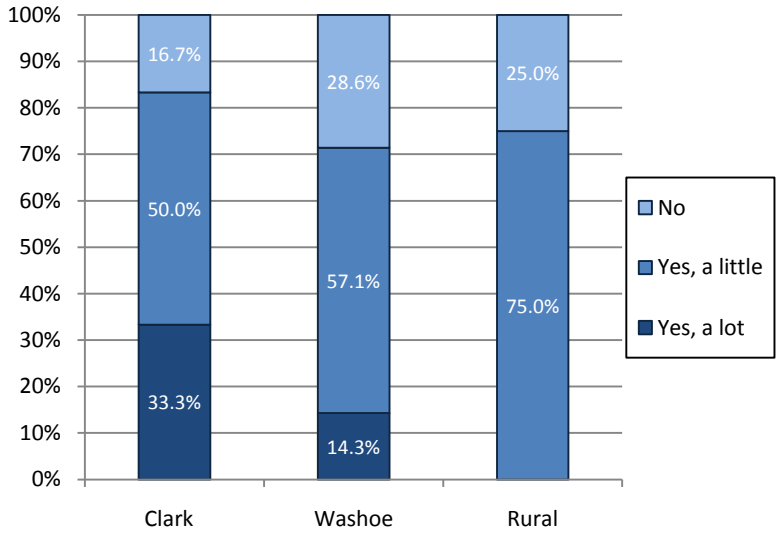


Figure. 8.12. Percent of DR workers in different areas who said they needed more training

The following is a summary of the training provided to new DR workers that was included in the second annual report: Training for new DR workers includes an introduction to DR and its procedures and an overview of CPS activities. Workers participate in three to five days of general training on DR, including instruction on documentation, the NCFAS-G, case plan implementation, DR case management and family engagement. Workers also participate in a two and a half day Safety Training and a one day UNITY training conducted by the CPS training team. In addition, new DR

workers observe the screening of incoming calls at the Child Abuse and Neglect Hotline and attend a session of Family Court. After this introduction, new DR case managers shadow CPS investigators for at least one day. Training also includes several days of observing more experienced DR workers at work. The experience of shadowing CPS staff provided an important education on the procedures of CPS and the process of handling a case in court. It also created a portrait of the way in which DR is distinct from an investigation. A county DR worker said:

> "One home I went to with CPS was an educational neglect case, lack of supervision. We go to the home, everyone is sleeping. The investigator just walks in, sits down and starts talking. She woke up the child she needed to speak to. It was clear that she 'had authority' and that was the point. She said who she was and expected people to let her in….people seem afraid of CPS. Some CPS workers have an attitude that the families are not being honest, that that's par for the course. The worker has seen it all before and knows what is going to happen. DR workers don't walk in thinking 'here we go again.' It's new for us. We have a lighter, fresher approach. Although sometimes you wish as a DR worker that you did have that authority. DR training was successful in conveying the differences between CPS and DR in the way authority is demonstrated, and the attitude and assumptions made by workers."

In 2009, evaluators attended a group training held in Reno. The week-long session targeted all current and new DR workers and supervisors in counties with active programs. Material covered during the training included: 1) a workshop on Child and Family Team Meetings; 2) a Q & A Panel on UNITY; 3) a presentation on how to recognize Suicide Risk; and 4) a comprehensive two-day session on Child Safety Decision-Making. Participants also spent valuable time interacting with one another in a group setting as well as sharing stories about their experiences with DR between sessions. Informal participant feedback on the training suggested that the Safety Decision-Making workshop provided the most practical information for workers, though most of the workers had already completed safety training. This session re-introduced DR personnel to the utility of the Nevada Initial Assessment (NIA) in identifying present and impending danger in families. Other feedback from workers implied that the session on Child and Family Teams was not tailored for DR and therefore seemed to have less relevance. Most DR meetings conducted with the family and their supports are done in a much more informal and unstructured. Participants would have liked the session to be more introductory and exploratory in how CFTs can be used for DR situations.

Supplementary training, like the session in Reno, might usefully emphasize strategies for encouraging family cooperation and participation, as this is an area of frustration workers mention most often. Future training might also include more peer coaching and special sessions on constructive ways to overcome the resistance of chronically reported families without the relying

on the involvement of CPS. Practical training provided by individuals with years of hands-on experience with the DR approach would be especially beneficial.

Worker Attitudes towards DR

In the survey, workers were asked their overall level of satisfaction with the differential response program in their county. The response of DR workers was significantly higher than that of CPS workers (p=.01). DR workers in rural counties tended to be more highly satisfied with differential response than those in Washoe and, especially, Clark. (See **Figure 8.13**.)

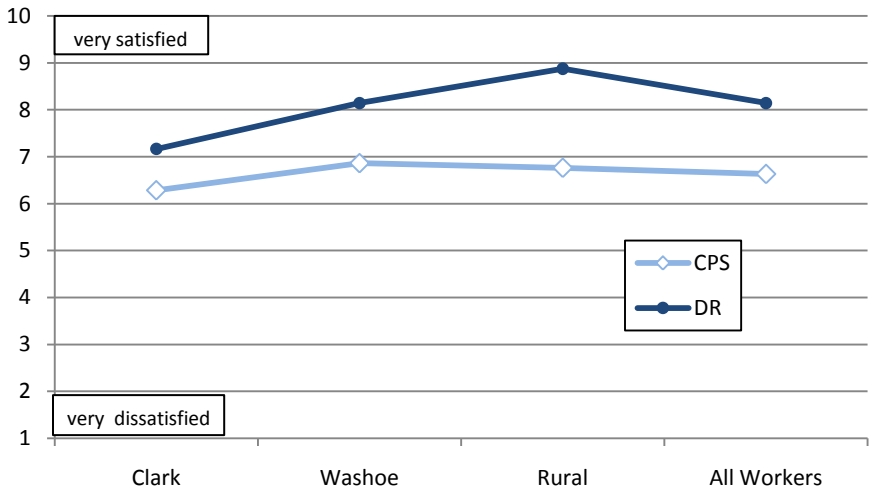


Figure 8.13. Worker satisfaction with DR in their counties

At the Big DR meeting in Clark County between FRC and CCDFS personnel that the evaluator attended in April 2009, county CPS staff were asked about any benefits they saw in DR from the point of view of CPS. Taking turns the CPS workers said that DR:

- Reduced CPS caseloads.
- Kept families from coming back.
- Helped the morale of CPS workers.
- Allowed CPS to stay focused on more serious cases.
- Helped CPS become more familiar with FRCs and the resources they have.
- Improved the development of and CPS knowledge about the broader resource base in the community.

Summary

DR workers were more positive than CPS workers when asked how families viewed their agencies. DR workers were also more positive than CPS staff in their assessment of how they themselves felt about the effectiveness of their work. DR workers were more likely to view the family assessment interventions with families and children as more effective than CPS workers viewed investigations and case management. DR workers expressed more confidence in their knowledge of service resources in the community.

A majority of both DR and CPS workers expressed a need for more training. The lack among CPS workers of both a comprehensive theoretical understanding of DR and of DR practice on the ground has important implications. Not only is it important in order to have a coherent, coordinated system, but it is unlikely that many key stakeholders in the community—such as judges, prosecutors, educators, policemen, child and family advocates, and community resources of all kinds—will understand DR as might be desired while some CPS staff remain less fully informed about it. Nor can CPS itself benefit from DR, or know how or why it might benefit from it, nor understand how it is part of the state's child protection system, as long as it remains out of view and out of mind.

Part 9. Comparative Outcomes: Subsequent Child Maltreatment Reports and Out-of-Home Placements of Children

The basic outcome of any child welfare reform program is the improved safety and general welfare of children and their families. One important measure of safety and by implication improved child welfare is the rate of subsequent reports of child abuse and neglect. It is reasonable to expect that successes in improving the conditions within families and the ongoing relationships between parents and their children might be reflected in a reduction of new reports alleging child maltreatment. A second general measure is the rate of subsequent child removals and out-of-home placements. This measure is focused on more extreme instances of child abuse and neglect. Like subsequent reports, however, it is logical to assume that positive and successful interventions in families that improve conditions might result in a reduction in later removals.

The perennial question concerning claims of reduced reports and child removals is, 'compared to what?' Increases and reductions in such outcomes occur every month and year for many different reasons. To determine whether such changes are the result of a particular reform program such as DR rather than simply random variations a comparison group of similar families is needed.

Under this approach, DR families are taken to constitute an experimental or *treatment group*. Other similar families that did not receive DR are selected and collectively referred to as a *comparison group*. DR represents a new approach. The comparison group embodies business as usual. The object is to compare the new with business-as-usual. Thus, the analysis consists of comparing the treatment and comparison groups for differences in outcomes. If the outcomes of the treatment group are relatively more positive than those of the comparison group, they may be attributable to the new program. Such comparisons speak to the benefits, if any, achieved through the introduction of DR.

We originally assumed that all or nearly all families with appropriate reports of child abuse and neglect that fit DR selection criteria would be referred to a Family Resource Center for a DR family assessment and possible services. However, it soon became apparent that not all the CA/N reports that might be appropriate for DR were receiving a family assessment. This is also evident from the analyses conducted at the end of Part 3 of the present report. This in turn resulted in an excess of DR-appropriate families that were instead approached by a CPS investigator. This permitted the evaluators to select a contemporaneous comparison group. Thus, the comparison group was composed of families that *could have* been provided with DR *but were not*. The process of selection

and the characteristics of resulting comparison group are discussed in greater detail below. The two groups are referred to as *DR families* and *comparison families*.

Comparison families were selected based on their overall similarity as a group to DR families as a group. This means that various proportions and averages—for example, the percentage with previous physical abuse reports—were similar between the two groups. The primary difference was that the families were treated differently by receiving either a family assessment or an investigation

Rates of Subsequent Reports. The UNITY (Nevada SACWIS) system records all reports that are accepted by the agencies for further actions. When a report is received, CPS personnel review it and a determination is made about how to respond to it. This determination is the initial disposition of the report. The report disposition along with the types of child abuse and neglect being alleged are also stored in UNITY. As noted earlier, before the introduction of DR, nearly all reports were either *investigated* or were assigned to one of two other categories: *information only* or *information and referral*. The two latter dispositions occurred when the allegations provided by the reporter did not appear to merit an investigation but it was thought the family might benefit from receiving information about or referral to services. DR was added to these three as a fourth major type of response.[11] This implies several possible measures of recurrence:

1. Any subsequent report received by the agency and accepted for a response of any kind
2. Subsequent reports classified as information only
3. Subsequent reports classified as information and referral
4. Subsequent reports accepted for investigation
5. Subsequent reports accepted for a DR family assessment

The fourth and fifth categories were also combined since some families in the DR group were reassigned to DR based on subsequent report, but comparison families were rarely so assigned. This made a fairer comparison of the two groups possible:

6. Subsequent reports accepted for either an investigation or a DR family assessment

In addition, it was possible to determine:

7. Subsequent investigated reports that were substantiated

[11] UNITY also accommodates a number of other dispositions, permitting referrals to other agencies and provision of treatment, but these account for only a small minority of reports.

This category could be used descriptively but is probably not a fair measure for comparisons since it is possible that reports on some families reassigned to DR *might have been substantiated if the report had been investigated.*

Each of these was measured by tracking families in UNITY. It was possible to track families in this system from 2000 forward, that is, for six years or more for each family.

Because differential response is *family centered*, the family was considered the unit of analysis for all measures of recurrence. Thus, *all reports were counted that occurred within the same family* regardless of which child in the family was reported to be the alleged victim or which adult was alleged to be a perpetrator.

Subsequent Child Removals. A second type of measure concerns removal and placement of children. This measure addressed the issue of whether providing families with DR dealt with issues that might avert later problems that would require removal and out-of-home placement of children. The expectation is that removals are generally less likely among the types of families that are deemed appropriate for DR. Nonetheless, child removals occur among a minority of DR families. The measure that was used was:

8. Subsequent removals and out-of-home placements of children

Different Lengths of Follow-up. The DR and comparison families entered throughout the course of the Nevada pilot project from February 2007 through the end of data collection in July 2010. The follow-up time during which subsequent reports and child removals might have been observed varied significantly from family to family—from one to 40 months. For this reason, it was also important to take variations in follow-up time into account when making comparisons, although it should be noted that *groups* of families selected partly on the basis of similar report dates are being compared and, therefore, differences in follow-up time tend to average out.

