

---

---

**Differential Response in Nevada:  
Implementation and Impact Evaluation  
After 32 Months**

---

**Prepared for the  
Nevada Department of Health and Human Services**

**by  
Gary L. Siegel, PhD, Christine Filonow Shannon, MSW, and  
L. Anthony Loman, PhD**

**Institute of Applied Research  
103 W. Lockwood, Suite 200  
St. Louis, MO 63119**

**November 2009**

---

---

Copyright © 2010 by the Institute of Applied Research  
Institute of Applied Research  
103 W. Lockwood, Suite 200  
St. Louis, MO 63119  
(314) 968-9625  
[www.iarstl.org](http://www.iarstl.org)

## Study Highlights

- The Nevada DR program began in February 2007 in two service zones in Clark County and has now been implemented in areas of the state where over 98 percent of residents live. The percent of maltreatment reports referred for a DR family assessment response is low but rising—about 9% for reports received in 2009.
- The Nevada DR model, which involves FRCs in all DR family assessment cases from start to finish, is unique among states that have implemented DR. Ten FRCs and the Children’s Cabinet in Washoe County provide DR services in 11 Nevada counties.
- The working relationship between CPS offices and FRCs is quite good overall. Both sets of staffs understand the role of the other and, in most locations, interact on a regularly scheduled basis.
- FRC DR workers are limited to 15 family assessment cases at any one time. In most rural areas, DR workers are at or near case capacity most of the time. In the two urban counties, but especially in Clark County, DR workers are often underutilized.
- A high percentage of families who receive DR family assessments are satisfied with how they are treated (96%) and with the help they receive (90%), and 3 out of 4 believe their family is better off because of the experience. These responses compare very favorably to family surveys conducted in other states that have implemented DR.
- Results of family surveys indicate that the DR program has been implemented in Nevada as designed and intended. Families report that DR workers listen to them, treat them in a friendly manner and involve them in decisions that affect them and their children.
- About equal percentages of families (67%) and workers (65%) report that services were provided to DR families. Emergency food and clothing were the most frequently provided assistance, followed by counseling, and assistance with utility payments and employment. Workers frequently connect families to other community resources.
- While workers see their intervention as effective and helpful to families, they also recognize the complex and often chronic nature of the problems of many families with whom they work.
- Although the follow-up period has not been long, DR families are somewhat less likely than non-DR families to have subsequent CA/N reports that require an investigation.
- Bottom Line: Overall the DR program has been well implemented with good effect, providing services to a set of families that have previously not received them. At the same time, a relatively small percentage of all child maltreatment reports are referred to FRCs for a DR family assessment, so that the impact on the broad CPS system in the state is limited.

## Recommendations

As DR implementation in Nevada has unfolded, two issues have arisen. On the one hand, relying solely on FRCs for DR effectively limits DR to a relatively small component of the child protection system. On the other hand, current DR capacity, although limited, is not being fully utilized. This reduces the programmatic and cost effectiveness of DR and results in many families who could benefit from a DR family assessment not receiving one. Currently, a report that is originally screened for a DR family assessment can be switched to an investigation if the well-being of children is a concern. However, there is no provision to switch the screening of a report from investigation to family assessment, even for the same reason. This can be problematic, especially in situations that involve very young children where investigations are statutorily mandated. To build on the positive work of the state's CPS agencies and the FRCs, the following courses of action are presented for the state's consideration. These considerations require an understanding of the differences between a traditional CPS investigation and a DR family assessment.

Recommendation 1. DR workers could be more fully utilized through a formal downgrading of certain reports that are screened for investigations and transferring them, following the investigation, to FRC-DR workers as family assessment cases. This may be done to two types of reports: 1) Reports in which an allegation is substantiated but the county CPS agency does not believe court involvement is necessary, although there are underlying issues that could be addressed to improve the well-being of children, particularly if the children are very young and the initial investigation was required by state statute. 2) Reports in which an allegation is not substantiated but the CPS worker has significant concerns about the well-being of the children nonetheless. The report could be switched to a family assessment with the family's consent and referred to an FRC-DR worker. If the family does not consent, the case could be held open without a final finding until a family assessment is completed; in this case the cooperation of the family may be gained by the FRC worker and services provided, but if not, the case could then be closed.

Recommendation 2. A unit within CPS agencies could be established to conduct family assessments as part of investigations, especially for reports involving very young children. This unit may or may not utilize the services of FRC-DR workers as part of the original investigation, depending on the availability of these workers. Having the assessment track operating within the same institutional environment as investigations has the potential to improve investigations by imbuing them with a sharper family-centered focus.

Recommendation 3. Considerations 1 and 2 could be blended into a single, revised system with a larger DR program. This would involve establishing a DR family assessment track within CPS and utilizing FRCs for ongoing involvement in family assessment cases in Priority 2 reports. This would not relinquish the valued role of Nevada's FRCs and Priority 3 reports could be handled as now, with immediate referral to FRCs.

Finally, Nevada has a unique tri-level CPS structure. It would be possible to establish a policy that permitted the execution of one or more of these recommendations without requiring changes simultaneously everywhere.

## Table of Contents

<b>Study Highlights and Recommendations .....</b>	<b>1</b>
<b>Part 1. Overview.....</b>	<b>4</b>
<b>Part 2. Child Maltreatment Reports and Screening for DR .....</b>	<b>12</b>
<b>Part 3. Report on Site Visits .....</b>	<b>25</b>
<b>Part 4. Family Surveys .....</b>	<b>40</b>
<b>Part 5. Family Satisfaction .....</b>	<b>43</b>
<b>Part 6. Practice Shift and Model Fidelity .....</b>	<b>49</b>
<b>Part 7. Services.....</b>	<b>56</b>
<b>Part 8. Recurrence of Maltreatment and Subsequent Child Removals .....</b>	<b>65</b>
<b>Part 9. Summary, Conclusions and Considerations .....</b>	<b>71</b>

## Part 1. Overview

This is the second evaluation report of the Nevada Differential Response (DR) program. The evaluation is being conducted by the Institute of Applied Research (IAR) and is focused on the new DR family assessment response track that is being 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 methodologies are similar in many ways to what has been employed by IAR in studies of differential response programs in other states, but the study has been adjusted to suit unique aspects of the Nevada DR program and child protection system. The evaluation is scheduled to be conducted over a three-year period.

**The Differential Response.** 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 tracks, those that are more severe and those that are less severe. Reports involving more severe abuse or neglect, situations in which the safety of children is at imminent risk, are investigated and dealt with in the traditional CPS response. Maltreatment reports that are less severe in nature receive a family assessment, a procedure that is 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.

The family assessment response has two core elements: the response protocol and the service component. The family assessment response protocol differs from a traditional investigation in specific and basic ways. In family assessments, families are approached in a non-accusatory, supportive, friendly, family-centered manner, and workers attempt to facilitate a discovery and remediation process in which family members themselves take the lead in identifying their problems and needs and how these might best be addressed. Secondly, family assessments are intended to be the vehicle through which issues that have given rise to allegations of child maltreatment and which may lead to future and potentially more severe child abuse or neglect, are addressed and resolved. Where investigations tend to have a narrow focus and result in a guilty or not guilty verdict, assessments are more wide ranging and, as the saying goes, seek to make forward progress by digging deeper down.

The logic model of differential response can be expressed in a simple formula:  $a + b = c$ . Element "a" is the manner in which families are approached (the family assessment protocol).

Element “b” is the provision of services or assistance specific to the immediate and often chronic needs of families. The product “c” represents the outcomes obtained. The new approach to families (a) and the services provided to them (b) are the investments made to produce improvements in the well-being of children and their families. These improvements are outcomes (c) desired by the child protection system and the families themselves, helping families through troubled times in the short run and reducing their longer-term contact with CPS.

Family assessments are meant to apply “a stitch in time” by providing assistance or services to families that traditionally have received few if any direct services through CPS. Historically, child protection has been a system that has tended to lurch from crisis to crisis, fully engaged with the most serious cases of child maltreatment with little time to give to other cases. It is a system that has had to juggle too many fragile eggs at any one time, trying to catch them before they hit the ground with tragic consequences. Differential response is an attempt to keep more of the eggs out of the air in the first place.

It should be noted at the outset that the term differential response was originally used to refer to a child protection system with more than one response track. The term is often 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 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 traditional investigation.

**CPS and the Geography of Nevada.** Before moving into the substance of this report, a word may be in order for any reader unfamiliar with CPS in Nevada about the structure of the state’s child protection system. CPS in Nevada 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).

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. 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.

**DR Phase In.** Nevada has implemented its DR program through a series of stages that began in February 2007. As of October 1, 2009, when this report was being prepared, the dual track approach had been operating for 31 months and was available in all but six very rural counties that, combined, account for less than 2 percent of the state’s population.

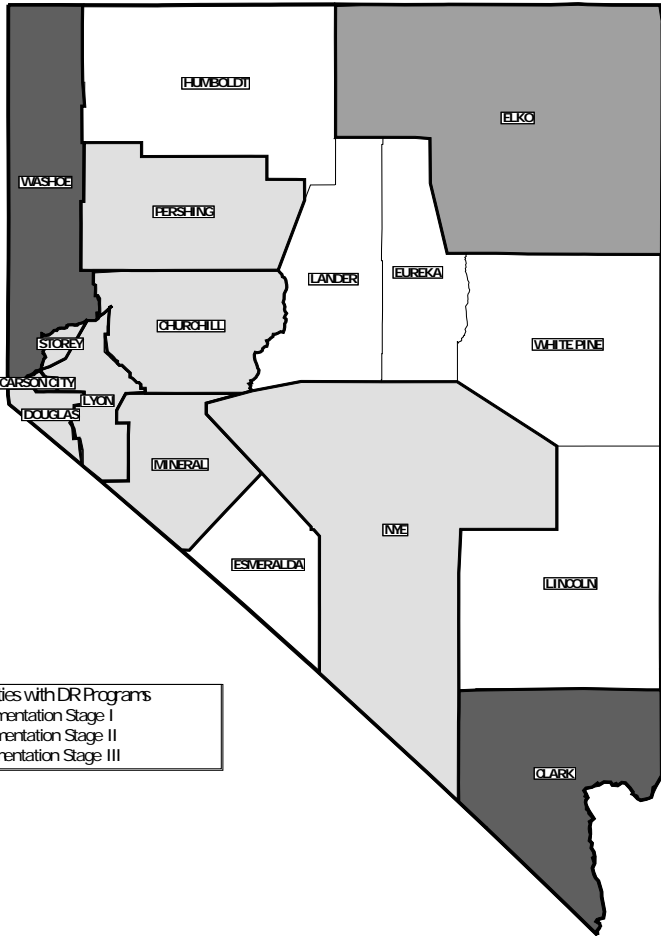
DR was implemented first in two parts of Las Vegas, the service zones of the East and South Las Vegas offices of the Clark County Department of Family Services. The second stage occurred in early 2008 when DR was implemented in Washoe County (in January), Elko County (in February), and in the Central and North Las Vegas offices in Clark County (in March). The third stage occurred in January 2009 when 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, most recently, Douglas.

**Map 1** shows the counties where DR has been implemented. The different shadings in the map indicate DR roll-out phases, from early (dark) to more recent (light). **Map 2** shows the Las Vegas service zones within Clark County where DR is underway.

**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 by county CPS supervisors or intake workers for a family assessment 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



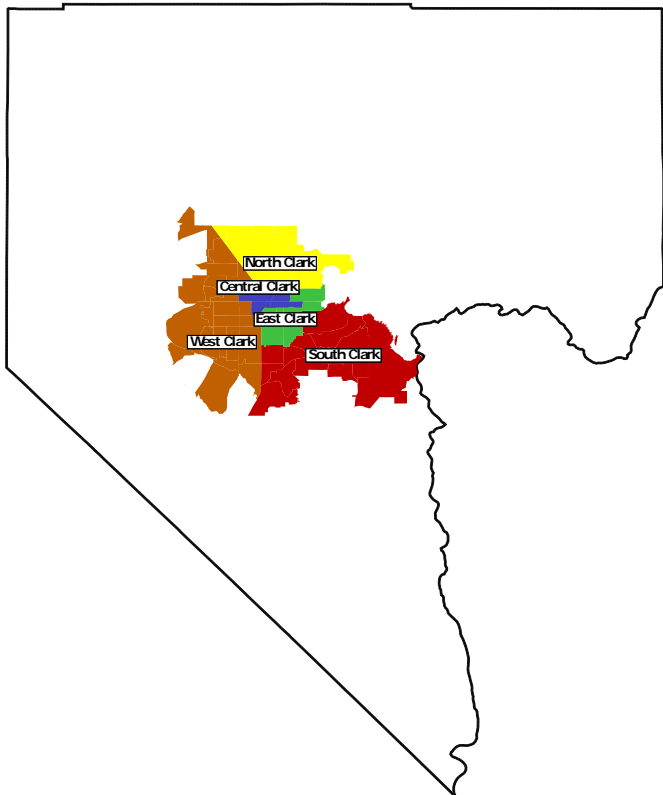


Map 1. Nevada Counties with DR Programs.