Delays in New Reports and Removals. The many months of time that most families were tracked also permits another measure of success. Regarding child maltreatment reports, for example, success can be measured not simply as reduction of the rate of new reports but as an increase in the length of time until new reports are received. Other things being equal, a family that has a new report in one month after the initial case closure might be viewed as less of a success than a family whose new report is delayed for a year and this family, in turn, would be considered less successful than a family that survived for two years without being reported again. Thus, both the rate of new events (reports or removals) and time until events took place (days until new reports are received or removals take place) were measures of success or failure.

Preparation for Comparison Group Analysis

By the end of July 2010, 2,305 Nevada families had been assigned to an FRC at least one time during the pilot period. This is an unduplicated count in that, as will be seen, some families assigned to DR for the first time had later reports and were reassigned to DR. Among these unduplicated families, FRC supervisors indicated that 63 had been returned to CPS for various reasons and that no casework occurred for an additional 39, usually because the family could not be found. From the UNITY system, we were also able to determine that 332 families subsequently had final report dispositions of *substantiated* or *unsubstantiated* (outcomes of traditional investigations), and therefore, must have been returned to CPS. Taking into account overlap these amounted to a total of 402 families that were assigned to an FRC for DR but did not receive DR. The final total was **1,903 unduplicated families**. In addition, UNITY data, as provided to us, were incomplete for 52 of these families, leaving 1,861 families available for the present comparative analysis.

The distribution of the 1,903 valid families across FRC locations is shown in the following listing (**Table 9.1**). Clark County served the largest number of DR clients, with 888 families, in part because the Clark East and South FRCs began DR a year before any other FRC and in part because Clark County is the largest population area in the state. Within Washoe, the Children's Cabinet served the largest number of cases. The rural counties served nearly as many as Washoe, although, save for Elko, the rural FRCs served DR families only during the final 17 months of data collection.[12]

Comparison Selection Method. The method for selecting comparison cases involved choosing all cases from the same county for which CA/N reports were received within a roughly comparable time period (plus or minus 60 days from the date of the target report for each DR case) and matching them on a set of demographic and report criteria. Only reports with a disposition of "investigation" were included. Two matches were selected for each DR cases. Subsequently, a procedure was followed that set aside matches to create greater similarity between the DR and comparison groups. This final step reduced the comparison group below the size of the DR group. For the present analysis there were 1,105 comparison cases and, as noted above, 1,861 DR cases with sufficient data for analysis.

We attempted to create separate comparison groups for the three areas shown in Table 9.1 (Clark, Washoe and Rural). The results were not satisfactory for separate analyses, primarily because of difficulties in finding suitable matches in Washoe County. For this reason, the analyses in this section were conducted for the entire statewide DR and comparison groups.

[12] Note that this is an analysis of unduplicated *families* rather than reports and proportions and averages may differ slightly from others provided earlier in this report.

Table 9.1. Cases Known to be Referred to FRCs

	Referred and Served Families	*Area of the State*	*Percent of State Total*
Clark		**888**	**46.7%**
Central	92		4.8%
East	213		11.2%
South	153		8.0%
West	101		5.3%
North	154		8.1%
Unknown	175		9.2%
Washoe		**564**	**29.6%**
Children's Cabinet	344		18.1%
Washoe FRC	192		10.1%
Unknown	28		1.5%
Rural		**449**	**23.6%**
Churchill	77		4.0%
Carson City	71		3.7%
Lyon	139		7.3%
Elko	118		6.2%
Pahrump	40		2.1%
Unknown	4		.2%
Unk. County/FRC	2	2	.1%
State Total	**1,903**	**1,903**	

Similarities and Differences between Comparison and DR Families. Given the outcome variables selection (report recurrence and subsequent removals) the most critical variables for matching are those indicating a past history with the system. *Past reports and investigations are the strongest predictors of future contacts with the system.* For example, among comparison families—which we take to represent the "business-as-usual" DR-appropriate families in the Nevada system—38.7 percent of families with one or more past investigations had one or more later investigations compared to 13.7 percent of families with no past investigations. The probability that this was simply a random difference was less than one in a thousand ($p < .001$). Past investigations predict future investigations.

In **Table 9.2**, such historical variables are shown for DR and comparison families. The aim of comparison selection was rough similarity between the two groups. In the event that such

similarity could not be achieved, the aim was to make sure that the DR group had *higher risk characteristics*. This latter is the most conservative method in the following way: if the DR group was higher risk and still exhibited better outcomes the conclusion that DR led to positive outcomes would be strengthened.

Table 9.2. Mean Number of Past Reports by Type and Allegation of DR Group Families Versus Comparison Group Families

Historical Contacts with CPS *Mean number of:*	***DR Group***	***Comparison Group***
Previous reports of any disposition*	2.26	1.81
Previous information only***	.63	.33
Previous information and referral***	.23	.12
Previous investigations	1.21	1.26
Previous DR family assessments	.10	.003
Previous removals	.33	.26
Mean number of previous reports with allegations of:		
Sexual abuse	.08	.06
Severe physical abuse	.02	.02
Physical abuse	.26	.24
Drug exposed infant	.004	.014
Severe neglect	.02	.02
Conflict/emotional abuse	.24	.23
Medical neglect	.06	.08
Unmet medical needs	.01	.01
Neglect of basic needs*	.75	.57
Lack of supervision	.31	.32
Educational neglect**	.12	.07

* p = .002 ** p = .005 ***p < .001

The average rates of past investigations in Table 9.2 were virtually identical for the two groups (DR: 1.21; Comparison: 1.26). However, DR families had more past reports (p = .002), more information only reports (p < .001) and more information and referral reports (p < .001). This might mean that DR families, as a group, could be considered at slightly higher risk for new reports. While DR had slightly more previous child removals on average (.33) than comparison (.26), this difference was not statistically significant.

Averages in Table 9.2 for various categories of allegations of previous reports differed in two areas: DR families had significantly more past allegations of neglect of basic needs, such as food, clothing

and housing, (p = .002) and educational neglect (p = .005). Overall, the match on allegations was good. The mismatch in the area of neglect of basic needs may indicate that DR families as a group were somewhat more impoverished than comparison families, because higher levels of these kinds of reports are associated with lower family incomes. The mismatch of educational neglect arose from an inability to find enough families on the comparison side with educational neglect reports that met other matching criteria. As seen earlier in the report, educational neglect cases were targeted as highly appropriate for DR leaving fewer to be assigned to the comparison group.

Priority was given to matching on previous child removals and reports of various kinds and less on family characteristics. Thus comparison families on average had slightly more children (DR: mean of 2.8 children; Comparison: mean of 3.2 children; p < .001) but slightly more two-parent households (DR: mean of 1.74 parents, Comparison: mean of 1.8 parents; p = .003). The former makes comparison families at slightly higher risk for new reports while the latter reduces their risk slightly. In addition, comparison parents were slightly older. For example, the primary parents/caregivers for DR averaged 35.7 years while the same for comparison families averaged 36.6 years (p < .001). These differences were all statistically significant but the sizes of the differences were small.

The two groups were also matched in other ways. The target report that led the family to a present investigation (for comparison) or family assessment (for DR) were limited largely to neglect cases and to reports with no preschool alleged victim child. Families were selected from around Nevada with a good mix of urban and rural locations. For example, among comparison cases 51.1 percent were from Clark, 20.4 percent were from Washoe and 28.3 percent were from rural areas. This can be compared to the proportions shown in Table 9.1 for DR of 46.7 percent from Clark, 29.6 percent from Washoe and 23.6 percent from rural areas.

Report Recurrence Outcomes

Figure 9.1 shows the proportions of DR and comparison families with new reports compared to past reports. Proportions of past reports were higher for both groups because past reports were counted for a period of six years or more—back to the year 2000. Subsequent reports were counted for various periods ranging from one to about 40 months—averaging considerably less than two years since more DR families entered later in the demonstration program. Thus, the apparent reduction in reports for both groups reflects the difference in the data period rather than any real reduction.

As was noted in Table 9.2 which examined means, DR families had more past reports than comparison families. This is reflected in the chart where 52.6 percent of DR families had at least one past report compared to only 45.4 percent of comparison families. The key in the chart is the

crossing of lines which reflects changes that may be attributable to the DR intervention with families. Among DR families during the follow-up period, 25.6 percent had one or more new reports compared to 31.9 percent of comparison families. Assuming the families were roughly comparable, we would have expected that the percentage for DR families would have been 37.0 percent (52.6 / 45.4 * 25.6). This difference is statistically significant ($p < .001$).

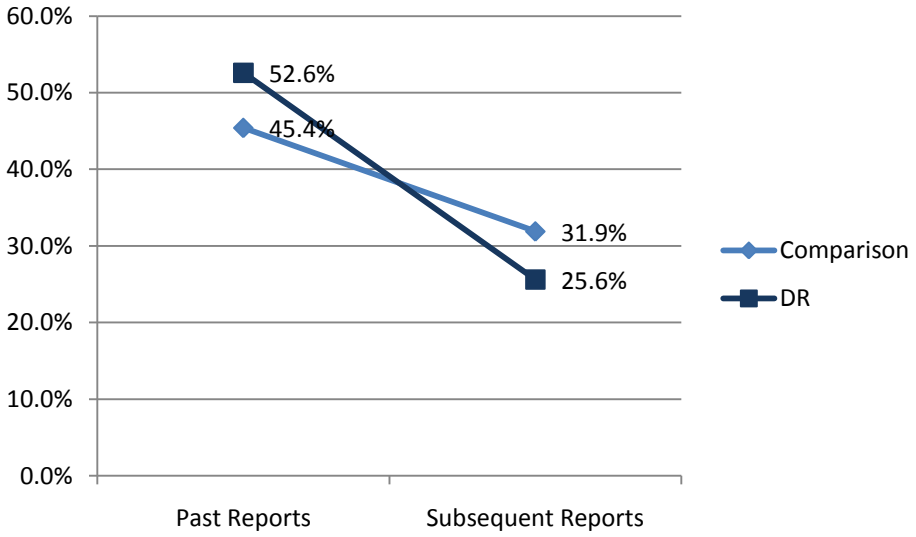


Figure 9.1. Proportions of DR and comparison families with one or more past and subsequent reports of any kind

The counts in Figure 9.1 include reports of all types. So the next question is: were there reductions in particular types of reports? There were none among subsequent IO dispositions, which were virtually identical (DR: 11.8 percent; Comparison: 11.1 percent) nor among IR dispositions, where DR families had slightly higher percentages (DR: 5.3 percent; Comparison: 4.3 percent). The reduction was found among the other types of reports. DR families had substantially fewer investigations (DR: 9.7 percent with one or more subsequent investigations; Comparison: 24.3 percent with one or more subsequent investigations) even though, as we have previously seen, the two groups had very similar investigations histories before entering the demonstration (DR: 42.4 percent with one or more past investigations; Comparison: 42.5 percent with one or more past investigations). However, as previously noted, this is not a fair comparison since DR families that did have later reports were much more likely to be referred back to DR with 13.3 percent of DR families receiving a second family assessment and no comparison families in this category. A fair comparison requires that we combine the two categories for subsequent reports and that is shown in **Figure 9.2**.

The same comments concerning the reasons for the apparent reduction (the downward slope of the lines) for both groups apply: differing lengths of review periods for past compared to subsequent reports. Again, the important difference is seen in the splitting of the two lines in the figure. Because the proportions of previous reports were nearly identical, we might have expected the future reports would follow the same pattern and be about the same. This did not happen. Some DR families returned and some were assigned to investigations while others were reassigned to DR. It can be assumed that many of the latter would have resulted in investigations had there been no DR program. *Overall, there was roughly a nine percent reduction in new reports requiring an investigation or DR.*

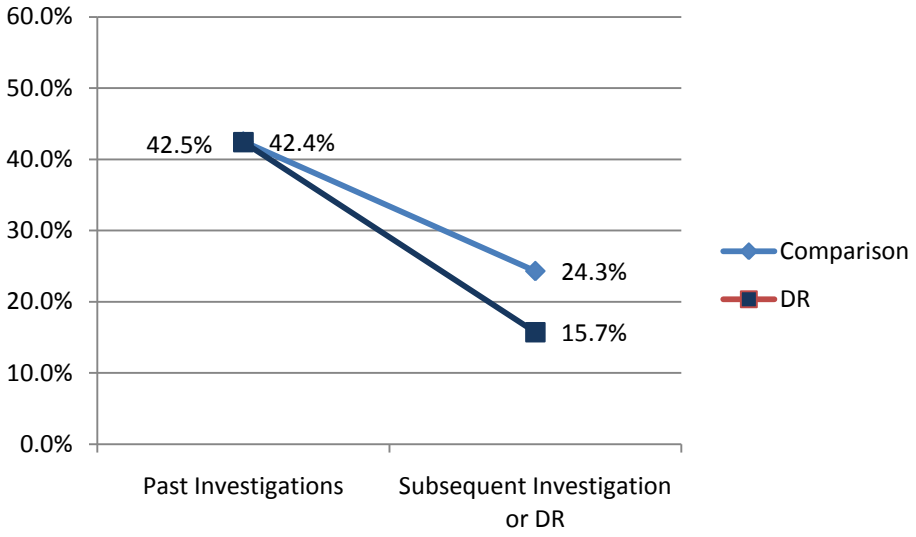


Figure 9.2. Proportions of DR and comparison families with one or more past investigations and one or more subsequent investigations or DR family assessments

For these kinds of data, *survival analysis* is a stronger and more appropriate statistical method. This family of statistical techniques is heavily utilized in medical studies where the object is to determine who survives before recurrence of a disease condition or before dying. It takes into account differing follow-up periods for each subject (family in this study), which is the case in the present analysis. The event of interest is a new report of child abuse and neglect, and the question is whether families experience a new report and how much time passes before a new report is received. Thus, the research question in this study was: *do DR families survive longer without a new report of child maltreatment than comparison families?*

The method used was proportional hazards analysis, which permits the introduction of covariates for statistical controls. As noted, past reports are the most important predictors of future reports. This statistical method permitted the introduction of this variable along with the experimental

variable to increase the comparability of the two groups. The results are shown in the top portion of **Table 9.3**. This analysis corresponds to the comparison of proportions shown in Figure 9.1.

In the top portion of Table 9.3, we see that past reports were significantly related to subsequent reports (p = .004). The introduction of the measure of past report into the analysis was a way of equalizing the risk associated with previous reports for all the families in the study. This means that differences that might have been caused by this risk factor were controlled or taken out of consideration.

Table 9.3. Variables in the Proportional Hazards Equation for DR versus Comparison Families

A Later Child Maltreatment Report Controlling for Previous Reports					
	Regression Coefficient	SE	Wald	p	Relative Hazards
One or More Past Reports	-.126	.044	8.329	.004	.882
DR versus Comparison	-.320	.046	49.270	.000	.726
A Later Investigation or DR Family Assessment Controlling for Previous Investigations					
	Regression Coefficient	SE	Wald	p	Relative Hazards
One or More Past Investigations	-.103	.041	6.194	.013	.902
DR versus Comparison	-.320	.043	54.831	.000	.726

The difference in report recurrence for the DR versus the comparison group was also statistically significant (p < .001). The relative hazards statistics are sometime referred to as *relative risk*. The value in the table (.726) for the group comparison may be interpreted to mean that the risk of DR families to experience a new child maltreatment report was about 73 percent that of comparison families over the period of study. Put in more concrete terms, *DR families can be expected to show a reduction in maltreatment report recurrence over a 40-month period of 27 percent compared to a similar group of families that are investigated.*

A similar survival analysis was conducted for any later investigation or DR and is shown in the bottom portion of Table 9.3. This analysis corresponds to the comparison of proportions shown in Figure 9.2. The results were similarly positive for families that had been referred to DR. The analysis can be interpreted to show that, *compared to similar families that were investigated;*

families provided with DR can be expected to experience about a 27 percent reduction in new investigations or DR family assessments over a 40-month period.[13]

Types of Report Recurrence. We have shown that subsequent reports are reduced for DR families. A further relevant question is what types of reports are reduced? By viewing the comparative means in Table 9.2, it was apparent that DR and comparison families differed in two areas. Compared to comparison families, *DR families had been reported significantly more often in the past for educational neglect*. DR families had also experienced *significantly more reports of neglect of basic needs before being assigned to DR*.

Looking at subsequent reports that essential equivalence of DR and comparison families remained unchanged for other the other types of reports referenced in Table 9.2. In addition, DR families continued to have more reports of educational neglect than comparison families. The one observed change was in the area of neglect of basic needs. This is illustrated in the following **Table 9.4**.

In Table 9.4, it is apparent that DR families had many more *past* reports of neglect of basic needs. These reports averaged 75 per 100 families during the six or more years before families were first assigned to DR compared to 57 reports per 100 comparison families. Such reports allege poverty-related concerns, such as lack of food, inadequate clothing, poor child hygiene, unsanitary homes and unsafe homes. As noted, these kinds of reports are usually associated with the lowest income families on CPS caseloads in which single parents predominate and adults are underemployed or unemployed. The difference was statistically significant ($p = .002$). After DR the relative rate of these kinds of reports diminished for DR families. During the months following DR reports came at the rate of 15 per 100 DR families compared to 13 per 100 comparison families. The difference was small and was not statistically significant. The previous large difference had disappeared in the follow-up period.

The implication is that some part of the reduction in reports observed among DR families was among reports of neglect of basic needs. One of the differences between DR family assessments and investigations is an increased emphasis on addressing the very factors that often underlie reports of basic needs neglect—poverty and the effects of poverty. This analysis supports that hypothesis that *the non-adversarial, voluntary and service-oriented approach of DR has real effects on the fundamentals of family situations that lead to neglect of children's basic needs.*

[13] That the two analyses resulted in identical relative hazard statistics (.726) was a purely chance outcome.

Table 9.4. Change in the Relative Rate of Reports of Neglect of Basic Needs among DR and Comparison Families Before and After Exposure to DR

	Rates of reports of neglect of basic needs	
Group	For the period from 2000 until entry into the study (72 months or more)	For the follow-up period (average of approximately 20 months)
DR	75 per 100 families	15 per 100 families
Comparison	57 per 100 families	13 per 100 families

Removal and Placement of Children

Prior to entry to the DR program 7.6 percent of DR families had one or more children removed in the period extending back to the year 2000 compared to 6.8 percent of comparison families. This difference was not statistically significant ($p = .21$). It is illustrated in **Figure 9.3**. As with previous figures, we note that the overall reduction (downward slope of the lines) results from the longer period available for detecting previous removals than for the follow-up period. The percent of DR families during the follow-up with a child removal was 0.5 percent compared to 1.1 percent for comparison families. This difference was not statistically significant with the probability associated with it ($p = .074$) is a statistically trend.

In **Table 9.5**, the results of a survival analysis are shown. As noted, this is a more powerful statistical technique that may detect differences that are not evident in simpler categorical analyses. In this case we controlled for past removals of children in an attempt to equalize the groups on this important variable. The analysis indicated that past removals were related to subsequent removals, that is, that families with children removed in the past were more likely to have children removed a second time. Most importantly, it shows that the DR program led to reduced child removals ($p < .001$). The relative hazard statistic (.786) indicates a reduction in child removals relative to the comparison group. This would indicate that *DR families can be expected to experience a reduction of removed children over 40 months of more than 20 percent compared to similar families in the comparison group.* However, this conclusion must be regarded with caution because these were small groups of families (DR children in 10 of 1,861 families; Comparison children in 12 of 1,105 families).

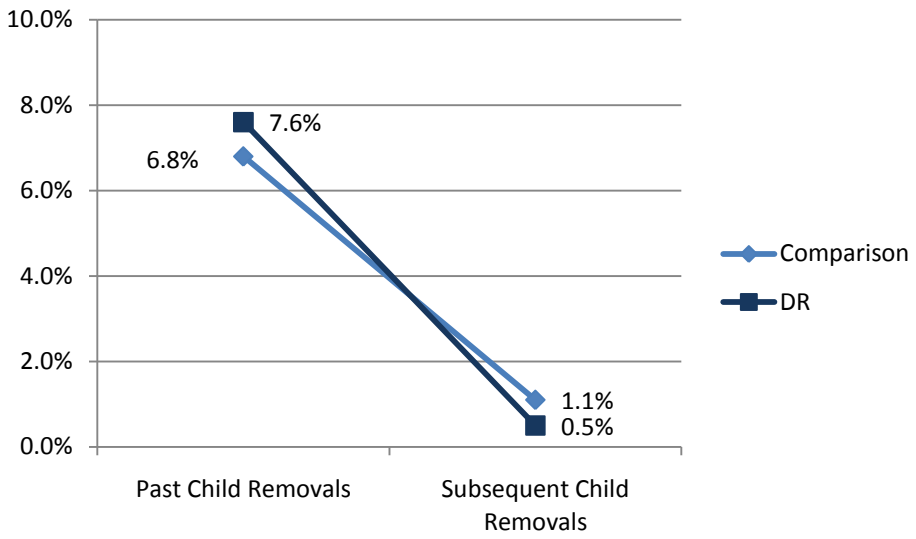


Figure 9.3. Proportions of DR and comparison families with one or more past investigations and one or more subsequent investigations or DR family assessments

Table 9.5. Variables in the Proportional Hazards Equation for Any Subsequent Child Removal Controlling for Past Removals

	Regression Coefficient	SE	Wald	p	Relative Hazards
One or More Past Removals	-.275	.073	14.253	.000	.760
DR versus Comparison	-.241	.040	36.975	.000	.786

Differences among Clark, Washoe and Other State Areas

It was also possible to compare results for families receiving DR among the three major service regions in Nevada: 1) Clark County, 2) Washoe County, and 3) the remaining rural counties that participated in DR (Carson City, Churchill, Elko, Lyon and Nye). These are comparisons of DR families *only*.

Answers to questions of the comparative success of DR outcomes among these three areas were hampered by difference in practice. Washoe County has traditionally utilized *information only* (IO) and *information and referral* (IR) dispositions for child maltreatment reports more often than either the rural counties or Clark County (see Chapter 3). Of the latter two areas, Clark used these

classifications the least. A reporter may indeed make allegations that they believe involve danger or actual abuse or neglect of children, but neither IO nor IR report dispositions are indications that an in person response needs to occur. When the intake worker agrees that the allegations in the report are appropriate for an investigative response she gives it a disposition of *investigation* and it is referred to an investigator for action.

Table 9.6 shows the levels of previous reports on families considered in this chapter before they were assigned to the DR or comparison groups.

Table 9.6. Types of Reports Dispositions of DR and Comparison Families in Three Nevada Areas for Reports Prior to the Evaluation

Nevada Area	One or more past reports: any disposition	One or more past IO reports	One or more past IR reports	One or more past investigations
Clark County	47.5%	13.4%	2.3%	44.5%
Washoe County	76.9%	57.5%	35.0%	50.6%
Rural Counties	48.6%	21.6%	13.1%	45.2%

Table 9.6 shows that Washoe County had a substantially higher rate of reports than the other areas. Does this mean that Washoe received more hotline calls on these families than other counties? If UNITY data indeed accounts for all reports received then this appears to be the case. Washoe had three to four times the number of IO and even a greater proportion of IR dispositions than Clark or the rural counties.

Washoe also had significantly ($p = .04$) higher rates of families with one or more previous investigations but the difference were smaller than the other three categories. The rates of past investigated families were in the 45 to 51 percent range for all three areas. (This does not mean that Washoe County has significantly more investigations for all reports received. Rather it means that the families in this study from Washoe were investigated significantly more often for the several years prior to study entry.)

This difference in intake across the three areas makes comparison of report recurrence for DR families more problematic. However, past history can be used as a guide. In **Table 9.7**, later reports of various kinds are shown for DR families only and it can be seen that the pattern of past reports shown in Table 9.6 is roughly replicated, but with the addition of subsequent DR family assessments. Washoe continues to have more reports classified as IO and IR but the levels of later investigations are roughly equivalent and not significantly different ($p = .24$). However, both

Washoe and the rural counties were significantly (p = .032) more likely to reassign families to DR family assessments.