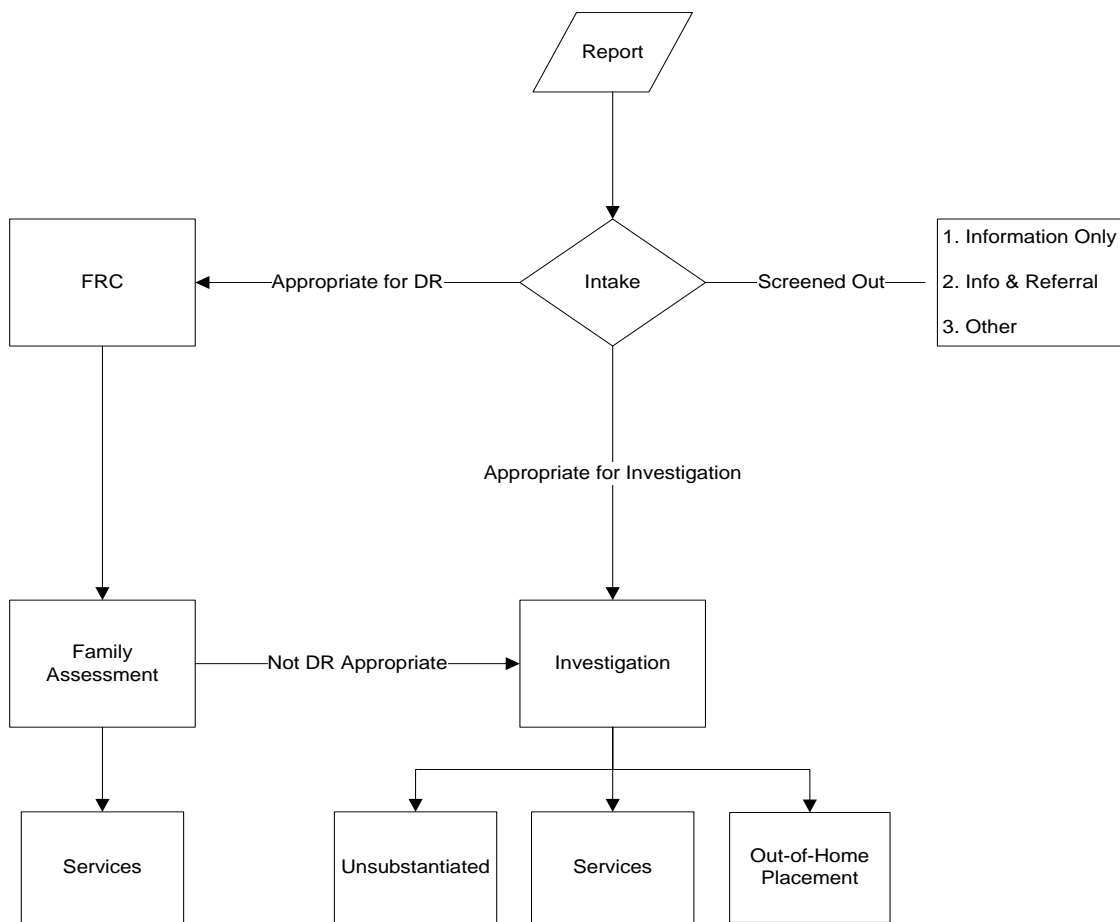
Nevada Counties with DR Programs

- Implementation Stage I
- Implementation Stage II
- Implementation Stage III

Map 2. Clark County Service Areas with DR Programs



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, and for any subsequent case planning and service provision, and for determining that the case should be closed. FRC staff is responsible for entering all case data on DR families into the state’s child welfare information system, which is called UNITY. 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 following flow chart 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, either by state agency policy or statute, to be referred for a DR-family assessment 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 statute requires an investigation of any report in which a child younger than the age of 6 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.** There are currently 10 FRCs and an independent community agency with contracts to provide DR 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.

Altogether there are 23 contracted staff in these agencies who provide DR-family assessment services. These are dedicated DR caseworkers and they are 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 1** 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.

**Evaluation.** The evaluation of the Nevada DR program includes an examination and assessment of the implementation of the program, a process study, and an analysis of the program's effects on children and their families, an outcome study. There are four major data

**Table 1. 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	4	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	1	January 2009

sources for the study: the state’s child welfare information system, UNITY; site visits and interviews; surveys of families; and case reviews by workers.

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 and outcomes. Evaluators receive monthly downloads of extracts from this system. Data extracts are converted through a multi-step process into a research database that is updated each month. The last extract received in time to be utilized for analyses in this report was received in September 2009 and consists of program data through August 31. These extracts provide monthly and cumulative information on maltreatment reports and the screening and selection of reports for a DR-family assessment or investigation. (See Part 2) UNITY is 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. These data are used in outcome analysis in Part 8.

2) Site visits and interviews. Evaluators make periodic site visits to county CPS offices and offices of Family Resource Centers to interview state, county and FRC child protection staff. During 2009 site visits were made to each Clark County service zone in the Las Vegas area, as well as to Washoe, Carson City and Pahrump counties. A summary of these visits and interviews can be found in Part 3.

3) Surveys of Families. Families who receive DR family assessments are being surveyed by mail once their case has been closed. Over the last year and a half, 205 DR families have returned completed surveys; 178 were received in time to be included in analyses for this report. A description of the survey and the families surveyed can be found in Part 4. The results of analyses are found in Parts 5, 6 and 7.

4) Case Reviews by Workers. A sample of DR families is being drawn each month and FRC workers who conducted the family assessment are asked to complete a detailed case-specific questionnaire. There were 95 completed case reviews available for analyses included in this report. The results of these analyses are found in Parts 6 and 7.

The research design being employed in this study is quasi-experimental. An experimental design, involving randomly selected experimental and control groups, was not possible. A comparison group that can serve in place of a control group had to be obtained in another manner. In this evaluation, families selected for a family assessment are being group-matched with similar families who have received a traditional investigation. 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. A preliminary outcome analysis has been conducted. The analysis examined two outcomes—new maltreatment reports and new child removals—to see whether there were differences between DR and comparison families. A description of the rationale and methodology for the group-matching procedure is found in Part 8, along with preliminary outcome analyses.

The evaluation plan called for comparison-group families to serve also as the control group for family surveys and worker case reviews. A test set of 126 comparison-group families were surveyed in September. At the time this report was being finalized, 58 of the surveys had been returned due to bad addresses, and it was by no means certain that comparison family responses will be available for the evaluation. To establish some frame of reference for interpreting the implications of the family surveys, comparisons have begun to be made between Nevada DR families with those in other states where we have conducted or are currently conducting evaluations of DR programs, namely Missouri, Minnesota and Ohio. See Parts 5, 6 and 7.

A sample of comparison-group families has been drawn for case reviews by DCFS, Clark County and Washoe County CPS investigators. These reviews are expected to begin in October 2009. For this report, some comparisons have been made between the DR case reviews that have already been completed by FRC-DR workers and CPS workers in the three other states where IAR has conducted evaluations of DR programs. See Part 7.

## Part 2. Child Maltreatment Reports and Screening for DR

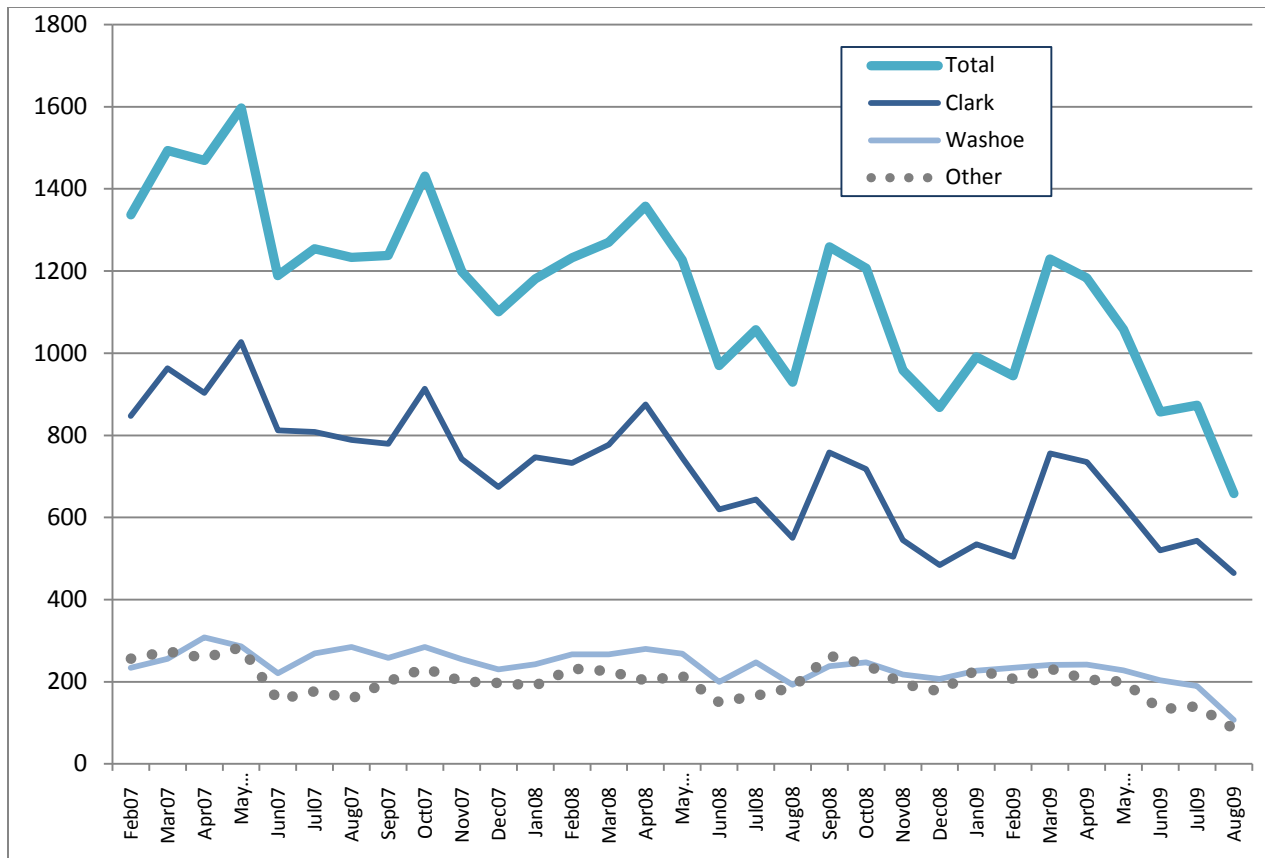
Differential response involves the selection of reports considered appropriate for a family assessment from among all child maltreatment reports received by a child protection agency. Before examining those reports selected for a DR-family assessment, we will briefly review the full population of reports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

**Number of Child Maltreatment Reports.** Reports involving the welfare of children are received by county and state CPS offices. Some of these reports require 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 above, 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 has been a steady decline in the number of accepted maltreatment reports requiring a home visit by a CPS worker. **Figure 1** plots the monthly number of these reports over the 31 month period from the start of the DR project in February 2007 through the end of August 2009. 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. As is evident there has been a decline in the number of accepted reports over the last two and a half years. The sharp decline at the very end of the graph, however, is due partly to the delay in data appearing in extracts received by evaluators.<sup>1</sup>

---

<sup>1</sup>Figure 1 is based on the UNITY extract received in September 2009. Based on previous experience, we would expect to see an additional 100 to 200 reports for the month of August 2009 in the next extraction received (October 2009), as well as 20-25 additional reports for June and July 2009.