Table 9.7. Types of Reports Dispositions of DR Families Only in Three Nevada Areas for Reports Subsequent to DR

Nevada Area	One or more later reports: any disposition	One or more later IO reports	One or more later IR reports	One or more later investigations	One or more later DR
Clark County	8.3%	4.8%	.3%	2.2%	2.6%
Washoe County	27.0%	17.7%	9.0%	3.2%	5.1%
Rural Counties	12.6%	5.5%	2.4%	3.9%	5.2%

Regarding child removals, the numbers were very small, but of the 10 DR families with later child removals, none were found in Clark County, five were from Washoe and five were from rural areas. This difference was statistically significant (p = .014).

Summary of Findings

A group of comparison families was selected based on overall similarity to DR families. DR and comparison groups were highly similar on variables related to risk of future of child abuse and neglect, especially frequencies of previous investigations, types of alleged child maltreatment and child removals.

Both sets of families were tracked to determine whether and how often they were re-reported to CPS and whether subsequent encounters with the agency led to children being removed. DR families had more previous total reports (whether investigated or not) than comparison families but fewer after exposure to DR. Similarly, while experience with past investigations were similar for both groups, DR families received fewer subsequent investigations (and/or DR referrals) than comparison families. A statistical analysis suggested that later investigations or DR referrals might be expected to be reduced by more than a quarter over a 40 month period for families provided with DR. It was revealing that the decrease in subsequent reports was strongest for families with reports of neglect of basic needs, such as food, clothing and safe and adequate housing. These allegations are found more often in families in poverty and poverty-related services increased under DR. Significantly fewer children were subsequently removed in new cases of DR families, although because of the small numbers of child removals in both DR and comparison families, this finding should be regarded with caution.

Some differences were found across the three areas previous considered in this report: Clark County, Washoe County and the remaining outstate counties. While there was no difference in the proportion of later investigations of DR families across the three areas, Washoe and the outstate counties were significantly more likely to re-refer DR families to new DR cases when they had been re-reported to CPS.

Chapter 10. Patterns of Recurrence

In the previous chapter we saw that DR families who received family assessments had fewer subsequent reports of child maltreatment than comparable families who received a standard investigation. While the difference may not appear large viewed in programmatic terms, it was nonetheless statistically significant and consistent with findings in other evaluations we have conducted of DR programs. And it is evidence that DR family assessments reduce threats to children in certain families more often than investigations. Why?

To try to understanding the dynamics at work and find an answer to this question, a special analysis was conducted of maltreatment reports received by CPS during the DR pilot project period. The analysis looked at reports during an initial period and then at any new reports that were made subsequently.

Analysis of Recurrence

During the first six months of 2007, as the DR pilot project was just getting underway, there were 6,467 families across the state with at least one maltreatment report.[14] In each of these instances a follow-up visit was made to the homes of the families. Because DR had started in February 2007, and in only two services areas in Clark County, nearly all of these reports (98.8 percent) were given a standard investigation. The reports included all the types of allegations that come in to a CPS hotline: everything from severe physical abuse and sexual abuse to educational neglect and various kinds of family problems. A majority (77.1 percent) of the reports included only a single allegation, while some (16.4 percent) included two different kinds of charges, and a few (6.5 percent) included three or more allegations. Note that the number 6,467 is an unduplicated count of families with reports during this period. Some of these families had more than one report and these other reports are not included in this number.

Table 10.1 shows the number of different allegations received in the 6,467 reports. It shows the number of reports with specific, single allegations, and the number with various combinations. The most frequent allegation received in these reports involved neglect of basic needs, which was included in 1,627 (25.2 percent) reports, sometimes (981; 15.2 percent) as the only allegation and other times (10.1 percent) in combination with other complaints. Many reports (1,432; 22.1 percent) also involved allegations of parent or family problems, a category that included a wide variety of problems by itself; again, this allegation was sometimes made in combination with other

[14] In this Chapter we are considering only reports that were accepted by intake for an investigation or DR response. IO and IR dispositions are not included.

complaints and sometimes not. The third most frequently made allegation in the reports involved less severe physical abuse (1,030; 15.9); when these allegations were made they usually (88.3 percent of the time) were not accompanied by other charges. Conflict or emotional abuse (14.2 percent) and lack of supervision were the fourth and fifth most common allegations in the reports.

Table 10.1. Number of Families with Specific Allegations included in Reports of Child Maltreatment January 1 – June 30, 2007

Types of reports received by CPS from 1/1/2007 to 6/30/2007	Number of families by category of initial report
Sexual Abuse	295
Severe Physical Abuse	96
Less Severe Physical Abuse (PHA)	910
PHA and CON	120
Drug Exposed Infant	125
Conflict or Emotional Abuse (CON)	670
CON and PAR	130
Severe Neglect	82
Medical Neglect	175
Unmet Medical Needs (UMD)	28
Neglect of Basic Needs (BND)	981
BND and LSP	213
BND and EDN	24
BND and PAR	409
Lack of Supervision (LSP)	725
LSP and EDN	14
LSP and PAR	149
Educational Neglect (EDN)	156
Parent/Family Problems (PAR)	744
Three or more allegations	421
Total	6467

Among allegations less frequently included in reports, thankfully, were charges of severe neglect (1.3 percent), physical abuse (1.5 percent), drug exposed infant (1.9 percent), medical neglect or unmet medical needs (3.1 percent) and sexual abuse (4.6 percent). Educational neglect was also among allegations less frequently made in this period (3.0 percent).

In tracking the reappearance of these families in UNITY, we found that 38.7 percent of them had at least one subsequent report by the end of June 2010, a three and a half year period. This is shown in **Table 10.2**. While there was some variation in this figure depending on the nature of the initial report, the percentage of families with new reports, whatever the original allegations may have been, may be considered high--from 49 percent among families whose initial report was for neglect of basic needs to 28.1 percent among families whose initial report was an allegation of sexual abuse.

Table 10.2. Number and Percent of Families with New Reports through July 31, 2010

Initial types of reports during the 1/07-6/07 period	Number of families by category of initial report	All reports	Sub-stantiated initial reports	Unsub-stantiated intial reports	Sub-stantiated less Unsub-stantiated
Sexual Abuse	295	28.1%	31.6%	27.9%	3.7%
Severe Physical Abuse	96	37.5%	30.8%	38.6%	-7.8%
Less Severe Physical Abuse (PHA)	910	36.4%	44.9%	35.4%	9.5%
PHA and CON	120	38.3%	33.3%	38.9%	-5.6%
Drug Exposed Infant	125	43.2%	33.3%	45.9%	-12.6%
Conflict or Emot. Abuse (CON)	670	34.5%	46.4%	34.0%	12.5%
CON and PAR	130	38.5%	18.2%	40.3%	-22.2%
Severe Neglect	82	31.7%	19.0%	36.1%	-17.0%
Medical Neglect	175	31.4%	61.5%	29.0%	32.5%
Unmet Medical Needs (UMD)	28	46.4%	50.0%	46.2%	3.8%
Neglect of Basic Needs (BND)	981	49.0%	57.0%	48.3%	8.6%
BND and LSP	213	41.3%	48.6%	39.8%	8.9%
BND and EDN	24	37.5%	0.0%	39.1%	-39.1%
BND and PAR	409	44.3%	44.1%	44.3%	-0.2%
Lack of Supervision (LSP)	725	33.8%	50.8%	32.1%	18.6%
LSP and EDN	14	50.0%	40.0%	55.6%	-15.6%
LSP and PAR	149	37.6%	25.0%	40.0%	-15.0%
Educational Neglect (EDN)	156	40.4%	42.9%	39.8%	3.0%
Parent/Family Problems (PAR)	744	36.2%	36.0%	36.2%	-0.2%
Three or more allegations	421	42.0%	34.4%	43.4%	-9.0%
Total	6467	38.7%	41.7%	38.3%	3.4%

The overall percentage of new reports among these families (38.7 percent) suggests that the standard approach to child maltreatment reports was not highly successful, whether the level of endangerment to the child judged by the initial report alone, might be considered more severe or less severe. As Table 10.2 also shows, the percentage of families with new reports was high whether or not the initial report was substantiated. Sometimes it was the case that there were more subsequent reports among families with an initial substantiated report and sometimes there were more new reports among families with unsubstantiated initial reports. (The last column in the table shows the difference in the percentages between the two sets of reports for easier reference. The first column shows the number of families in each allegation category so that large differences can be understood as a function of a small *n* in certain categories.)

Based on interviews with CPS personnel in the state, it is our understanding that significant intervention was much more likely when reports were substantiated than when they were not, although some information about sources of assistance in the community might be provided to any family. In the end, however, it did not make that much difference in the rate of new reports whether the initial report had been substantiated or not: 41.7 percent of families with initial reports that were substantiated had at least one subsequent report, while 38.3 percent of families with unsubstantiated initial reports had a later report.

Also consequential is the diversity in the types of maltreatment reports received, initially and subsequently. In standard investigations, the allegations made in any report are the specific targets of the inquiry: Did it happen? Can the report be substantiated? If so, what kind of remediation can address the problem? A particular report, however, is not always a good compass for what other troubles may lay ahead. Nor is an investigation the best method of unearthing the hidden markers that may point the way.

Recurrence Table

Table 10.3 shows a cross tabulation of the types of allegations in initial and subsequent reports that were examined. The first column in the table shows the number of families with reports of child maltreatment during the first six months of 2007. (Note that the types of allegations have been collapsed for simplicity. The full data table is given in the Appendix.) The number of new allegations in reports during the tracking period can be found in the second to last column. The last column gives the percent of the time an allegation in the new report was also included in the initial report. The middle columns give the percent (top portion of the table) and number (bottom) of specific types of allegations in subsequent reports any time during the three and a half year tracking period. Adding the percentages associated with the initial allegation (those in a row) yield 100

Table 10.3. Types of Allegations in Initial and Subsequent Reports

Allegations in Subsequent Reports ----------→

Collapsed Allegation Categories	# of Families with Allega-tions in Initial Report	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse	Drug Exposed Infant	Conflict or Emot. Abuse	Severe Neglect	Medical Neglect or Unmet Medical Need	Neglect of Basic Needs	Lack of Super-vision	Educa-tion Neglect	Parent/ Family Prob-lems	# of New Allega-tions	Match Between Iinitial & Later Reports
Sexual Abuse	295	21.3%	0.0%	18.6%	0.5%	9.0%	4.3%	1.6%	17.6%	16.5%	3.7%	6.9%	188	13.6%
Severe Physical Abuse	96	5.5%	4.1%	16.4%	0.0%	11.0%	6.8%	4.1%	23.3%	15.1%	1.4%	12.3%	73	3.1%
Less Severe Physical Abuse	1030	5.7%	1.5%	29.9%	0.2%	15.4%	3.0%	3.0%	15.7%	15.1%	1.6%	9.0%	963	28.0%
Drug Exposed Infant	125	2.9%	0.0%	6.8%	8.7%	3.9%	3.9%	2.9%	30.1%	19.4%	1.9%	19.4%	103	7.2%
Conflict or Emot. Abuse	920	5.3%	2.5%	24.3%	0.4%	17.4%	2.6%	3.4%	15.2%	15.2%	1.9%	11.9%	798	15.1%
Severe Neglect	82	0.0%	0.0%	17.1%	1.3%	17.1%	10.5%	2.6%	14.5%	17.1%	2.6%	17.1%	76	9.8%
Medical Neglect/Unmet Med Need	203	4.8%	0.5%	15.6%	0.5%	8.1%	1.1%	10.8%	24.7%	16.7%	1.6%	15.6%	186	9.9%
Neglect of Basic Needs	1627	3.4%	1.1%	10.8%	0.9%	8.8%	3.5%	3.1%	29.5%	20.9%	2.8%	15.2%	2117	38.4%
Lack of Supervision	888	3.1%	1.8%	11.8%	1.4%	9.4%	2.2%	3.3%	22.0%	27.5%	2.9%	14.6%	829	25.7%
Educational Neglect	170	6.6%	1.2%	7.8%	1.8%	9.0%	3.6%	4.8%	15.1%	15.1%	22.3%	12.7%	166	21.8%
Parent/Family Problems	1432	3.6%	1.2%	12.0%	2.5%	8.9%	2.4%	2.1%	21.5%	20.2%	2.3%	23.2%	1453	23.5%
Sexual Abuse	295	40	0	35	1	17	8	3	33	31	7	13	188	13.6%
Severe Physical Abuse	96	4	3	12	0	8	5	3	17	11	1	9	73	3.1%
Less Severe Physical Abuse	1030	55	14	288	2	148	29	29	151	145	15	87	963	28.0%
Drug Exposed Infant	125	3	0	7	9	4	4	3	31	20	2	20	103	7.2%
Conflict or Emot. Abuse	920	42	20	194	3	139	21	27	121	121	15	95	798	15.1%
Severe Neglect	82	0	0	13	1	13	8	2	11	13	2	13	76	9.8%
Medical Neglect/Unmet Med Need	203	9	1	29	1	15	2	20	46	31	3	29	186	9.9%
Neglect of Basic Needs	1627	73	23	229	19	186	74	66	624	442	59	322	2117	38.4%
Lack of Supervision	888	26	15	98	12	78	18	27	182	228	24	121	829	25.7%
Educational Neglect	170	11	2	13	3	15	6	8	25	25	37	21	166	21.8%
Parent/Family Problems	1432	52	17	174	37	130	35	31	313	294	33	337	1453	23.5%

percent (top); the number of specific new allegations for any row gives the total number of subsequent allegations (bottom).