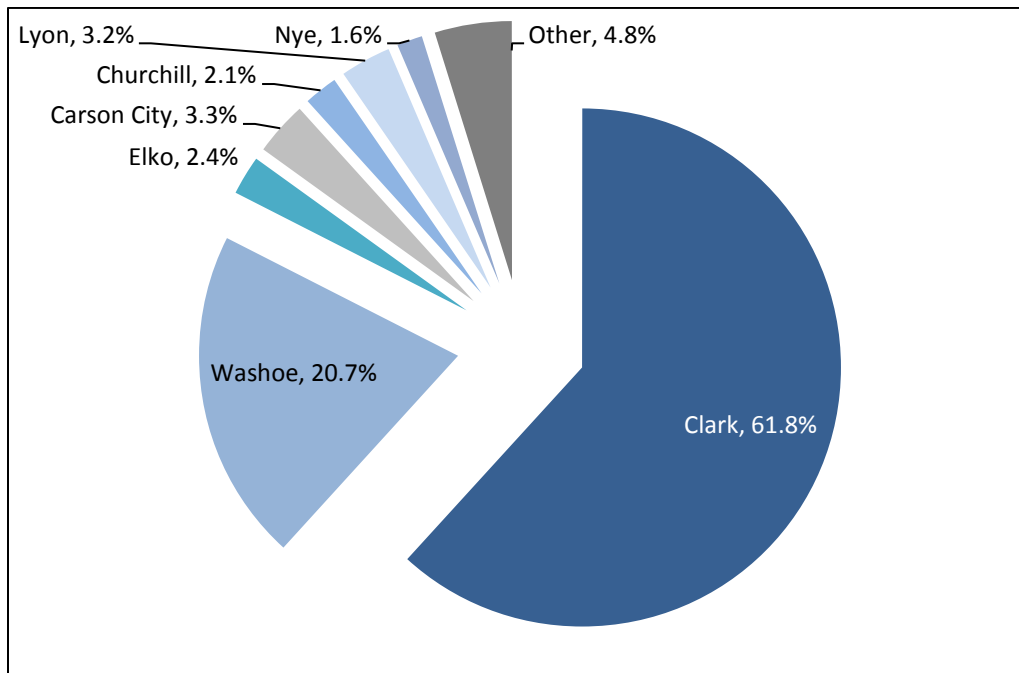
**Figure 1. Monthly number of CPS reports statewide and by county**

The hills and valleys of the graph are probably associated with the school year and reports of educational neglect.

The decline in reports in Nevada is most impacted by the decline in reports in Clark County, which accounts for 71 percent of the state’s population and 64 percent of all CPS reports. The relative relationship between the parts (counties) and the whole (state) can be seen in **Figure 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.

Nationally there has been 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 is the establishment in 2008 of a central (24/7) intake unit in Clark County. Previously, reports made outside of office hours and on weekends were received by law enforcement personnel. Whatever may be behind the falling numbers in Figure 1, Clark County

CPS workers reported during our last site visits (September 2009) that they have been less busy. Part of this is attributable to the referral of some reports to FRCs for family assessments. But Clark CPS workers have also reported that, in recent months, they have had an insufficient number of DR-appropriate reports to refer to FRCs to keep DR workers fully occupied.



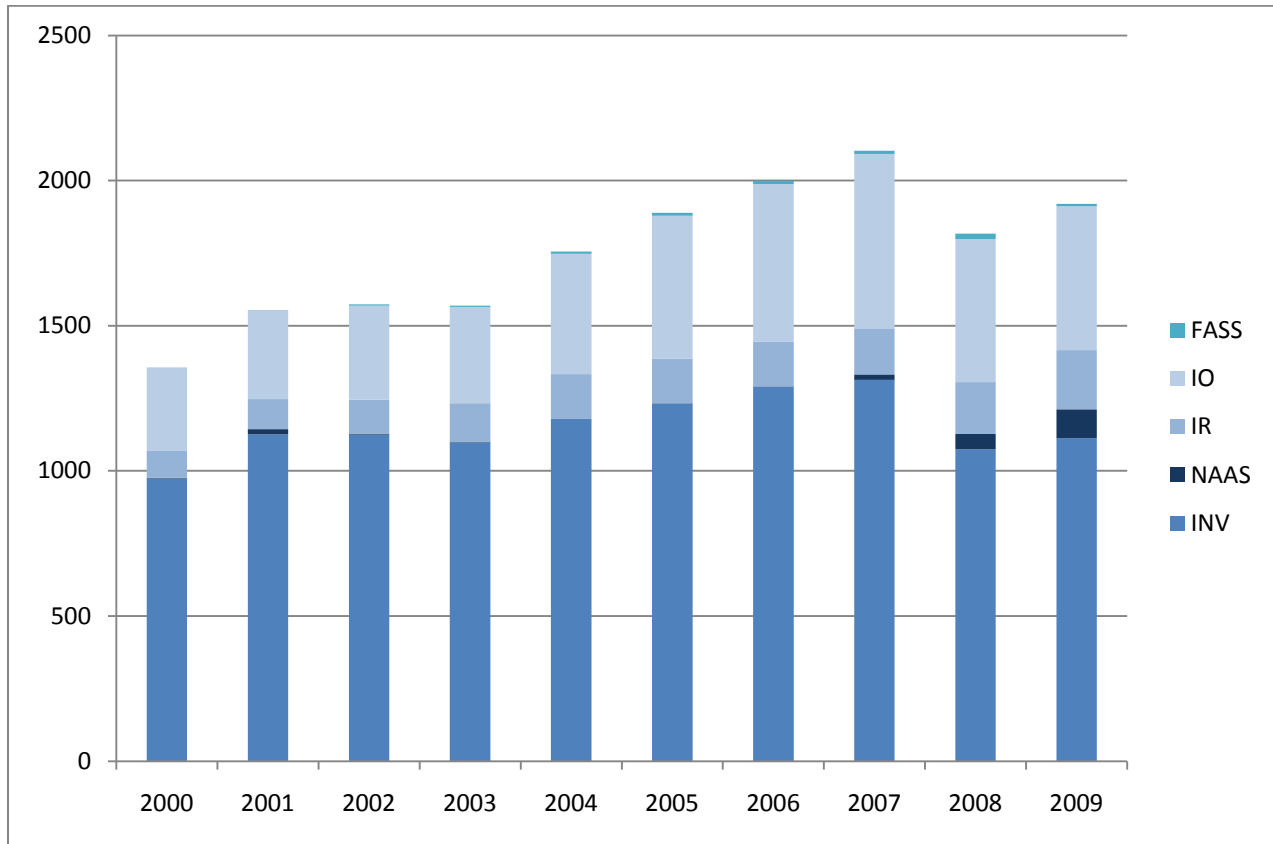
**Figure 2. Percentage of Maltreatment Reports by County, from February 2007 through August 2009**

The decline in reports related to child welfare received by county and state offices appears less dramatic when all report dispositions are included. **Figure 3** shows the monthly average number of reports by disposition type that were received from 2000 through mid 2009.<sup>2</sup> (Monthly averages were used so that 2009 could be included; the figures for other years include 12 month averages and for 2009 the figure includes the first six months only.) The graph includes five types of dispositions: investigations (INV); non-agency assessments (NAAS), a category that has been in use for some time, but since the beginning of the differential response program refers only to DR family assessment responses conducted by FRCs in locations where DR has been implemented; information and referral (IR); information only (IO); and family assessment service system cases (FASS), cases that receive services through title IV-B family preservation and prevention grants. The difference between IR and IO cases is essentially that in an IR case some action follows the report, generally the referral of the family to some service

<sup>2</sup> The data in **Figure 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.



resource in the community. In most counties, FASS cases fall outside of CPS and the families are referred to FRCs for services. In Clark County, IV-B funds are utilized within CPS to provide homemaker and other home-based services.

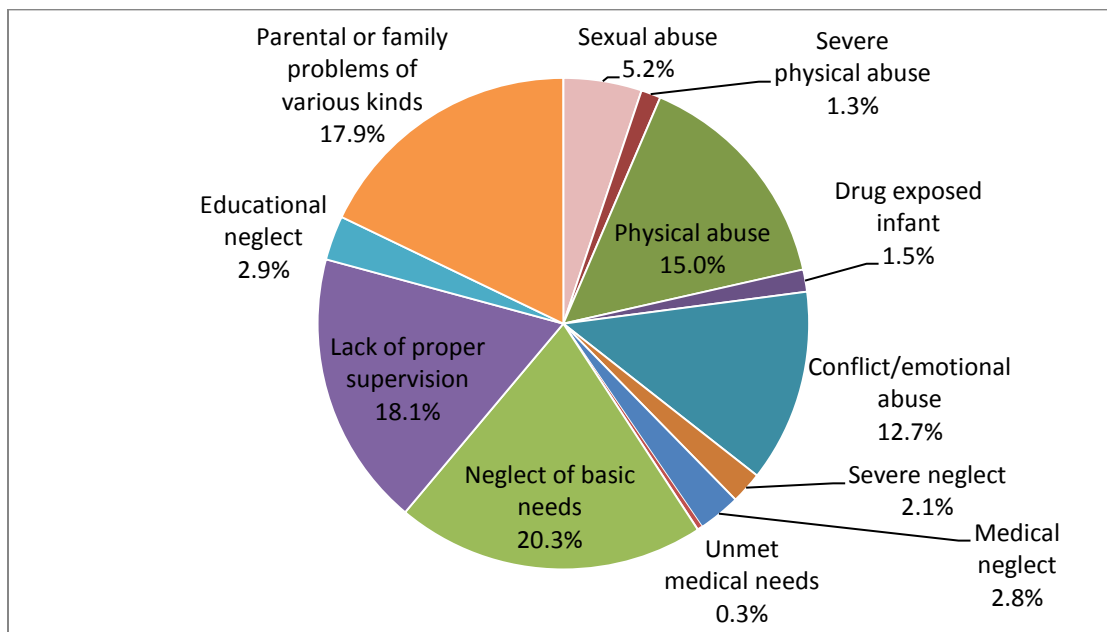


**Figure 3. Monthly average of all child welfare reports received by county and state CPS offices, from January 2000 through July 2009**

Comparing the first year of the DR project, 2007, with the first six months of the current year (January-July 2009), the percentage of investigations conducted is down 26 percent, but NAAS dispositions (DR family assessments) are up over 5 fold, and IRs are up 130 percent. Excluding IOs, the change among the other types of dispositions as a group is down less than 5 percent.

**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. Reports of child maltreatment have averaged 1.3 different allegations per report. **Figure 4** shows the relative frequency of different types of allegations that have been reported since the start of the DR

program. The most common involved the lack of basic needs (20.3 percent), such as inadequate food, clothing or shelter. A broad category included in many reports (17.9 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 lack of proper supervision (18.1 percent), physical abuse (15.0 percent), and conflict or emotional abuse of a severe nature (12.7 percent). Less frequent allegations included sexual abuse, medical abuse and educational neglect.



**Figure 4. Frequency of different types of allegations in all reports of child maltreatment statewide**

### **Reports Screened for DR-Family Assessment (DR-FA)**

In the most recent UNITY extract available to evaluators (September 2009) there are 1,452 reports with DR family assessment dispositions. This figure is the number of NAAS dispositions in counties or sub-county regions with a DR program from February 2007 through August 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. At the present time, the precise number of DR referrals returned to CPS cannot be determined from UNITY. The latest reports of FRCs to DHHS indicate the number of returned reports to be 248 (as of 9/30/09). Included in

this number are those that were subsequently investigated as well as some that were simply closed and no further action taken.

**Figure 5** shows the cumulative number of DR dispositions by county from the beginning of the program through August 2009. Over half (52.9 percent) are Clark County families and 31.3 percent are families in Washoe. The other families (15.2 percent) are 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 is often that of the Family Resource Center and not necessarily the county of residence of the family; but in most instances these are the same.

Since February 2007 there have been 19,042 accepted reports of child maltreatment in areas where the DR program was operational. These were reports that were given either an investigation or DR-FA disposition. The 1,452 reports screened appropriate for family assessments (NAAS) represent 7.6 percent of these.<sup>3</sup> The large majority (92.4 percent) of accepted reports were screened for investigations.

**Figure 6** shows the percent of accepted reports screened for DR-FA each month from the beginning of the program in locations in which DR was operational. The percent has fluctuated from month to month and has ranged from 2.8 to 10.9 percent. Since January 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 has averaged 8.8 percent.

Overall, the rural counties have screened a higher percentage of maltreatment reports for the DR-FA track than the state's two larger and more urban counties. Combined, the figure for the rural counties stands at 18.3 percent. Nye, Lyon, and Elko counties all have rates over 18 percent. Nye's rate is 26 percent and Lyon County is not far behind. Washoe County has screened 1 in 10 (9.9 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 (5.7 percent). (See **Figure 7**.)

**Figure 8** shows the percent of child maltreatment reports screened for family assessments by month for the state (in areas where DR has been implemented) and for Clark and Washoe counties and for the rural counties combined.