The cells along the diagonal from upper left to lower right that have been darkened show the percent and number of cases in which an allegation in a subsequent report was contained in the initial report. If the initial report were a good predictor of subsequent reports, these cells would have high percentages and numbers. In the top portion of the table, the darkened (orange) cells are those with the most frequent allegations in subsequent reports when this was not the same as the original report. The lighter shaded (purple) cells are the next most frequent allegation across a row.

Rather than falling mostly along the diagonal, the new report data tend to be dispersed across the rows (initial types of reports). For example, there were 295 families with reports that involved allegations of sexual abuse in the initial set of reports. During the tracking period these families had 188 new allegations, 40 (21.3 percent) of which were for sexual abuse, but 148 were for various other matters—35 (18.6 percent) were for less severe physical abuse and 33 (17.6 percent) were for a lack of basic needs. On the other hand, of the 170 families with allegations of educational neglect in the initial report, 11 (6.6 percent) had an allegation of sexual abuse during the tracking period. The upshot is that you cannot foresee what may later occur based on any given report.

One obvious reality that can be seen from the table is the large percentage of times new reports involve neglect of basic needs, a reminder that we are dealing with a large number of families experiencing poverty. That there is a link between this and other problems that threaten the wellbeing of the children in these families cannot be easily denied.

The Appendix contains the full, non-collapsed data table showing the cross tabulation of initial and subsequent maltreatment allegations. In the Appendix, the table has also been broken down for initial reports classified into the three priority levels. As referring to these tables will show, while 38.7 percent of families with a maltreatment report during the initial six month period had a subsequent report over the three and a half year period, this figure did not vary too much by priority level. Of the families with initial reports classified as Priority 1, 41.6 percent had at least one subsequent report. For families with initial reports classified as Priority 2, 42.8 percent had a new report in the tracking period. And for families with initial Priority 3 reports, 36.8 percent had one or more subsequent reports. What can be seen in each of these tables, as well, is that subsequent reports are made across the spectrum of child maltreatment whatever the priority level given to the original report.

We also examined recurrence of reports in the three main service regions in the state, Clark County, Washoe County and the rural counties. There were differences in the recurrence figures for the three regions. Washoe County had more families with one or more new accepted reports (45.8 percent) than either the rural counties (43.2 percent) or Clark County (35.4 percent). These figures seem to be a reflection what was seen in Chapter 3, with Washoe County generally experiencing a higher reporting rate than Clark County. The diversity in the types of allegations contained in new reports, however, was found in all regions. For example, the percent of time an allegation in a new report had been contained in the first report was 24.4 percent in Washoe County, 26.4 percent in Clark County, and 32.7 percent in rural counties. More often than not, therefore, the subsequent report was different from the first report in the sequence examined. Full cross tabulations of initial and subsequent reports in each of the three regions can also be found in the Appendix.

This pattern of report recurrence is not particular to Nevada. We have found it consistently in analyses of CPS data in other states and places. The longer the tracking period, the clearer the pattern of report diversity becomes. The relative risk level of reports does not cause an increase in either the consolidation or spread of new types of reports. Families judged low risk at one point in time may be assessed as high risk on a recurring report. Many families judged to have high risk conditions at one point are found to have a number of other conditions at a later time which in themselves would be classified as low risk.

Chapter 11. Challenges and Recommendations

Rolling Icebergs

We first saw the pattern of diversity in recurring maltreatment reports that was discussed in the previous chapter in our evaluation of the Missouri two-track pilot project. We began to refer to the phenomenon as being like rolling icebergs.

The pattern is that there is not a pattern where one is often expected. A particular reported allegation about a family is generally not predictive of what kind of allegation will be made in subsequent reports that may be received. Experienced child welfare workers know that a particular report to a child abuse/neglect hotline is often only the tip of the iceberg. The report is only what an observer—a teacher, a doctor, a neighbor—happens to notice that leads to a hotline report being made. There are often other, and sometimes more serious things, hidden below the surface. Repeated reports on families over time, then, may best be understood as rolling icebergs, with different aspects of the family and its troubles revealing themselves and being observed. To some extent, what may be seen by an outsider at a particular time is an accident; many things that go on within a family are never noticed by anyone outside the family. This argues for a process in which families are approached broadly and prospectively, along the lines prescribed in the family assessment model. This is not to relegate the accusation to a less important status, but to understand that any accusation or incident is part of a broader context or pattern or condition within a family. With an investigation's often tight focus on a particular allegation, other important aspects of the family's life may never be discovered or, if hinted at, not pursued. By probing beneath the surface, however, other problems and issues that may have profound consequences on the lives of children may be discovered. Factors likely to lead to problems in the future can be identified, and only if identified can they be addressed and resolved before something else happens to a child, something that may have tragic consequences.

Safety and Prevention

The decision to refer a report to the investigative response may be seen as the safer course of action in situations where the actual threats to a child cannot be fully appreciated through allegations alone. The choice may be viewed as one between child safety (the province of CPS investigations) and preventive social work (the area for family assessments). This, however, is a false choice, a false dichotomy and a misreading of differential response. It may apply to the hotline situation in which the decision must be made to accept or reject an incoming report of child maltreatment, determining whether the report requires some formal system response or can be

addressed in some other way, if it needs to be at all. The safety versus prevention distinction is not a calculation meant to be made by a child protection system employing a differential response approach. The safety of children is not assumed or taken for granted in the family assessment pathway any more than in an investigation. Safety of children is always of paramount importance in a family assessment. However, the differential response assumes that the actual safety of children, in the present and in the future, often requires attention to what may formerly have been relegated to preventive services and that investigating specific accusations without addressing underlying conditions that may adversely affect a child's wellbeing and safety in the future, is an insufficient response. Differential response is not simply about approaching families in a more friendly, supportive manner, to gain the family's cooperation and participation, but it is also about rationality and system accountability: intervening in an effective way, for the sake of children now and for the sake of children tomorrow.

While family-centered practice, to some degree or another, has made its way into CPS, best practice is not always common practice in a crisis-driven program, and the focus of investigations in most instances remain relatively narrow. This is not to say that a good investigation, having substantiated a report, may not look at the range of factors that may have led to the incident: Was the excessive discipline caused by an ignorance of child development or the alcoholism of a parent or on-going domestic violence in the home? Knowledge of the cause can direct the case plan and remediating services. However, in the best of systems this occurs in a minority of cases where allegations are substantiated. Moreover, even in these the full extent of underlying problematic conditions is often not fully explored, much less addressed. When reports are not substantiated it is the rare child protection system that delves further. A fully implemented differential response system involves institutionalizing family-centered practice, transforming it from an ideal into required practice (and subject of training) done to the maximal extent possible by all workers.

High levels of poverty, often of a chronic nature, complicate the work of CPS. Unless such underlying conditions are addressed the wellbeing of children will continue to be threatened. Whatever particular threat is represented in a specific maltreatment report received by the child welfare agency and whatever immediate problems may exist and threaten the safety of children, unless underlying conditions that give rise to such threats are addressed or remediated at least minimally, even the temporary removal of children from these home environments can only put off problems that are likely to persist and which represent long-term threats to many children. Removing children from unsafe situations without addressing the situations themselves may be viewed as a short term solution but it often does not resolve threats to the wellbeing and safety of children in the longer term.

Two Families

Focusing on specific cases runs the risk of drawing conclusions from nonrepresentative and anecdotal data. At the same time, looking at some cases in detail can be instructive. During the evaluation, case notes from a set of CPS and DR cases were examined. Two examples are given here. Both reports involved allegations of lack of supervision. The first, a highly complex case, involved a report classified as Priority 3 and was referred to the FRC for a DR family assessment response. The second report involved police officials, was classified Priority 2 and was not referred for DR but retained by CPS for an investigation.

Case 1. Report: Lack of Supervision. Classification: Priority 3. Response: Referred to FRC for DR Family Assessment.

A referral was made to DR in mid-summer regarding a mother who had been hospitalized for mental health issues. The mother, who had stage IV breast cancer, admitted she had abandoned her children and went on a drug and gambling binge with her disability check. After losing all her money and realizing she had nothing left, the mother had a break down and was taken to the hospital by authorities. A case worker at the hospital made the report to CPS after learning the woman had left her children, ages, 12, 15, 17 and 19, and was unsure where they were staying.

At the time of the DR worker's involvement the whereabouts of the children were not known. The worker's initial plan was to locate the children, contact the biological father as a possible placement, and provide forms for Nevada Checkup and Child Support.
The children were soon located at a friend's home. One of the older children had already begun organizing the family situation, and was hoping to send the younger children to their father in California. The two older boys were both planning to find employment and begin to support themselves. Food assistance was brought to the family friend who was offering refuge to the children.

At the time the worker met the family, no one in the home was working and the only source of income was the mother's disability check for $1,100.00 plus $380.00 in monthly food stamps. The recent binge by the mother had wiped out this money for the month. Both older boys were upset by their mother's behavior, but were willing to do what was necessary to keep the family safe. Both also welcomed help to finish school and find work. The two younger children were stable but very unhappy and disappointed in their mother. Apparently, similar things had occurred with the mother in the past. Referrals were given to the older boy, who was the caretaker, for employment assistance at the FRC.

Several visits to the family were made by the DR worker and phone contact was frequent. The father, in California, agreed to take the two younger children and the FRC offered to assist with transportation funds.

The mother was discharged from the hospital about a week after the case was opened. The DR worker assisted the mother with seeking a place to stay and in determining her eligibility for medical assistance. Several barriers were encountered, as she would not qualify for Medicaid until early next year, and her disability benefits had temporarily been suspended. The worker coached the mother through contacting a Social Security Supervisor and getting seeking help from the Bureau of Consumer Protection.

The family reunited shortly after the mother's release from the hospital and stayed for a brief period with a friend. Once disability benefits were restored, the family was able to look for an apartment. The oldest two boys chose to stay with a friend, the third child decided to return to California with her father, the youngest child remained with his mother.

The DR worker pursued many options to try to secure medical help for the mother's breast cancer. The worker and the mother contacted foundations, social services, and even the governor's office. As school began in the fall, the worker ensured that the youngest son was enrolled and attending classes in Las Vegas and checked on the daughter's stability and progress in California. When an apartment was found, a referral was made for furniture assistance. Beds, linens, a couch, chairs, dresser, armoire, and miscellaneous kitchen items were secured for her apartment.

By the end of September, a little over two months after case opening, the case plan had been met for the family. All of the children were considered safe and supervised. The two older brothers were living with the family of a friend. The daughter was in a stable living arrangement with her father and grandmother. An apartment and furnishings were secured for the mother and her youngest son. Both young children were attending school regularly. Medical benefits were found through County Social Services and treatment options were available for the mother. The case was closed with connections made to the FRC for ongoing help as needed.

Case 2. Report: Lack of Supervision. Classification: Priority 2. Response: Retained by CPS for an Investigation.

A CPS referral was received from police regarding two children, ages 6 and 9, observed playing at McDonalds unsupervised for over an hour. A police officer was notified by the establishment and the officer transported the children to their home, which was within walking distance. The maternal grandmother was subsequently arrested for child endangerment and taken to the County Department of Corrections. The children were left in the care of the natural mother.

At the first home visit, the natural mother told the CPS investigator that the family was having financial difficulties due to the economy and that her mother, the maternal grandmother of the children, had been helping out by watching the children during their winter school break. The grandmother, who had health problems, was from Central

America and did not speak English. Both the mother and grandmother worked at a local hotel. The family did not receive any benefits or services and had no prior criminal or CPS history. Interviews were conducted with the natural mother, the children and the grandmother. The mother and children were interviewed first, as the grandmother was in jail.

At the first interview, the mother and children explained the grandmother's actions. The children verified that they had requested to stay at the playground at McDonald's while their grandmother ran errands. Both boys stated that their grandmother told them no initially, but that they convinced her that they were allowed to play at the McDonalds all the time and it would not be a problem. The children denied being left along on a regular basis. The boys said that their grandmother was walking out of the door with the car keys in her hand to get them, when the officer took the keys and arrested her. The boys told the CPS investigator that they were upset and crying and begged the officers not to arrest their grandmother. The mother cried and said she was very protective of her children. The investigator stressed to the mother that she was ultimately responsible for ensuring the children were always appropriately supervised and that she might be held responsible should anything happen to them.

A home visit was held with the grandmother after she was released from jail. She was extremely remorseful about the events that occurred and also cried throughout the interview. The grandmother said that she initially took the boys to McDonalds to eat dinner, but needed to go to a grocery store located in the same shopping complex. She said that the boys "begged" her to let them stay in the play area while she went to the store. After a half hour, she returned to the McDonald's to pick them up, but again the boys asked for another 30 minutes. As the house was in walking distance, the grandmother went home to put a load of laundry in the washer. Upon locking up the residence with the keys in her hand to return to the play area, two officers approached her at the front door and arrested her. The family waited outside until the mother arrived from work to take the boys. The grandmother was taken to the Detention Center without access to her medication for her health conditions.

All family members were remorseful, but stated that they were now afraid to let the children outside to play or ride their bikes. A lawyer was retained by the family to assist them with getting the charges dropped. The investigator discussed Spanish speaking parenting classes and various methods of disciplining with the mother and grandmother. The risk level was determined to be low based on the nature of the report and case was closed.

Deciding whether to assign a report to an FRC for a DR family assessment or retain it for a CPS investigation has real consequences. Sometimes intake screeners have no choice, sometimes they do. The views of most DR workers who were interviewed were consistent with the worker who said:

"It isn't really a substantiation or unsubstantiation problem, but giving families the support that they need. If kids are safe but it's not an ideal environment, CPS will just close. Maybe the family will get a referral…depending on the knowledge of the worker. And that's it. From that perspective, that is the most critical function of DR…[CPS] does not have the same resources. That is not the intent of it. I think that is the blessing of DR that we have the time, because it's placed with FRCs, there are resources. It's a completely different mindset. I think it truly makes a difference for these families. Nobody has been able to give them that time and attention before. …What can be pretty serious issues that might not directly affect the immediate safety of the child, certainly directly affect the child in many ways." (DR worker, Washoe)

Service Anomaly

In Nevada there are regions in which the traditional child protection system has focused nearly exclusively on the immediate safety of children and less on providing services to families. Much CPS activity, therefore, revolves around cases in which children have been made wards of the state and placement has occurred. The introduction of DR offers the prospect of increasing services to families. Ironically, however, this service prospect primarily involves families in which a judgment has been made that the safety of children is less threatened and the family condition less problematic.

Differential response introduces a CPS component that is family-centered, broad in scope, and service focused. But it concentrates on reports with less severe allegations, those in which the safety of children is not immediately threatened but in which their wellbeing is nonetheless jeopardized. Reports involving more severe allegations that continue to receive traditional investigations are more likely to be approached with a narrow focus on the specific allegations. The underlying causes that have given rise to the problems within these families may receive less attention than the problems of families with less severe reports who receive a DR assessment. Ironically, DR can introduce a process in which a broader scope of attention and a greater focus on services occur in response to reports of less severe maltreatment than is the case for reports of more severe maltreatment. Such a programmatic environment can result in less assistance being provided in situations in which logic would suggest more assistance is called for.

The well being of most children is inextricably tied to the well being of their families. Enhancing the well being of the family, therefore, is the surest way to enhance the well being of children. As noted above, focusing on the immediate, short-term safety of children while ignoring their longer term welfare may have long term consequences on their safety.

The predicament for the Nevada child protective system is that those who often need family assessments the most are the ones least likely to receive it, the youngest, most vulnerable children. The following comment was made by a DR worker who was required to return a case to CPS because a young child was found in the home after the initial assessment. Because there was an allegation of environmental neglect, CPS considered the child to be affected, and the DR worker was told it was ineligible for DR and an investigation had to be conducted.

> "My environmental neglect with the child under five…I was so upset that I had to give that back. Because I knew…. The house was completely filthy, it smelled like urine, they didn't have a working washer or dryer, they had no power, so they were cooking off camping stoves. Five kids were eating like that. And the CPS worker did not do anything to change that situation. And I feel like it was a disservice that I couldn't keep it. Because at least we could have helped them find donations, get a washer, help them get their power back on. There was nothing they did. The baby wasn't in the report, it came from the school. But I go there, and here's the baby. They wanted it back, but we could have helped so much."

Two Views

Richard Wexler and Leroy Pelton are vocal critics of child protection systems. Both have strong views and a passionate concern for the wellbeing of children. And both agree on one thing: a child welfare agency cannot simultaneously help and investigate troubled families. But they propose different solutions to the problem.

Pelton has argued that all investigative aspects of child protection should be removed from child welfare and turned over to the police. He has written that legal definitions of child abuse and neglect should be narrowed so police investigations are limited to cases of "severe harm or endangerment resulting from clearly deliberate acts or gross abdication (deliberate or not) of parental responsibility."[15] This would lead, he maintained, to the vast majority of reports being defined as child welfare problems so that most reports would go to case workers who would respond non-punitively. But, while he believes police investigations would occur in only a small percentage of serious cases, his approach would require screeners with the wisdom of Solomon, and "caution" would likely lead to more not fewer punitive responses. The danger of his approach

[15] Pelton, L. (1989). *For Reasons of Poverty: A critical analysis of the public child welfare system in the United* States. Praeger Publishers.

is the potential for overreactions that would inevitably follow (as in Case 2 above) and the unnecessary damage that might be done to families and children in the name of child protection.

Wexler, on the other hand, would prefer to strip the non-severe cases away from CPS, leaving child protection only with cases that require a police-like investigation. In his assessment of the Missouri two-response system, Wexler has recommended that "If the case is deemed suitable for assessment, it should not be referred to DFS at all. Rather it should be referred to a private agency that has contracted with DFS to do assessments and offer voluntary help to the family."[16] The reason for this, in Wexler's view, is that the agency has demonstrated an inability to perform both functions and what is meant to be a family assessment is often little more than an investigation in a friendlier tone of voice. He sees the police side of CPS as corrupting the social work side. This at least admits the possibility of contamination within an agency, but only allows the poisonous kind. The integration of DR into the child protection system in Minnesota has increased the use of family assessments over time until it has approached 70 percent of reports statewide. The momentum of any new program spun out like a dradle will eventually run down and stop without proper administrative oversight and management and, given the rate of turnover in CPS, without an effective, on-going training program.

Keeping all remnants of the family assessment pathway outside of CPS does not allow a fully interactive, integrated system to fully develop. One in which, for example, the following can happen:

> "The incident had originally been screened investigation, and the family initially was completely uncooperative, uncommunicative, and defensive. The bruises were not as severe as reported and there was less a pattern of abuse than we had been led to believe. The mother was more cooperative when she saw the bruises. The father didn't drink when the mother wasn't there. When I told them I thought the incident did not warrant an investigation and was being switched to a family assessment, and when this was explained, the family unfolded, opened-up. Their body language changed. And I learned more from them about what had happened and about their problems and needs. The family became involved in the course of action that followed. The mother came up with the solution that the children would go stay with a neighbor for a night or two. A [service] case was opened and we provided anger management, and through supports they identified we were able to address

[16] Wexler, R. (2003, 2nd Ed). *The Road Less Traveled by: Toward real reform of child welfare in Missouri*. National Coalition for Child Protection Reform. Alexandria, VA.

important supervision problems. A relatively minor incident was helped from becoming a major one. With assessment this happens more and more often."[17]

Challenges

The strength of DR in Nevada arises from the strong social work orientation of staffs of local Family Resource Centers and the hard work of many people in each of the three CPS service regions. The current model and funding structure, however, restricts family assessments to a relatively small percentage of cases. Both Pelton and Wexler see the bulk of reports coming into child protection agencies as requiring a social work rather than a forensic response and both are trying to find better ways of addressing the problems found in this larger share of families. The challenge is to find ways of growing the family assessment approach and its positive effects in Nevada, and to build upon what has already been done, and done well.

The involvement of community-based Family Resource Centers has the advantage of linking families immediately to resources in the community and providing a social work approach that families like and has produced demonstrably positive outcomes. However, reliance on FRCs as the only DR delivery device severely constrains its potential development. The involvement of FRCs in the state's differential response program, therefore, is both the program's strength and its weakness. It is due to the FRCs that the positive effects described in this report have been realized, and this is the program's strength. At the same time, any major expansion of DR using the current model without substantial alterations would require an expensive expansion of FRC staff.

Beyond this, as long as the family assessment component is completely separated from CPS, it will tend to be viewed from within CPS as not quite part of CPS. Further limiting family assessments conducted by FRCs to reports classified as Priority 3, reinforces this view—as expressed by one CPS supervisor that the reports sent to FRCs are those of families that do not have "a real child abuse or neglect issue." The DR pathway in this scenario runs the risk of being and remaining the not-quite-full-fledged-CPS pathway: Family assessments are not CPS so much as "CPS-Lite."

The lack among CPS workers of both a comprehensive theoretical understanding of DR and of DR practice on the ground has important implications. Not only is it important in order to have a coherent, coordinated system, but it is unlikely that many key stakeholders in the community—police officers, prosecutors, judges, teachers, counselors, etc.—will understand and accept DR as an element of CPS if CPS staff does not. CPS does not operate in a vacuum, but intersects on a regular

[17] Siegel, G.L. & Loman, L.A. (1997). *Missouri Family Assessment and Response Demonstration: Final evaluation report*, p. 195. St. Louis: Institute of Applied Research. Retrieved at http://www.iarstl.org/papers/MO FAR Final Report-for website.pdf

basis with an array of community agencies and institutions. The relationship between CPS and these entities is fundamentally dynamic and integrative. Any significant modification to the child protection system will in some way affect the work of professionals in these organizations and will be impacted in return by their understanding and acceptance of it. DR in particular, with its non-labeling and its service components, requires the involvement and participation of the community.

In addition, having the family assessment pathway operate only outside the organizational walls of CPS limits its potential to benefit the child welfare system by imbuing investigations with a sharper family-centered focus. In a child protection system with a small proportion of reports selected for family assessments, there will be a very large number of reports not selected that would have been served more effectively through family assessment techniques. This particularly applies to families with very young children, where more than a forensic evidentiary analysis may be necessary to secure their long-term well-being. The establishment of a differential response system is more than the introduction of a second response track; it involves a different way of thinking about child protection.

Recommendations

1. Ultimately, the development of differential response within the state can and should be guided only by the judgment and decisions of Nevada stakeholders and program administrators. Within the context of a) the DR pilot project and what has been learned in it and b) the common visions in the strategic plans of DCFS, CCDFS, and WCDSS, we recommend the re-articulation and/or development of a clear and concrete plan with goals and objectives for the role of differential response within the Nevada child protection system along with actions steps with timelines and role responsibilities for the enactment of the plan. In this process, consider the other recommendations listed. These recommendations are meant to expand on the successes and increase the use and effects of the family assessment approach with the minimal amount of organizational back-tracking and within a realistic view of the economic and budgetary situation in the state.