---

<sup>3</sup> 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  $NAAS/(NAAS+INVS)$ .

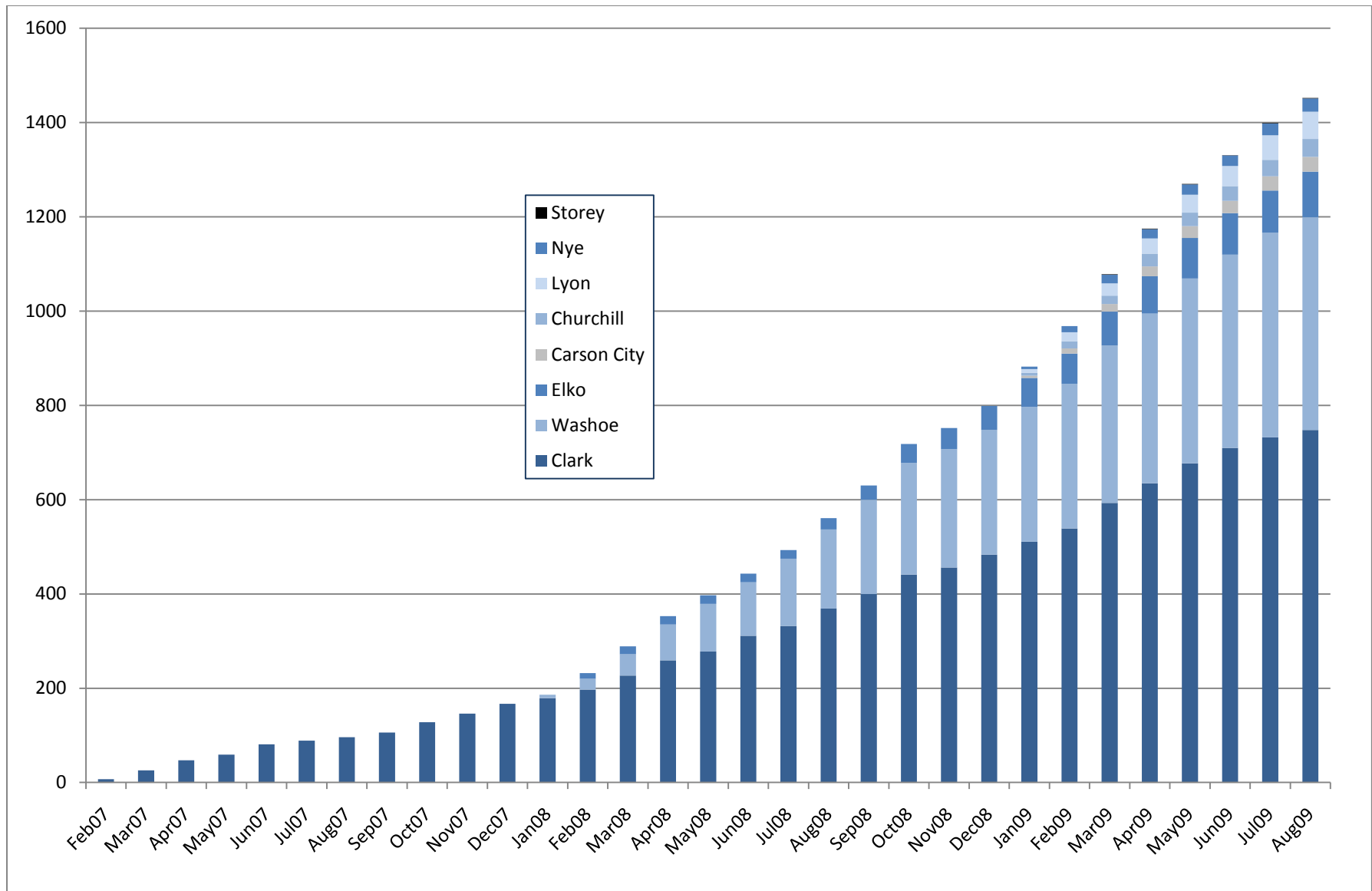
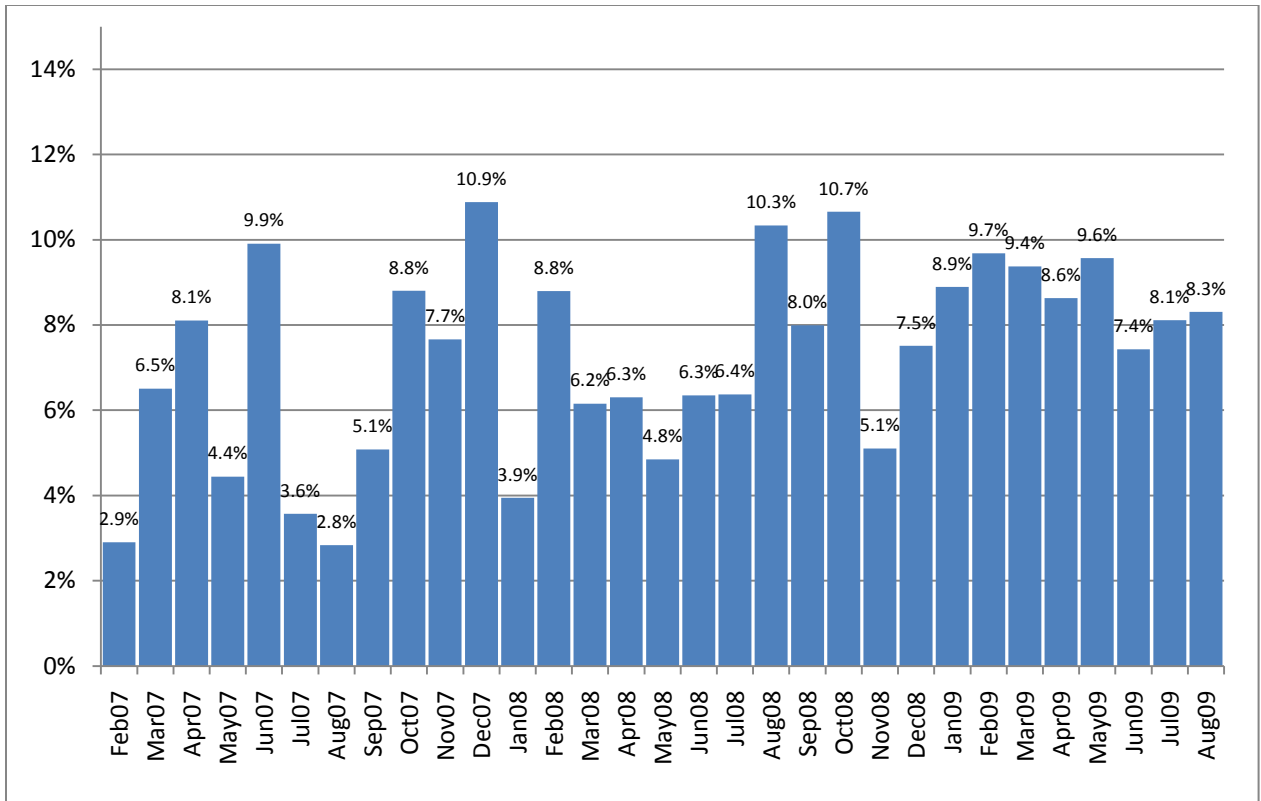
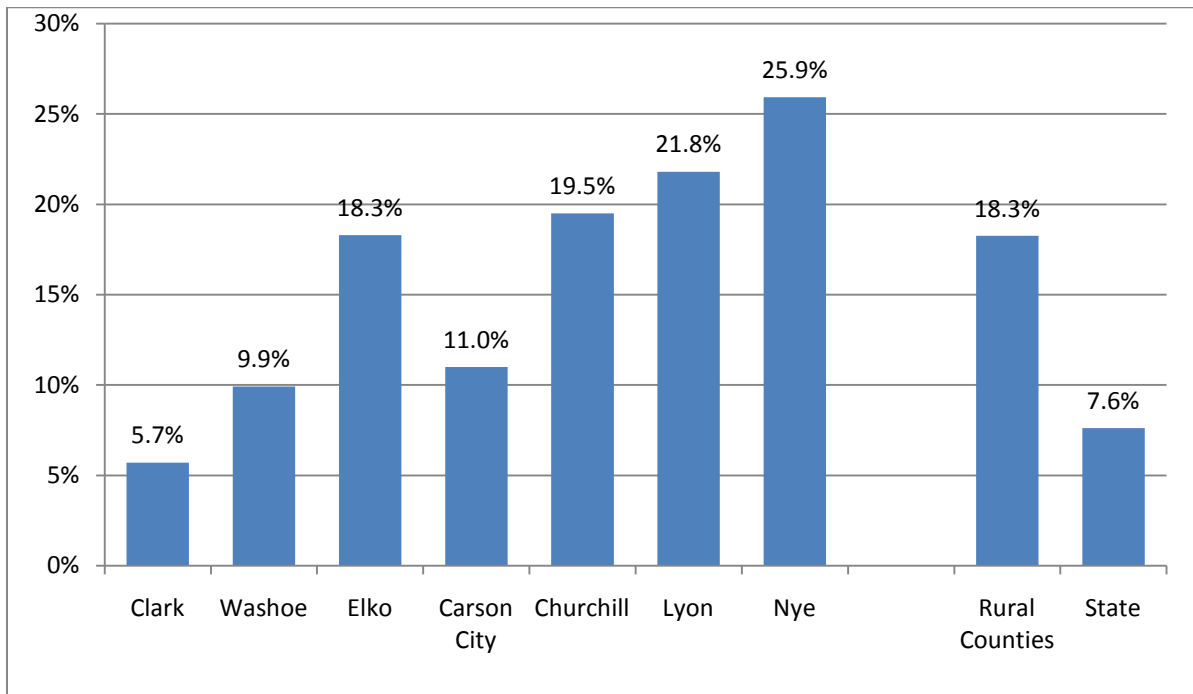


Figure 5. Cumulative number of DR-Family Assessment referrals by project month and county