2. Expansion of DR-family assessments through FRCs would not appear to be financially possible at the moment. However, consideration should be given, once training has occurred, to CPS workers utilizing the family assessment approach in response to reports classified as Priority 2. Given current financial limitations, adopting the full Minnesota model, with an increased emphasis on the provision of services, would not seem to be feasible at the present time. However, adopting the Missouri model, emphasizing the family assessment protocol within CPS even without additional service funds, would be possible. The FRCs would play an important role in any such reports when services were needed as both a source of direct assistance and of referrals to other resources.

3. Just as state statutes draw attention to the vulnerability of very young children by requiring an investigation whenever a report identifies a potential child victim aged 5 or younger, state and regional policies should likewise do this, by requiring some back up to the investigation. Logically, this would be a family assessment – always conducted after a report involving very young children is substantiated, and always in other reports when any conditions are observed that suggest a child's wellbeing is potentially threatened by factors included or not included in the report. This follow-on family assessment could be carried out by FRC-DR workers who may not be fully utilized or by trained CPS workers.

4. Develop clear, detailed guidelines for determining the priority levels of reports that can be agreed to by each of the three service regions and use these guidelines as the basis for training of hotline and intake workers and supervisors.

5. Within each region, establish guidelines for how to effectively utilize FRC-DR workers who do not have full caseloads. One way to do this is to permit referral to FRCs of some P2 reports by requiring that the FRC respond in the time designated.

6. Provide training of CPS personnel on differential response and the family assessment approach. This training should be provided by professionals with direct hands-on experience in the management and operation of mature DR programs at both the state and county level.[18] Limiting the intensive phase of this training to a small core group of supervisors in the three service regions, would produce a cadre of local trainers.[19]

7. Similar training in differential response and the family assessment approach provided by similar outside professionals should be considered for a core group of FRC DR supervisors, who could likewise form a future training team.

8. Community outreach is essential for a differential response program. This would be aided indirectly through training in DR provided to CPS supervisors and case workers. But direct outreach to key stakeholders in the community—such as judges, prosecutors, educators, policemen, child and family advocates, and representatives of public and private community resources—is also necessary.

[18] Three such individuals available through the Quality Improvement Center for DR operated by American Humane and funded by the Children's Bureau are Rob Sawyer, Brenda Lockwood, and Sue Lohrbach.
[19] Outside funding, such as the Casey Foundation, might be sought for this.

Appendix

All reports																
Initial allegations- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/ Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	295	28.1%	40	0	35	1	17	8	3	0	33	31	7	13	188	13.6%
Severe Physical Abuse	96	37.5%	4	3	12	0	8	5	3	0	17	11	1	9	73	3.1%
Less Severe Physical Abuse (PHA)	910	36.4%	47	11	251	2	125	25	24	2	132	135	12	75	841	27.6%
PHA and CON	120	38.3%	8	3	37	0	23	4	3	0	19	10	3	12	122	50.0%
Drug Exposed Infant	125	43.2%	3	0	7	9	4	4	3	0	31	20	2	20	103	7.2%
Conflict or Emot. Abuse (CON)	670	34.5%	26	11	143	1	94	17	19	3	79	87	12	52	544	14.0%
CON and PAR	130	38.5%	8	6	14	2	22	0	1	1	23	24	0	31	132	40.8%
Severe Neglect	82	31.7%	0	0	13	1	13	8	2	0	11	13	2	13	76	9.8%
Medical Neglect	175	31.4%	7	1	20	1	12	2	14	1	33	24	3	25	143	8.0%
Unmet Medical Needs (UMD)	28	46.4%	2	0	9	0	3	0	3	2	13	7	0	4	43	7.1%
Neglect of Basic Needs (BND)	981	49.0%	46	17	134	8	118	50	39	6	430	265	39	171	1323	43.8%
BND and LSP	213	41.3%	10	2	23	1	20	6	6	0	51	58	5	37	219	26.3%
BND and EDN	24	37.5%	4	1	3	0	2	1	1	0	7	3	2	6	30	54.2%
BND and PAR	409	44.3%	13	3	69	10	46	17	14	0	136	116	13	108	545	61.6%
Lack of Supervision (LSP)	725	33.8%	19	14	80	4	69	17	19	3	155	200	19	84	683	27.6%
LSP and EDN	14	50.0%	3	0	0	1	0	1	0	0	3	2	2	2	14	28.6%
LSP and PAR	149	37.6%	4	1	18	7	9	0	4	1	24	26	3	35	132	40.9%
Educational Neglect (EDN)	156	40.4%	8	2	13	2	15	5	8	0	22	23	35	19	152	22.4%
Parent/Family Problems (PAR)	744	36.2%	27	7	73	18	53	18	9	1	130	128	17	163	644	21.9%
Three or more allegations	421	42.0%	21	8	57	5	44	19	6	1	86	74	9	97	427	
Total	6467	38.7%	300	90	1011	73	697	207	181	21	1435	1257	186	976	6434	26.8%
Percent of types of new allegations			4.7%	1.4%	15.7%	1.1%	10.8%	3.2%	2.8%	0.3%	22.3%	19.5%	2.9%	15.2%		

P1 only																
Initial allega-tions- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	42	26.2%	4	0	7	1	1	1	1	0	3	1	0	0	19	9.5%
Severe Physical Abuse	35	37.1%	2	1	5	0	5	2	0	0	7	3	0	6	31	2.9%
Less Severe Physical Abuse (PHA)	155	43.2%	15	1	57	0	28	2	7	1	54	36	4	29	234	36.8%
PHA and CON	25	36.0%	3	1	8	0	5	1	1	0	7	3	1	5	35	52.0%
Drug Exposed Infant	4	75.0%	0	0	0	1	0	0	0	0	2	0	0	1	4	25.0%
Conflict or Emot. Abuse (CON)	84	39.3%	4	3	24	0	17	3	1	1	15	12	0	10	90	20.2%
CON and PAR	10	80.0%	1	3	1	0	5	0	0	0	7	6	0	4	27	90.0%
Severe Neglect	22	36.4%	0	0	6	0	8	6	0	0	6	6	1	3	36	27.3%
Medical Neglect	18	27.8%	1	0	2	0	2	0	1	0	4	1	0	6	17	5.6%
Unmet Medical Needs (UMD)	3	33.3%	0	0	1	0	0	0	0	0	3	1	0	1	6	0.0%
Neglect of Basic Needs (BND)	112	51.8%	5	5	15	1	12	7	7	2	61	50	6	25	196	54.5%
BND and LSP	30	50.0%	2	1	6	1	4	1	1	0	7	10	0	7	40	23.3%
BND and EDN	1	100.0%	1	0	0	0	0	0	0	0	0	1	0	0	2	0.0%
BND and PAR	53	43.4%	3	0	4	3	5	2	1	0	13	8	5	15	59	39.6%
Lack of Supervision (LSP)	119	34.5%	5	4	18	1	12	7	9	1	29	28	5	12	131	23.5%
LSP and EDN	1	100.0%	0	0	0	0	0	1	0	0	0	0	1	0	2	100.0%
LSP and PAR	11	27.3%	0	0	1	0	1	0	0	0	1	1	0	1	5	18.2%
Educational Neglect (EDN)	2	50.0%	1	0	0	0	0	0	0	0	0	0	1	0	2	50.0%
Parent/Family Problems (PAR)	93	38.7%	2	2	18	3	10	4	0	0	22	24	6	30	121	32.3%
Three or more allegations	58	48.3%	3	1	6	1	9	2	1	1	17	12	0	18	71	
Total	878	41.6%	52	22	179	12	124	39	30	6	258	203	30	173	1128	32.1%
Percent of types of new allegations			4.6%	2.0%	15.9%	1.1%	11.0%	3.5%	2.7%	0.5%	22.9%	18.0%	2.7%	15.3%	100.0%	

P2 only																
Initial allega-tions- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	88	33.0%	16	0	13	0	7	1	0	0	18	10	3	8	76	18.2%
Severe Physical Abuse	41	34.1%	0	2	6	0	2	2	3	0	5	3	1	4	28	4.9%
Less Severe Physical Abuse (PHA)	377	39.8%	18	7	114	1	57	16	10	0	52	65	4	29	373	30.2%
PHA and CON	31	41.9%	2	2	12	0	9	2	2	0	4	2	2	2	39	67.7%
Drug Exposed Infant	21	47.6%	1	0	1	1	2	1	1	0	10	3	1	5	26	4.8%
Conflict or Emot. Abuse (CON)	203	34.5%	9	1	36	1	32	6	9	0	38	33	2	17	184	15.8%
CON and PAR	50	36.0%	3	1	9	1	6	0	1	0	6	12	0	13	52	38.0%
Severe Neglect	23	21.7%	0	0	1	0	1	1	0	0	3	0	0	2	8	4.3%
Medical Neglect	62	37.1%	3	2	9	1	11	1	2	0	14	13	3	14	73	3.2%
Unmet Medical Needs (UMD)	8	75.0%	0	0	5	0	0	0	1	0	1	3	0	1	11	0.0%
Neglect of Basic Needs (BND)	471	53.5%	25	7	65	6	62	23	20	4	242	113	15	100	682	51.4%
BND and LSP	70	34.3%	3	0	6	0	5	3	0	0	13	18	1	11	60	20.0%
BND and EDN	4	50.0%	2	0	0	0	2	0	0	0	3	1	0	3	11	150.0%
BND and PAR	167	46.7%	6	2	32	4	19	8	5	0	67	53	0	49	245	71.9%
Lack of Supervision (LSP)	212	39.2%	5	4	20	0	22	6	7	0	60	72	4	22	222	34.0%
LSP and EDN	2	100.0%	1	0	0	1	0	0	0	0	1	0	1	1	5	50.0%
LSP and PAR	44	43.2%	2	0	8	2	1	0	0	0	6	11	0	9	39	45.5%
Educational Neglect (EDN)	11	36.4%	0	0	3	1	1	1	0	0	1	0	0	6	13	0.0%
Parent/Family Problems (PAR)	247	41.7%	12	1	19	2	25	6	8	0	63	48	8	66	258	26.7%
Three or more allegations	157	47.1%	8	4	24	3	16	11	4	0	44	33	4	42	193	
Total	2289	42.8%	116	33	383	24	280	88	73	4	651	493	49	404	2598	33.5%
Percent of types of new allegations			4.5%	1.3%	14.7%	0.9%	10.8%	3.4%	2.8%	0.2%	25.1%	19.0%	1.9%	15.6%	100.0%	

P3 only																
Initial allegations- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	175	29.1%	20	0	17	1	13	5	3	0	15	26	7	8	115	11.4%
Severe Physical Abuse	24	41.7%	2	0	2	0	1	1	0	0	5	7	0	0	18	0.0%
Less Severe Physical Abuse (PHA)	405	33.3%	22	5	105	1	53	10	6	1	47	45	7	27	329	25.9%
PHA and CON	71	38.0%	3	1	18	0	11	1	0	0	9	5	0	5	53	40.8%
Drug Exposed Infant	100	41.0%	2	0	6	7	2	3	2	0	19	17	1	14	73	7.0%
Conflict or Emot. Abuse (CON)	397	35.3%	15	5	84	1	46	13	11	2	40	50	10	30	307	11.6%
CON and PAR	68	36.8%	4	2	5	1	11	0	0	1	10	6	0	14	54	36.8%
Severe Neglect	42	31.0%	0	0	6	1	4	1	1	0	3	7	1	8	32	2.4%
Medical Neglect	96	31.3%	5	0	9	0	5	2	10	0	18	10	1	10	70	10.4%
Unmet Medical Needs (UMD)	18	33.3%	2	0	3	0	3	0	2	2	9	3	0	2	26	11.1%
Neglect of Basic Needs (BND)	392	46.9%	21	5	66	1	46	23	17	0	145	104	17	71	516	37.0%
BND and LSP	115	42.6%	6	1	17	0	12	3	5	0	30	29	4	20	127	29.6%
BND and EDN	20	35.0%	1	1	3	0	0	1	0	0	7	4	3	6	26	65.0%
BND and PAR	203	42.4%	10	1	41	2	22	7	8	0	60	63	9	51	274	60.6%
Lack of Supervision (LSP)	401	33.2%	16	6	50	3	38	5	4	1	72	110	13	49	367	27.4%
LSP and EDN	10	40.0%	2	0	0	0	0	0	0	0	2	2	0	1	7	20.0%
LSP and PAR	92	39.1%	2	0	10	5	7	0	4	1	22	15	3	28	97	46.7%
Educational Neglect (EDN)	142	40.1%	7	2	10	1	14	5	8	0	18	23	33	13	134	23.2%
Parent/Family Problems (PAR)	406	32.3%	13	5	37	13	20	10	0	1	50	55	4	75	283	18.5%
Three or more allegations	220	39.1%	12	3	27	2	22	6	2	0	36	36	7	45	198	
Total	3397	36.8%	165	37	516	39	330	96	83	9	617	617	120	477	3106	25.6%
Percent of types of new allegations			5.3%	1.2%	16.6%	1.3%	10.6%	3.1%	2.7%	0.3%	19.9%	19.9%	3.9%	15.4%	100.0%	

Initial report substantiated																
Initial allegations- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	19	31.6%	2	0	3	0	3	4	0	0	1	3	0	0	16	10.5%
Severe Physical Abuse	13	30.8%	0	0	1	0	2	0	0	0	1	0	0	2	6	0.0%
Less Severe Physical Abuse (PHA)	89	44.9%	8	1	21	0	10	3	2	0	12	10	3	8	78	23.6%
PHA and CON	12	33.3%	2	1	2	0	2	0	1	0	0	2	0	0	10	33.3%
Drug Exposed Infant	27	33.3%	0	0	3	0	0	0	0	0	7	2	1	6	19	0.0%
Conflict or Emot. Abuse (CON)	28	46.4%	1	2	9	0	9	3	0	0	4	5	0	1	34	32.1%
CON and PAR	11	18.2%	0	0	0	1	1	0	0	0	1	2	0	2	7	27.3%
Severe Neglect	21	19.0%	0	0	2	1	0	1	0	0	1	2	0	1	8	4.8%
Medical Neglect	13	61.5%	2	0	2	0	2	0	1	0	5	1	0	5	18	7.7%
Unmet Medical Needs (UMD)	2	50.0%	0	0	0	0	0	0	1	0	0	0	0	0	1	0.0%
Neglect of Basic Needs (BND)	79	57.0%	6	2	6	1	10	4	8	2	46	19	3	22	129	58.2%
BND and LSP	37	48.6%	2	2	4	0	1	1	0	0	10	13	1	8	42	29.7%
BND and EDN	1	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
BND and PAR	68	44.1%	3	1	10	3	13	5	3	0	11	14	0	15	78	36.8%
Lack of Supervision (LSP)	65	50.8%	10	1	4	0	12	3	4	1	25	29	3	10	102	44.6%
LSP and EDN	5	40.0%	1	0	0	1	0	1	0	0	0	0	2	1	6	40.0%
LSP and PAR	24	25.0%	0	0	0	1	0	0	0	0	6	3	0	2	12	20.8%
Educational Neglect (EDN)	28	42.9%	1	1	3	1	5	1	6	0	4	6	8	2	38	28.6%
Parent/Family Problems (PAR)	114	36.0%	4	1	11	3	7	4	2	0	24	23	5	29	113	25.4%
Three or more allegations	64	34.4%	4	0	4	1	9	0	0	0	18	11	2	21	70	
Total	720	41.7%	46	12	85	13	86	30	28	3	176	145	28	135	787	22.3%
Percent of types of new allegations			5.8%	1.5%	10.8%	1.7%	10.9%	3.8%	3.6%	0.4%	22.4%	18.4%	3.6%	17.2%	100.0%	

Clark only – all reports																
Initial allegations- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	196	22.4%	30	0	22	0	7	2	2	0	14	14	3	7	101	15.3%
Severe Physical Abuse	67	35.8%	4	1	6	0	3	3	2	0	9	11	1	3	43	1.5%
Less Severe Physical Abuse (PHA)	598	36.5%	28	8	169	2	82	17	12	1	74	91	7	41	532	28.3%
PHA and CON	103	39.8%	8	3	36	0	22	3	2	0	17	10	3	10	114	56.3%
Drug Exposed Infant	115	40.0%	3	0	6	8	3	3	2	0	23	19	1	15	83	7.0%
Conflict or Emot. Abuse (CON)	495	32.1%	16	7	107	1	69	15	14	2	42	66	11	35	385	13.9%
CON and PAR	102	37.3%	8	5	10	2	15	0	1	1	16	17	0	19	94	33.3%
Severe Neglect	27	48.1%	0	0	5	1	7	4	1	0	6	6	2	8	40	14.8%
Medical Neglect	114	26.3%	3	1	12	1	6	2	6	0	18	15	0	17	81	5.3%
Unmet Medical Needs (UMD)	8	37.5%	0	0	4	0	0	0	0	0	0	2	0	1	7	0.0%
Neglect of Basic Needs (BND)	305	43.3%	16	7	47	4	33	9	8	1	102	93	11	57	388	33.4%
BND and LSP	168	37.5%	9	1	15	1	14	4	6	0	23	42	4	26	145	16.1%
BND and EDN	14	35.7%	3	1	2	0	2	1	0	0	2	1	2	3	17	35.7%
BND and PAR	285	40.7%	9	3	48	6	27	6	8	0	79	82	11	72	351	56.5%
Lack of Supervision (LSP)	486	32.1%	10	9	52	4	31	8	7	1	75	121	6	53	377	24.9%
LSP and EDN	3	66.7%	1	0	0	1	0	0	0	0	1	0	1	1	5	33.3%
LSP and PAR	124	38.7%	4	1	14	5	7	0	3	1	20	22	3	33	113	44.4%
Educational Neglect (EDN)	112	39.3%	5	1	10	2	8	1	6	0	14	13	19	15	94	17.0%
Parent/Family Problems (PAR)	523	32.5%	17	5	54	15	26	7	5	1	67	78	9	100	384	19.1%
Three or more allegations	311	38.9%	15	7	37	4	23	8	4	0	42	58	7	68	273	
Total	4156	35.4%	189	60	656	57	385	93	89	8	644	761	101	584	3627	24.0%
Percent of types of new allegations			5.2%	1.7%	18.1%	1.6%	10.6%	2.6%	2.5%	0.2%	17.8%	21.0%	2.8%	16.1%	100.0%	

Washoe only - all reports																
Initial allegations- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	45	42.2%	4	0	8	1	6	3	1	0	12	11	3	3	52	8.9%
Severe Physical Abuse	18	38.9%	0	2	4	0	3	2	1	0	7	0	0	5	24	11.1%
Less Severe Physical Abuse (PHA)	143	35.7%	6	1	33	0	15	2	3	0	28	19	2	11	120	23.1%
PHA and CON	2	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
Drug Exposed Infant	6	83.3%	0	0	1	1	0	0	0	0	5	1	1	2	11	16.7%
Conflict or Emot. Abuse (CON)	65	38.5%	2	1	9	0	6	1	3	0	15	8	0	5	50	9.2%
CON and PAR	10	30.0%	0	0	1	0	1	0	0	0	4	2	0	2	10	30.0%
Severe Neglect	23	26.1%	0	0	2	0	3	3	0	0	3	4	0	2	17	13.0%
Medical Neglect	25	40.0%	1	0	2	0	0	0	3	1	5	2	3	3	20	12.0%
Unmet Medical Needs (UMD)	2	100.0%	0	0	0	0	1	0	0	1	3	0	0	1	6	50.0%
Neglect of Basic Needs (BND)	528	53.0%	26	6	67	3	61	37	24	4	269	137	21	90	745	50.9%
BND and LSP	20	60.0%	1	1	1	0	2	2	0	0	12	8	0	3	30	60.0%
BND and EDN	2	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
BND and PAR	64	45.3%	4	0	11	3	3	5	3	0	32	13	0	15	89	70.3%
Lack of Supervision (LSP)	134	37.3%	8	2	12	0	12	6	7	1	48	42	8	16	162	31.3%
LSP and EDN	4	25.0%	0	0	0	0	0	0	0	0	0	1	0	0	1	25.0%
LSP and PAR	5	40.0%	0	0	1	1	0	0	0	0	1	3	0	0	6	60.0%
Educational Neglect (EDN)	8	37.5%	1	0	0	0	0	0	0	0	0	1	1	1	4	12.5%
Parent/Family Problems (PAR)	77	42.9%	3	0	8	1	5	6	2	0	23	13	2	13	76	16.9%
Three or more allegations	29	55.2%	3	0	5	0	2	3	0	0	18	4	0	10	45	
Total	1210	45.8%	59	13	165	10	120	70	47	7	485	269	41	182	1468	26.4%
Percent of types of new allegations			4.0%	0.9%	11.2%	0.7%	8.2%	4.8%	3.2%	0.5%	33.0%	18.3%	2.8%	12.4%	100.0%	

Rural counties only - all reports																
Initial allegations- Jan-Jun 2007	# of families by type of 1st report	% of families with new reports	Sexual Abuse	Severe Physical Abuse	Less Severe Physical Abuse (PHA)	Drug Exposed Infant	Conflict or Emot. Abuse (CON)	Severe Neglect	Medical Neglect	Unmet Medical Needs (UMD)	Neglect of Basic Needs (BND)	Lack of Supervision (LSP)	Educational Neglect (EDN)	Parent/Family Problm (PAR)	Total of new allega-tions	% match betw 1st & subseq reports
Sexual Abuse	54	37.0%	6	0	5	0	4	3	0	0	7	6	1	3	35	11.1%
Severe Physical Abuse	11	45.5%	0	0	2	0	2	0	0	0	1	0	0	1	6	0.0%
Less Severe Physical Abuse (PHA)	169	36.7%	13	2	49	0	28	6	9	1	30	25	3	23	189	29.0%
PHA and CON	15	33.3%	0	0	1	0	1	1	1	0	2	0	0	2	8	13.3%
Drug Exposed Infant	4	75.0%	0	0	0	0	1	1	1	0	3	0	0	3	9	0.0%
Conflict or Emot. Abuse (CON)	111	43.2%	8	3	27	0	19	2	2	1	22	13	1	12	110	17.1%
CON and PAR	18	50.0%	0	1	3	0	6	0	0	0	3	5	0	10	28	88.9%
Severe Neglect	32	21.9%	0	0	6	0	3	1	1	0	2	3	0	3	19	3.1%
Medical Neglect	36	41.7%	3	0	6	0	6	0	5	0	10	7	0	5	42	13.9%
Unmet Medical Needs (UMD)	18	44.4%	2	0	5	0	2	0	3	1	10	5	0	2	30	5.6%
Neglect of Basic Needs (BND)	151	47.0%	6	4	20	1	25	4	7	1	60	37	7	25	197	39.7%
BND and LSP	25	52.0%	0	0	7	0	4	0	0	0	16	8	1	8	44	68.0%
BND and EDN	8	50.0%	1	0	1	0	0	0	1	0	5	2	0	3	13	100.0%
BND and PAR	61	60.7%	0	0	10	1	16	6	3	0	26	21	2	22	107	77.0%
Lack of Supervision (LSP)	105	37.1%	1	3	16	0	26	3	5	1	32	37	5	15	144	35.2%
LSP and EDN	7	57.1%	2	0	0	0	0	1	0	0	2	1	1	1	8	28.6%
LSP and PAR	20	30.0%	0	0	3	1	2	0	1	0	3	1	0	2	13	15.0%
Educational Neglect (EDN)	36	44.4%	2	1	3	0	7	4	2	0	8	9	15	3	54	41.7%
Parent/Family Problems (PAR)	145	45.5%	7	2	11	2	22	5	2	0	40	37	6	50	184	34.5%
Three or more allegations	82	50.0%	4	1	15	1	20	8	2	1	30	14	3	20	119	
Total	1108	43.2%	55	17	190	6	194	45	45	6	312	231	45	213	1359	32.7%
Percent of types of new allegations			4.0%	1.3%	14.0%	0.4%	14.3%	3.3%	3.3%	0.4%	23.0%	17.0%	3.3%	15.7%	1	