**Figure 6. Percent of reports selected for DR-Family Assessment referrals in areas with an operational DR program**



**Figure 7. Percent of reports selected for DR-Family Assessments by county**

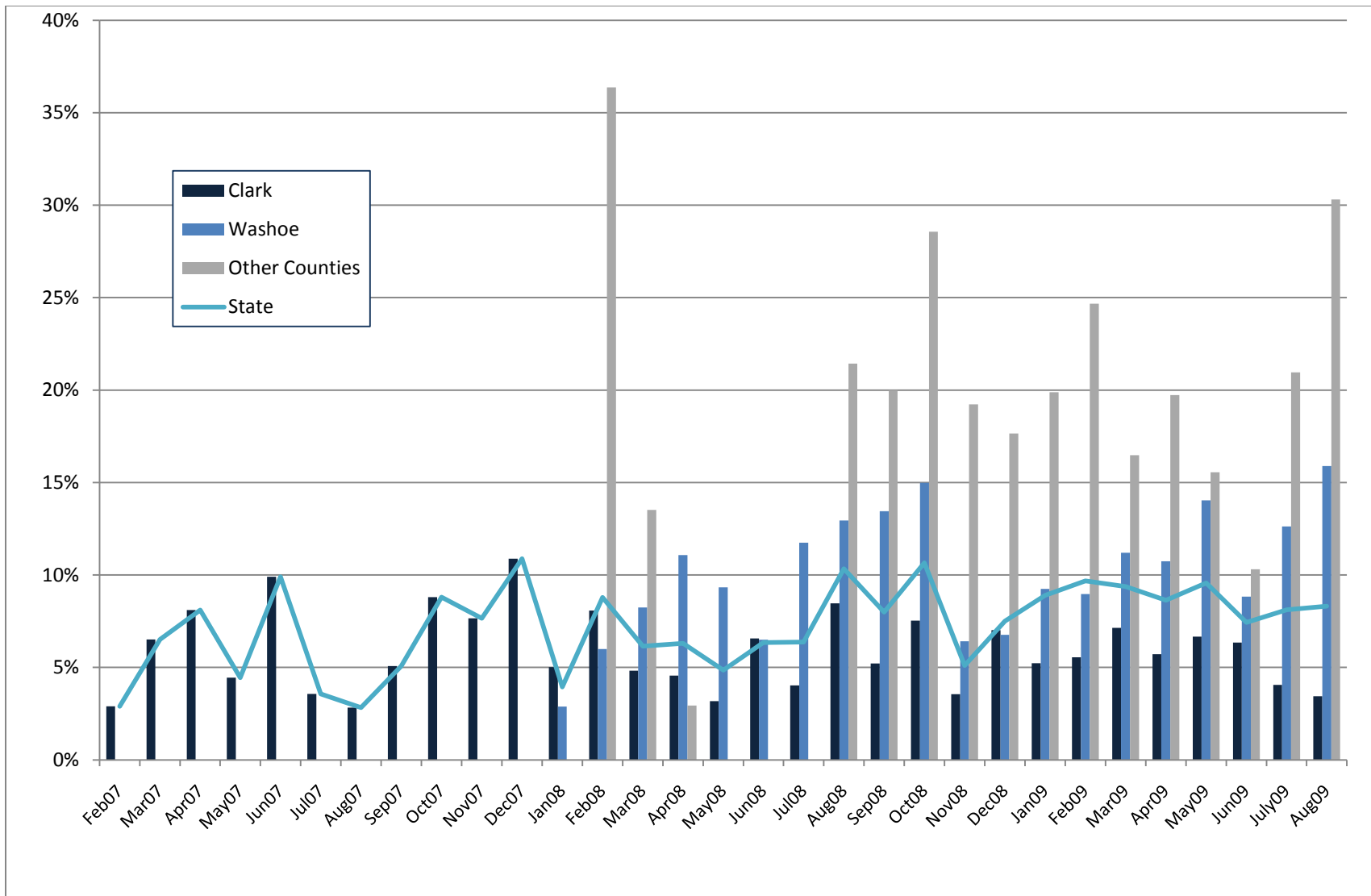
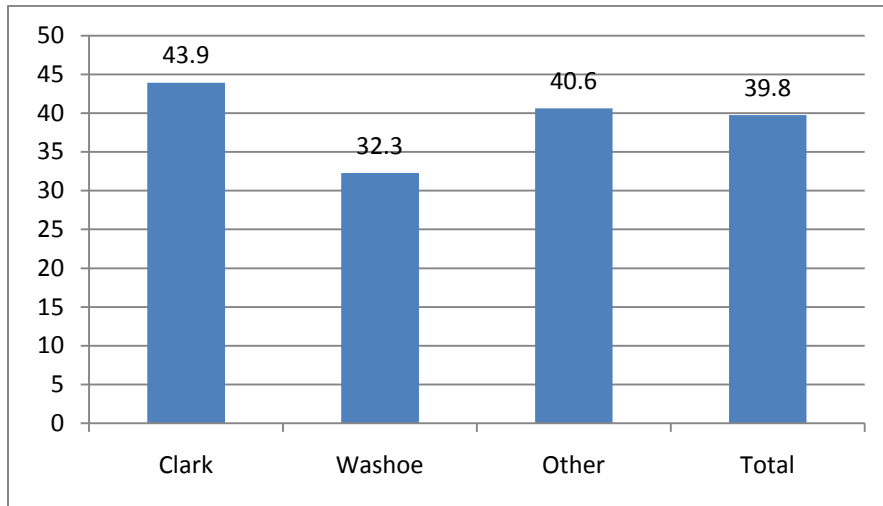
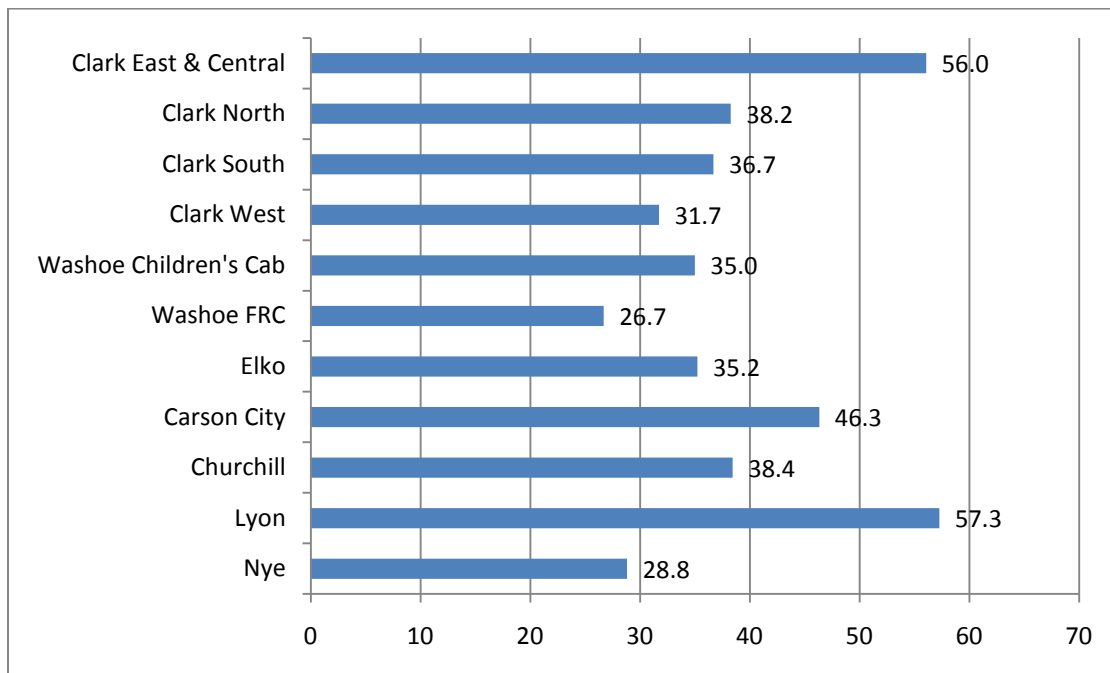


Figure 8. Percent of child maltreatment reports screened for DR-FA by county and month

**Length of Family Assessment Cases.** DR-family assessment cases have remained open an average of 40 days. In Clark County this number is a little higher (44) and in Washoe somewhat lower (32). **Figure 9** shows the average length of FA cases for the three major county groups. **Figure 10** shows the average length of DR-FA cases broken down by service area and



**Figure 9. Mean number of days DR-FA cases remain open by county**



**Figure 10. Mean number of days FA cases remain open by service area and FRC office**

FRC office. The number of open DR-FA case day ranges from the mid 20's, among families served by the Nevada Outreach Training Organization FRC in Pahrump and the Washoe County FRC in Sparks, to the mid 50's in the East and Central service zones of Clark County, served by East Valley Services FRC, and by families served by Lyon County Human Services.

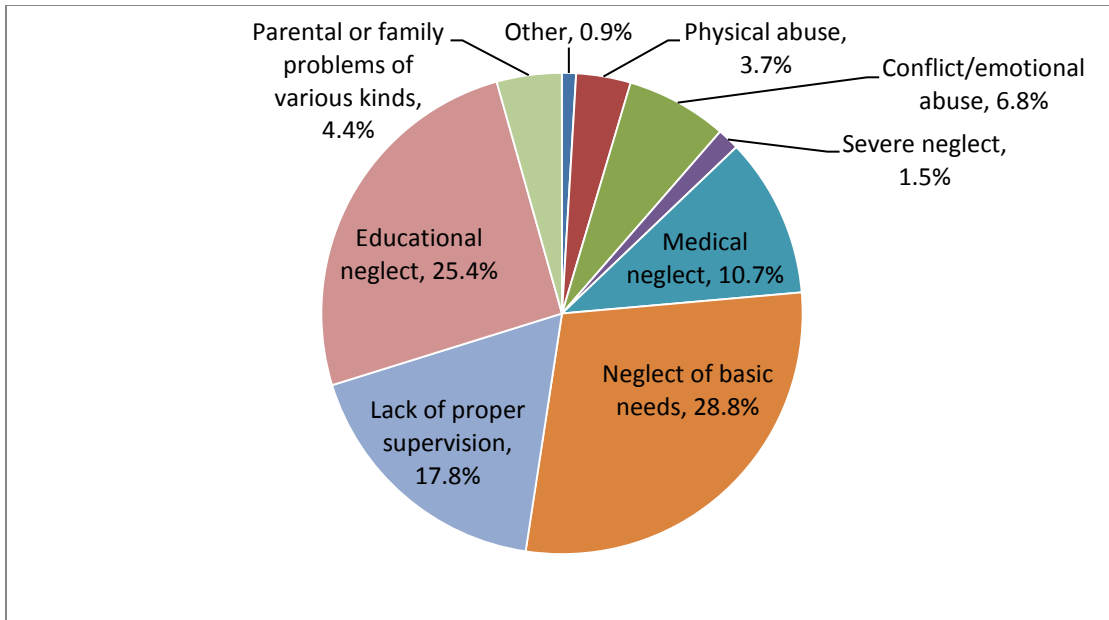
**Allegations in DR-FA Reports.** The frequency of different types of allegations found in reports that were screened for a family assessment and referred to an FRC can be seen in **Figure 11**. Families in which children lacked basic needs were the most frequently referred (28.8 percent). One in four (25.4 percent) of the families had complaints of educational neglect. Also common among these families were allegations of a lack of proper supervision (17.8 percent) and medical neglect or unmet medical needs (10.7 percent). Other allegations in reports involving these families were conflict or emotional abuse (6.8 percent), parental or family risk factors (4.4 percent), physical abuse (3.7 percent), severe neglect (1.5 percent) and a small number of others (0.8 percent).

Since January 2009, when the third implementation phase brought DR to most of the state, a majority (62.3 percent) of educational neglect allegations have been referred to FRCs for a family assessment. During this period over a quarter (26.2 percent) of medical neglect allegations received a family assessment, as did 14.9 percent of allegations for neglect of basic needs, 9.2 percent of conflict or emotional abuse allegations and 6.3 percent of improper supervision allegations. These percentages were held down by at least three factors: Some of these allegations were part of reports that included more serious allegations; some involved families with children under the age of 6; and some were made before implementation of the new eligibility rules that permit broader discretion in referring reports to FRCs. As a result, many of the reports with these allegations were required to be investigated. It is also the case that some allegations 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. **Figure 12**, in the bar graph, shows the percent of specific allegations that received a family assessment or an investigation between January 2009 and August 2009.

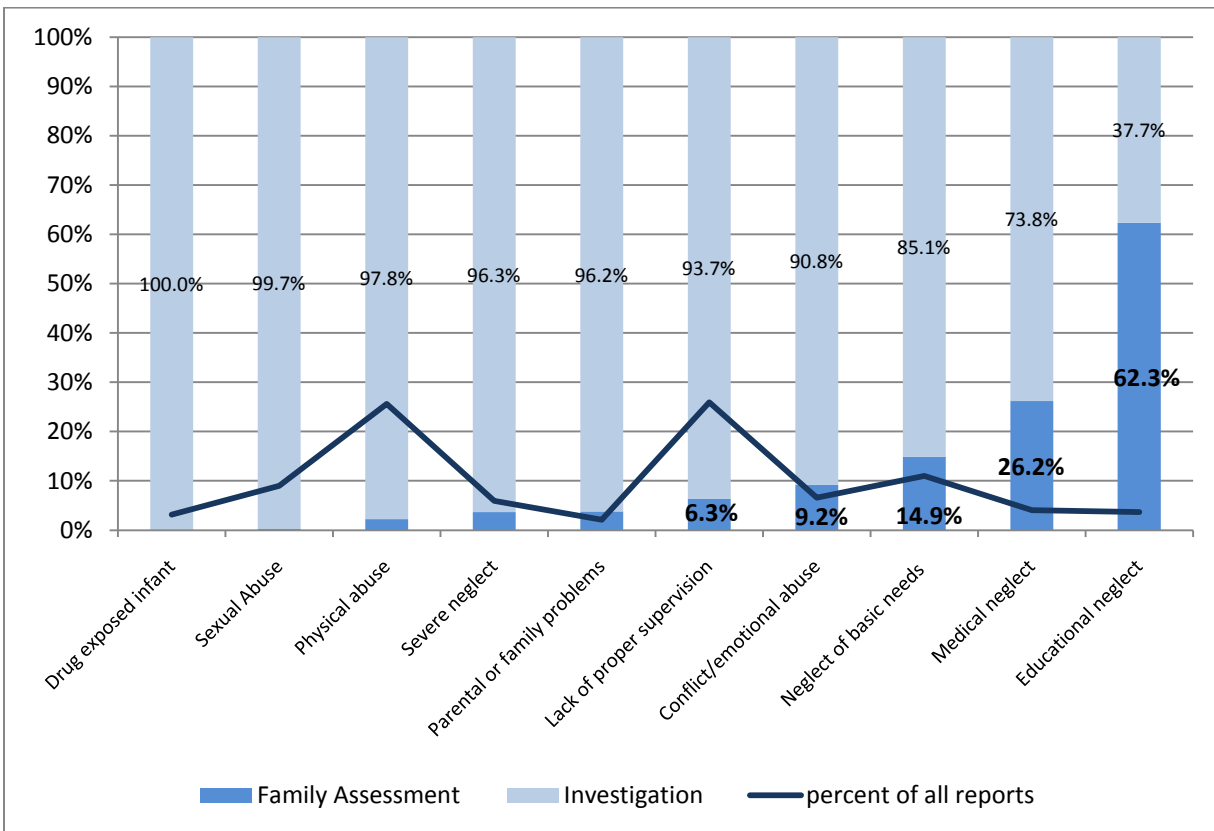
**Figure 12** also shows, in the line running through the bars, the percent of all reports that included specific allegations. Thus, while a majority (62.3 percent) of educational neglect reports received a DR-family assessment, educational neglect reports account for only 3.7 percent of all reports.

Similar information is shown in a different form in **Figure 13**, which shows the total number of reports that contained specific allegations between January 2009 and August 2009. And the figure shows the number of these reports that received a family assessment or investigative response. It suggests areas where an increase in family assessments are possible.



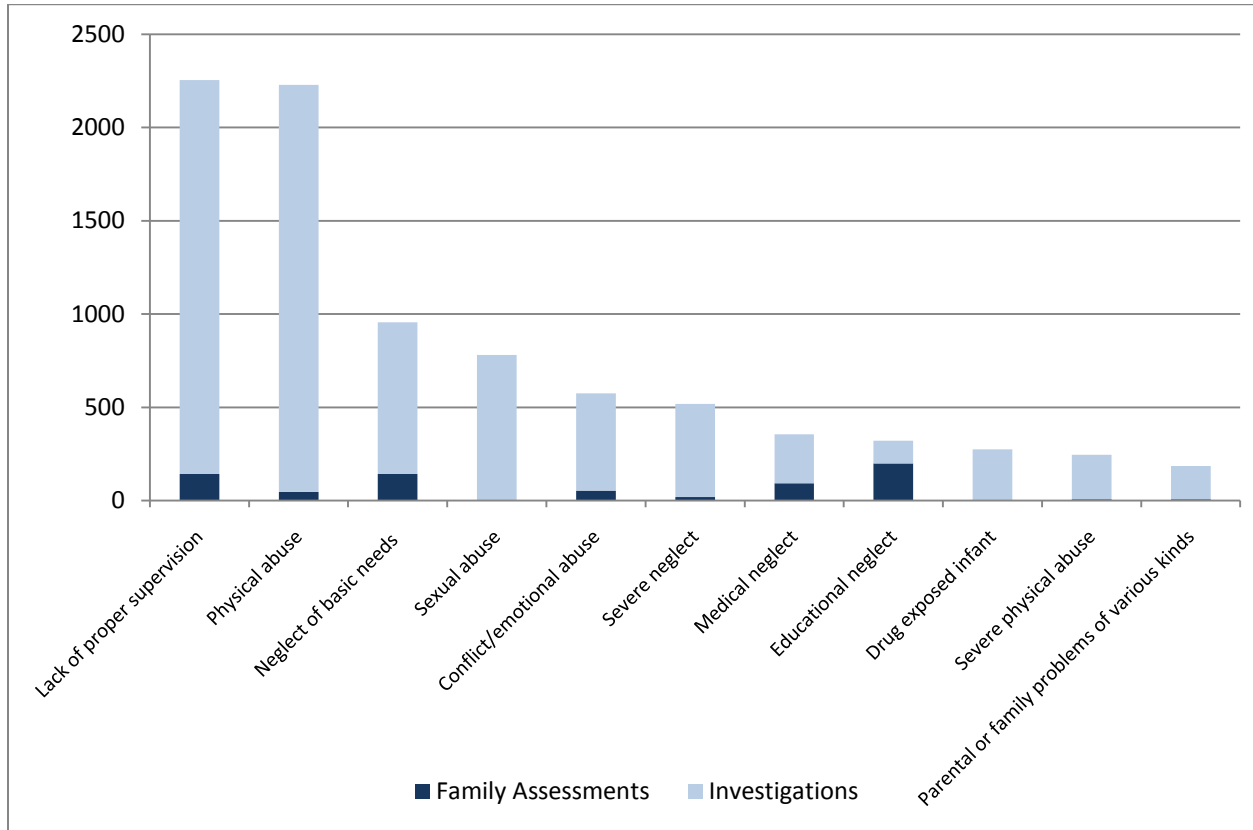


**Figure 11. Types of allegations in reports screened for DR-FA, February 2007-July 2009**



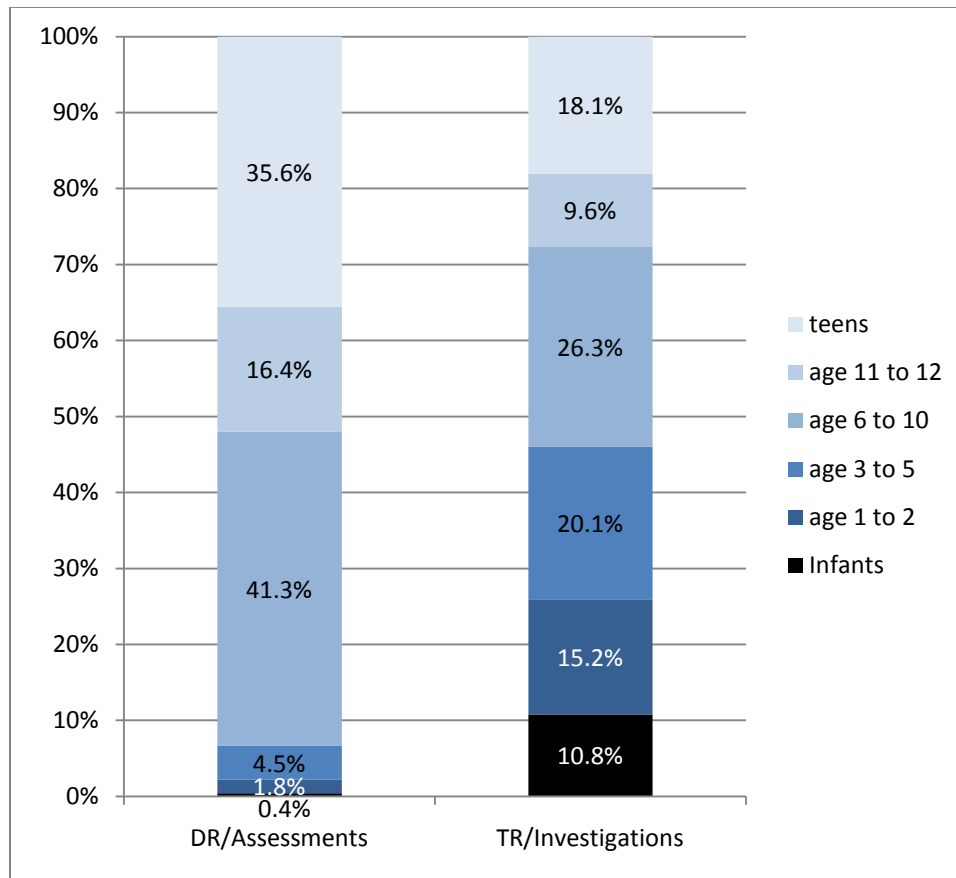
**Figure 12. Percent of different allegations in reports screened for family assessment vs an investigation and the percent of each type of allegations in all reports from January 2009-August 2009**

This includes reports with allegations involving improper supervision, which account for a large number of reports, and reports with allegations of neglect of basic needs, conflict or emotional abuse and physical abuse.



**Figure 13. Number of reports with specific allegations and the number that received an investigation or family assessment (January 2009-August 2009)**

**Age of Children.** Figure 14 shows the percent of children by age group in families that were selected for a family assessment or an investigation. As can be seen there were few very young children in families that were referred for DR, compared to families with investigated reports. Forty-one percent of the children in families that received a DR-FA response were aged 6 to 10 years; 35.6 percent were teenagers. Correspondingly, traditional investigations frequently involved families with very young children: 46 percent of the children in these families were aged 5 or younger.



**Figure 14. Percent of children by age group in DR-family assessments and traditional investigations**

### Part 3. Report on Site Visits

Evaluators conducted three sets of site visits in 2009. In April, visits were made to Carson City, Nye County and Clark County. Meetings were held with the DCFS Rural Region Manager, the Carson City DCFS Office Manager, a DCFS Social Work Supervisor (Carson City), and caseworkers who cover Carson City, Churchill and Lyon counties. Meetings were also held with the DR supervisor and social worker at the Ron Woods FRC in Carson City, the DR supervisor with Nevada Outreach Training FRC in Pahrump (southern Nye County), a social worker with Lyon County FRC and the supervisor with the Boys and Girls Club FRC in Clark West service zone. The evaluator also attended the scheduled county-wide, joint CCDFS-FRC meeting (called the Big DR meeting) held in April in Las Vegas at the Boys and Girls Club. The meeting brought together FRC-DR and CCDFS workers from all metro Clark County service zones.

Washoe County was visited in June for the purpose of meeting with DR personnel and attending the statewide DR training held in Reno. Interviews were completed with the DR liaison (Intake Supervisor) and Division Coordinator in Washoe County DSS. The Children's Cabinet and Washoe FRC (Sparks) were visited and a supervisor interviewed at each site.

Clark County DR and CPS personnel were interviewed in September. Site visits were conducted at each DR site: East Valley Family Services (East and Central), Boys and Girls Club (West), Olive Crest (North), and HopeLink (South). Workers and/or supervisors were interviewed at each location. Meetings with unit supervisors and investigators were also held in the CCDFS regional offices in the North, South, and Central service zones.

**CPS in Rural Nevada.** Rural Nevada, consists of 15 counties—that is, all counties except Clark and Washoe—and is sparsely populated and very large. The Division of Child and Family Services is responsible for child protection throughout the region. The agency is responsible for the full range of services, including intake, investigation, and case management, as well as child removals and foster care. Services are provided through a network of 12 offices in four regional districts, with some offices responsible for responding to child maltreatment reports in more than one county. The normal caseload for a DCFS rural caseworker is between 20 and 22 families.

All of the DCFS offices had working relationships with the FRCs in their districts prior to implementation of DR. 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).

**DR in Rural Nevada.** The differential response program is available to families in 9 of the 15 rural Nevada counties—Elko (in District 1), 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.

DCFS supervisors in district offices screen incoming maltreatment reports and refer those they consider appropriate for DR-family assessments to the geographically-appropriate FRC.

The referrals are generally made through emails or telephone calls or are faxed to the FRCs, or, as one FRC DR worker said, “they just show up in Unity on my list.” Within some locations, the method for sending referrals has changed over time or “depends on who sends it.” As in Clark and Washoe counties, FRC DR workers are limited by contract to a caseload of 15 families at any one time. Contact and communication between DCFS and FRC staff varies by location. DR caseloads of some FRCs are more closely monitored and more likely kept at capacity than are others. FRC DR workers receive all the current and historical information about a family who is referred to them, except for any criminal history. Most DR workers were new hires by the FRCs and most do not have a background in CPS.

The DCFS rural area manager noted that there is a problem knowing from the data system, UNITY, which DR-appropriate reports may not have received a family assessment. A report may, for example, not have been referred to an FRC in the first place because all DR workers have full caseloads. Or, it may have been referred but returned because a safety problem was discovered by DR worker. It also happens that a family does not cooperate with the DR worker or cannot be located by the worker. Sometimes when a family assessment is not done and the report is returned to CPS, an investigation is carried out, but this is not always the case. Sometimes the FRC is told to close the case in which an assessment was not done, and sometimes the case is returned but no further action is taken by CPS depending on the allegations in the report. Evaluators have found each of these scenarios throughout the state with their attendant uncertainties about the meaning of UNITY disposition codes.

**CPS in Washoe County.** Washoe County DHS operates from a central site in the city of Reno. The county has recently restructured its CPS office, from one with a separate unit for assessments (investigations) and permanency to a system of “Paired Teams.” Paired Teams contain assessment and permanency workers on the same team, allowing a child to be moved from assessment to permanency under the same supervisor. All teams are essentially equivalent, with the exception of two teams that take Drug Court cases. The Intake unit receives and screens all referrals, then assigns each referral to a Paired Team based on a rotating schedule. Re-referrals on the same family will go back to the same worker. The goal of this new structure is to create more consistency for the family and to facilitate more communication between the assessment and ongoing worker.

**DR in Washoe County.** Washoe County operates its DR program through two community organizations: The Children's Cabinet and Washoe County FRC in Sparks. Prior to implementing DR, The Children's Cabinet (which is not formally an FRC) operated a number of social service programs in Reno and the surrounding community. To accommodate DR, the agency transitioned a number 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 DR case workers and one overflow worker.

The Sparks FRC operates a range of family assistance programs outside of DR, including short term emergency energy assistance and a parenting program. The coordinator for the DR program began work at the FRC as a Family Advocate and has several years of experience working in social services and mental health. This individual, who oversees the program as well as carrying a DR caseload, works with one other full time DR staff.

Washoe County DHSS has designated the title of 'DR liaison' to the Intake Supervisor. This individual serves as the contact point between the county and the DR sites. It is seen as the responsibility of the FRCs to keep the DR liaison informed about the current caseload status of DR workers—there are four at the Children's Cabinet and two at the Washoe FRC. 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. Both agencies typically operate at just below the full capacity of 15 cases per worker.

**CPS in Clark County.** In the last four years, since the Program Improvement Plan (PIP) was introduced in 2005, CCDFS has made significant alterations and improvements in its policies, procedures and service provision. Work with CPS families is now more structured, service oriented, family focused, and permanency driven. New case workers have been hired, and some reorganization has taken place to make the county system run more effectively. County administration now requires more thorough justification from investigators before cases are opened when child removal is a possibility. This has led a reduction in the number of children removed from their homes in recent years. 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.

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. Each CPS office has separate units for investigation and permanency. The North site has four investigative units, while the other regions have two units per site. Investigative units have four to six workers. All regional sites have more than one out-of-home permanency unit and one in-home unit. Any case that it is referred to an ongoing unit is formally court involved.

Since the implementation of the PIP, there has been more emphasis on using the Nevada Initial Assessment instrument to direct case planning. All investigations are to close within the 30 day assessment period, 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 able to stay in the home for short-term (3-6 months), 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.

For cases with no immediate safety risk, investigators try to refer families to services that may help improve their circumstances or family dynamics. However, the number of working days during the investigative period is functionally equivalent to only 16 days, due to the four day work week of each unit. Investigators are not usually able to follow up with a family to ensure they have connected with services they may need. In addition, the short assessment period can mean that referrals given to families may or may not be appropriate for the family's real needs. Workers also may not be able to meet with a family as frequently as necessary to fully stabilize the situation.

CPS workers often are not as able as DR workers to advocate actively on their families' behalf to connect them with appropriate community resources. Many cases that would be serviced for several weeks in a program like DR are closed rapidly out of necessity in the CPS system. 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. Ironically, the more comprehensive and service-oriented DR approach is more likely to occur following a less serious report.

**DR in Clark County.** The FRCs in each Clark County service zone operate multiple programs and services. Many of these resources are designed to meet basic needs, such as food, clothing and emergency assistance and often also have programs such as employment training, job placement, and services for the homeless. The DR program for each region is housed alongside the regional FRC at a local agency.

For a short period at the beginning of the DR program, Central and North referrals were accepted by University Medical Center of Southern Nevada. This contract was transferred to East Valley Family Services in July 2008. EVFS covered three zones until July 2009, when Olive Crest formally began accepting North cases.

Each of the five regions has two full-time case managers assigned to the DR program. From the beginning of the DR program until September 2008, all referrals to DR were passed through an investigation supervisor in each region for approval before being sent to the appropriate DR agency. Beginning in September 2008, the central intake hotline staff at the Central Office began to assign cases directly to the appropriate FRC DR programs. This procedural change was meant to bypass the investigative supervisors in the individual CPS regions in Clark County and streamline the referral process. A hotline supervisor approves the assignment of reports to FRCs for DR and sends the referral to the geographically-appropriate FRC. Caseloads for DR in Clark County are currently below capacity.

**DR Referrals.** Case managers at all agencies in both Clark and Washoe generally feel that the cases currently being assigned to DR are appropriate for DR. DR supervisors do not typically refuse reports at the time of referral except when the zip code may be incorrect (as may occur in Clark). If there are questions about the content of the referral, the DR supervisor will address these concerns with a CPS supervisor before sending a DR worker out for an assessment. Both DR workers and CPS unit supervisors, however, believe that there are a number of reports that could be well served in DR that must be excluded due to present restrictions. This includes the statutory requirement that maltreatment reports involving child victims under age six must receive an investigation. Under current policy, as long as none of the identified victims is under six, the report can be referred to DR. If the intake worker happens to include younger children in the report, regardless of whether those children were actually of primary concern, the report is excluded from DR. This may prevent appropriate DR candidates from receiving service. CPS personnel in Clark County have occasionally re-written intake reports to exclude younger children from the list of victims to allow the case to be served under DR.

Other recent changes to the DR assignment policy could potentially affect the types and numbers of cases seen in DR. Families with previous substantiations can now be referred to DR, and reports that identify “inappropriate discipline resulting in minor physical injury” can also be assigned. DR supervisors in Clark and Washoe County expected the number of referrals to increase substantially following this change, but this has not yet occurred. The number of reports has declined, especially in Las Vegas, where there have been fewer referrals for DR to FRCs. None of the DR workers in Clark or Washoe have maintained full caseloads during the last year. Some concern was expressed by Clark County DR staff that hotline intake workers may be screening more conservatively in an effort to maintain reasonable caseloads for CCDFS investigators.

In rural Nevada, where distances are great and staffs are small there are many challenges for child protection workers. Some of these are logistical and practical, and some involve the scarcity and quality of resources, whether private or institutional. DCFS relies on law



enforcement to man the intake phones after 5 pm and on weekends. Once a month telephone meetings are held across the rural districts to bring together county DCFS 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.

Reportedly, DCFS in rural service areas operates perennially at full capacity. “DR has been a lifesaver,” one supervisor said. “DCFS doesn’t have the staff.” With DR, she said, “DCFS caseloads could be reduced, but we are learning the value of opening cases more often. We couldn’t before....We lost a lot of CHINS (children in need of services).” The DR program is viewed as relieving the caseload pressure from DCFS staff. As the new rural DR programs have come on line, their caseloads were filled quickly. “We have kept DR full with mild and moderate neglect reports. We don’t expect minor physical cases to go to DR.” (Time will tell whether this latter point will continue with recent changes in DR eligibility criteria.) This supervisor noted that in all rural parts of the state there is a good relation between DCFS offices and the FRCs. DCFS has “always relied on FRCs for open cases or IRs, for parenting, food stamp and TANF (public assistance) applications, as well as direct services and referrals. Before DR we used FRCs for FASS, to help us provide some services these families need.” Perhaps because of this, there has been “some role ambiguity. FRCs are seen as an extension of DCFS. Carson has worked from the beginning to keep them (DR workers) full and effectively separate.” This DCFS supervisor saw DR as an important improvement in the child protection system. Many of the DR cases would formerly have had IO, IR or FASS dispositions. “This is a more stable approach. More controlled.”

DR workers in two FRCs noted that sometimes, if a DR referral is made to a rural FRC and the worker already has 15 cases and returns the referral, the report is changed from NAAS to FASS and referred back to the FRC so that another (non-DR) worker can work with the family using IV-B funds. Although there may be some question about the propriety of such actions within the formal system, this is an alternative way for families to be helped who might not have been otherwise. Ironically, when referrals screened for a DR family assessment are returned for cause, in the instance of an underage child, or because of lack of DR capacity, CPS may not investigate and may consider that there is nothing they would or could do given that there was no indication in the report that a child was in danger. Changing the disposition to FASS or IR and sending the family back to the FRC may be the only way to ensure some follow-up occurs and some assistance is provided.

Most DR workers statewide do not have a background in CPS, although two DR workers in rural counties visited most recently are exceptions to this. One, who was interviewed, said she saw DR family assessments as “not that different from an investigation, except there is no substantiation.” Nonetheless, she views DR as the better approach because of the focus on

prevention. Compared with her peers, this caseworker seems more ready to return a family to CPS for an investigation based on cause. Two such cases described during the interview involved physical abuse cases in which “the fathers were hostile.”

DCFS supervisory staff believe that, overall, rural FRC DR workers are at near capacity most of the time. 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. The FRC supervisor in Pahrump (Nye County) who was interviewed, said: “We could be busier. There are a lot of DR cases out here, but CPS isn’t sending them. [the DR worker] has about 16 cases, but 6 to 8 are effectively finished. I am waiting for CPS to close cases.”

**Family Engagement.** DR case managers across sites express confidence in their ability to work productively and meaningfully with the families they serve. As the program continues and workers have become more familiar with the types of situations encountered in child protection, this confidence has grown. While the allegations for DR reports tend not to reflect high risk, the actual circumstances of families vary widely, from “open and shut” cases with families that are essentially healthy and safe, to complex cases of families with multiple, intense and chronic needs that may require support for a considerable period.

In Clark County, initial contact with the family is made within three days of assignment to DR. DR workers in Clark County usually make first contact themselves by phone or drop-in visit, and, if contact cannot be made, leave a letter requesting a return phone call. The Children’s Cabinet in Washoe has a different system in which the DR supervisor makes all initial phone calls to the family and sets up the first home visit. The Children's Cabinet established this practice to utilize the strong engagement skills of the supervisor and reduce the number of families that may be hesitant to meet with the worker. DR workers in Carson City and Lyon counties also make most first contacts by telephone to set up home visits. The worker in Carson City said: “We telephone first and explain DR and its relation to CPS. We try to set up the appointment quickly and do the safety assessment within three days.” However, it is not always easy. The DR supervisor in rural Nye County said “contacting the families is sometimes difficult. They often have no telephone and even no address. You need persistence. [The DR worker] has gotten a good reception when she is able to make contact,” but she often has had to negotiate past fenced-in dogs to knock on the door.

Each DR worker has developed her or his own strategy for approaching families. Most workers will emphasize that they are not CPS but have the authority to involve CPS if necessary. Workers have generally become comfortable with the types of families referred to them. During an interview a DR worker in Washoe County said:

*“Once you start doing it (DR), you develop a sense of what it is: You want to tell the families, ‘I’m not CPS, I’m not here to investigate; I am here to address what is in the report, but I’m not here to take your kids.’ Once I tell people that, they say ‘oh, okay’....When I used to first walk into a really filthy home [a neglect situation], I’d be mortified, but now, I ask, ‘Is there a safety hazard?’ Just because it’s dirty doesn’t mean the child is in danger. Sometimes the reporter overreacts. We go by ourselves now, so everyone is pretty comfortable.”*

As they have gained experience, DR workers try to emphasize a family-focused approach and de-emphasize the specific allegation during the initial contact with the family. A DR worker in Clark County said:

*“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.”*

During the first home visit, a DR worker must have the family sign a consent form granting permission to proceed with the assessment. Only after the form is signed can the worker begin to gather information about the family. Case managers cannot interview the child without completion of this form, nor call any institution that may know about the family’s whereabouts or situation. These restrictions have led to minor frustrations among workers who have had difficulty locating families or securing their cooperation. In such situations DR workers often consult with CPS for information and advice. The county has legal authority to call schools directly and access databases in order to locate families and will perform these searches to assist DR. A DR worker in Clark County indicated that occasionally, if a family has been contacted but refuses to comply with the assessment, a CPS investigator has accompanied the DR case manager on a home visit to support them in their attempts to get in the door. Other questions or concerns about cases are often discussed in phone calls or during monthly DR meetings where cases are reviewed. In general, DR workers view CPS as being supportive and positive.

The response of families has also tended to be positive in the experience of most workers. Children are rarely seen alone and usually, but not always, are included in the assessment interview. A DR worker in Lyon County said:

*“The reaction of families has been nearly all positive. Family assessments always involve the children. We always see the kids. The children we see have always been safe so far. CPS has done a good job screening.”*

Some cases are inevitably returned to CPS. When CPS is consulted for a possible return, it is more often because the family cannot be located or the family has refused to meet initially. In a few cases referrals have been returned to CPS when new reports of abuse and neglect have been made or when a worker considers a situation as too complicated for DR and the family is unable or unwilling to access needed services. More often than not, however, CPS will advise the DR worker to close the case at that point if there is no identified safety threat, preferring not to open an investigation. DR workers have observed that CPS would much prefer that the FRC keep a case, rather than re-accept it as an investigation, and often strongly encourage the DR worker to continue to try to engage the family. Workers state that this is because CPS understands that DR has the ability to serve these families to a greater degree than they can: “We can’t help them; you can help them.”

**Case Management and Intervention.** As part of the first visit, DR workers complete a safety assessment on each family, using the same instrument that is a part of CPS investigations. Only if no safety threats are discovered may they proceed to work with the family. Once the children are determined to be safe, the general needs of the family can be explored and addressed. The North Carolina Family Assessment Scale version G is being used for this. The NCFAS-G is an instrument intended to identify the level of family functioning and to assist with the development of the case plan. The NCFAS-G is designed to be completed at the start and end of the worker’s involvement with the family. Workers are mixed in their assessment of the instrument. Some find it useful, while others believe it does not add anything to what they learn themselves in the course of talking to families or that it is somewhat excessive and not fully needed with all families. Some use it because they are required to and because they see it as justification and documentation for what they do. One DR worker in Clark County, speaking about case planning in the context of the instrument, said:

*“I am formulating the case plan the first time I meet them. I usually don’t wait three weeks. The intervention starts at the first meeting, so I want the case plan to reflect the steps that were taken from the beginning. And the improvements.”*

If the family is amenable to receiving ongoing visits from the DR worker, the case proceeds until the goals of the family are met.

The primary role of the worker as case manager is to broker resources that will support the family. A DCFS supervisor said: “DR workers do our research. They look for services, and they share what they find with us.” But 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 DCFS supervisor noted that,

“Mental health clinics in rural Nevada have closed, and these were often the only vendor in a rural area.”

Because of the flexibility of the DR program, and the smaller caseloads, DR workers are typically able to form intensive, supportive relationships with the families needing services. Workers often provide direct consultation regarding interactions among members of the family, home management skills, or various practical matters. DR workers may spend an hour or more helping a mother read and complete applications for benefits or developing an organization plan for the home. One FRC supervisor noted: “[the DR worker] shows the family how to manage things—how to shop, prepare meals, plan.” Some DR workers have learned they can help families in small ways even when they cannot resolve the larger issues they face. Sometimes these issues arise from factors outside the family and sometimes from within. DR cases can be very complicated. A rural FRC supervisor described a recent case:

*“We have a family with a mother and her two children and the father and his child. He has no job. She is secretive. The house has no electricity or water. The father’s daughter is suicidal, had been molested years before. There had been a previous CPS case involving this. Nothing was resolved. Both parents are embarrassed and angry. They came to parenting class. But it is no longer a CPS case and they [CPS] don’t want it to be their case.”*

The amount of interaction the worker has with the family depends on the level of need, but families often have at least weekly contact with the DR worker, either in person or by phone. A few DR sites currently have specific policies that outline the frequency of contacts (for example, both The Children’s Cabinet in Washoe and Olive Crest in North Clark require weekly visits), and a uniform policy is planned for all sites in Clark.

**Services.** The increased intensity of the support available from DR can allow the worker and parent to work more closely together on ensuring that progress is made and risks to the child and family reduced. Proximity to the FRC allows DR workers to refer quickly and easily to emergency services and other resources in the agency. Families are often transferred to FRC case management with a ‘warm hand-off.’

DR workers appear to do everything they can to meet a family’s immediate needs. DR workers have paid rent and utility bills, purchased groceries, offered bus passes, and provided gift cards to local stores. However, flexible funding for concrete basic needs is limited in all agencies, and staff must make difficult choices about which families should receive monetary help. As a result, workers have become creative advocates for their families in the community.

DR workers in Clark and Washoe counties, for example, have negotiated with doctors for free or very low-cost services and medications.

In addition to services common among the FRCs, some of the DR agencies have special programs or expertise in certain areas that allow them to serve particular needs of families. The Children's Cabinet in Washoe has arranged for all DR families to be eligible for 10 free counseling sessions through the agency's counseling department. The Children's Cabinet has a number of other programs that benefit 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.

In rural areas the FRC is often the major, and sometimes only, source of help for DR families. 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.”*

**Distinction between Investigations and DR Family Assessments.** 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 are 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.” (DR supervisor, Washoe)*

*“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.” (DR worker, Clark)*

*“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...that system (CPS) does not have the same resources. That is not the intent of it. I think that is the blessing of DR...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 safety of the child, certainly directly affect the child in many ways.” (DR worker, Washoe)*

*“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.” (CPS supervisor, Clark)*

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)*

*“Most families have some need for services. Some families want this right away, others don’t want any involvement. Sometake time to warm up to the idea. Less than one percent get no services at all.” (DR worker, 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.”

At the Big DR meeting in Clark County between FRC and CCDFS personnel that the evaluator attended in April 2009, county 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.

The last CPS worker to respond said:

*“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.”*



**Training.** 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. At the start of the DR program in early 2008, the training schedule did not include an opportunity to shadow other DR workers, but later training sessions included several days of observing more experienced DR workers from other sites.

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 June 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.

Because DR emphasizes constructive working relationships with the family and family-driven services, the case manager needs to have strong engagement and problem-solving skills. Although DR case managers say that the overall training they have received was adequate to understand and conduct DR, they also say that the most effective training takes place on the job and in the field.

While the individuals hired to be DR workers are typically people with a background in serving families and children, the majority of workers are practicing assessments with child protection cases for the first time. Securing voluntary participation from a family that has been reported for possible abuse or neglect is complex and requires a high level of skill. In addition to getting in the door, DR workers in Nevada must be successful in getting the parent to sign a consent form. When resistance from the family is sometimes encountered, DR workers may resort to warning the family about involvement from county CPS. Adding to the frustration of family resistance is the knowledge that often this is an empty threat. CPS will not typically pursue reports that are lower risk. While this type of family resistance does not happen often, when it does it leaves DR workers wondering how they could have handled it differently.

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.

## **Part 4. Family Surveys**

Families affected by the introduction of differential response are being surveyed as part of the evaluation and they are a critical data source. The family survey is 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 learn about the kind of services or assistance being provided to families and how effective and sufficient this help is viewed by them. And fourth, we are 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. Families are clients but also consumers of important public services that are provided at the public expense.

The surveying of families with closed DR cases began in June 2008. For two months, all families with closed DR cases were mailed the survey questionnaire, asked to return the completed form to evaluators and told they would receive \$20 in compensation for their assistance. However, a significant majority (61 percent) of these surveys were returned as undeliverable due to a bad address. A new procedure was devised in September 2008—in which the FRC DR worker hands a copy of the questionnaire with cover letter and return envelope directly to the families at the time of the last visit prior to case closure—to make sure the questionnaire is actually received by the family. This procedure has been in place for one year now and appears to be working well. At the time this report is being prepared, 205 family survey responses have been received by evaluators, 178 were received in time to be included in analyses for this report. Of the 178 family responses reported on here, 98 (55.1 percent) were from families from Clark County, 57 (32.0 percent) from families in Washoe County, and 23 (12.9 percent) from families in other counties in the state. These numbers will grow over the next 12 months, but the statewide number is large enough to begin to see how Nevada families are reacting to the DR approach.

**Characteristics of Families.** The survey of families, then, tells us something about how the program that has been implemented, but it also tells us more about the families themselves who are being encountered by the child protection system. The next section is a brief description of what families have told us about themselves.

**Educational Attainment.** The majority of family survey respondents (71.3 percent) have at least a high school diploma or GED, while many (29.7 percent) do not. About 3 in 10 (29.2 percent) have attended college or taken college courses, but only a small percentage (5.6 percent) have a college degree. Statewide, 20.9 percent of the adult (over age 25) Nevada population has a Bachelors degree and 16.6 percent have less than a high school diploma.

**Employment.** On average survey respondents were employed less than five of the previous 12 months. About a third (32 percent) of respondents in Clark and Washoe counties

had full-time employment at the time of the survey, but only 19 percent of those living in rural counties reported working full-time. Unemployment was high in Clark and Washoe Counties (55.7 percent and 53.6 percent, respectively), but was even more dramatic in rural counties, where 76.2 percent of respondents were not currently working. These statistics for the families surveyed far exceed the national and state data on unemployment. According to the current figures from the U.S. Department of Labor (2009), the unemployment rate in Nevada for the first six months of 2009 was averaged to be 10.58 percent.

**Income and Public Assistance.** Most families in the DR population have very low incomes and many live in poverty. Nearly 20 percent of survey respondents reported a total household income from all sources in the last 12 months of less than \$4,999. Nearly half (48.2 percent) reported a household income of less than \$15,000. This is \$3,310 less than the 2009 Federal Poverty Guideline for a family of three. Across the state of Nevada, 9.9 percent of families have incomes less than \$15,000. Nearly nine out of 10 families in the survey population reported an income less than the state's median of \$54,996. In addition, close to half (46 percent) of surveyed families indicated their income had decreased in the past year. Just over half (52.8 percent) reported their families received food stamps, 39.3 percent said their children participated in school breakfast or lunch programs; about one in five received TANF benefits.

**Marital Status.** Survey respondents had a lower rate of marriage and a higher rate of divorce compared with state averages. About a third (32.8 percent) of those who completed a survey said they were married, compared to 50 percent of adults statewide, and a quarter (24.9 percent) reported being divorce, compared with 13.4 percent statewide.

**Housing.** Overall, the DR population is highly mobile. About half of the respondents (54.2 percent) have been at the same address for a year, compared to 78.3 percent of Nevada's general population, and 24.3 percent had moved two or more times in the last 12 months. A third of the respondents had lived in their current residence for six months or less.

**Stress and Well-Being.** Challenges with employment, housing, and meeting basic needs translate into emotional stress for many of the families. Parents reported the most stress around their financial situation. Three out of four (75.6 percent) reported feeling 'a lot' or 'some' stress about their economic outlook; 13.6 percent indicated 'a little' stress. Compared to one year ago, feelings of financial stress have increased to some degree for two out of three respondents. Correspondingly, three out of four felt 'a little' to 'a lot' of stress around their current and prospective job opportunities.

The majority of respondents felt stress in both their home life and their life in general (64.4 percent and 79.0 percent, respectively). A minority reported there was no one in their

lives who could provide important things they might need like financial help (29.8 percent), transportation (20.8 percent), or childcare (12.1 percent). Despite high stress levels and low socio-economic status, only 8.7 percent of respondents reported they were less able to care for their children now than a year ago; two out of three said they felt more confident in their ability to deal with issues in life compared to last year at this time.

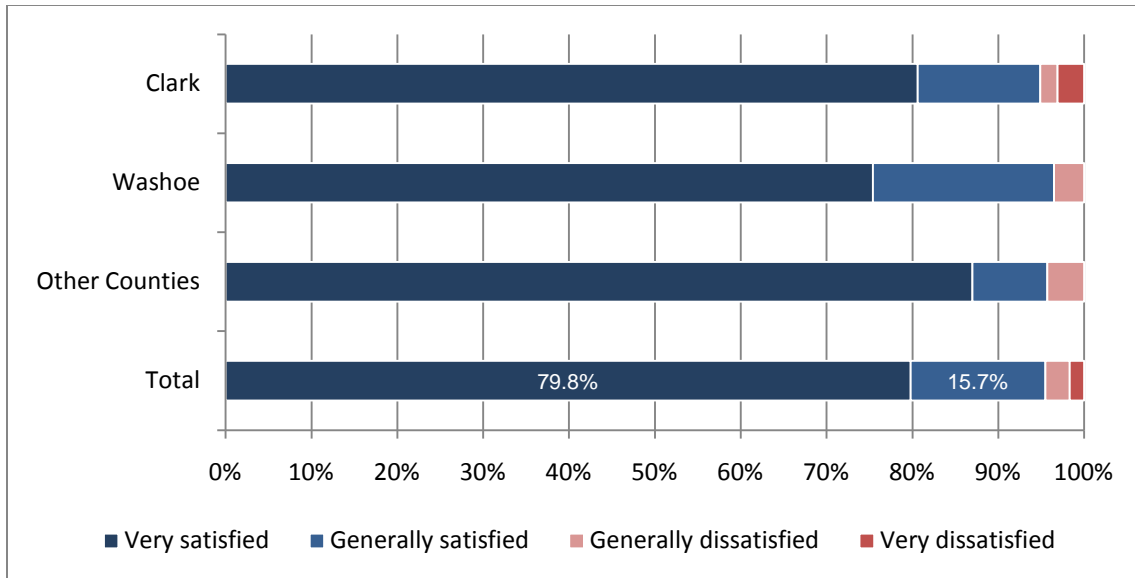
**Regional Differences.** The caseworkers in rural counties are encountering families that differ from those seen in Clark and Washoe counties in a number of ways. In the surveys completed thus far, respondents in rural Nevada have reported more unemployment, divorce, and higher rates of poverty, as well as higher rates of social isolation and lower social connectedness. Rural families have also indicated greater reliance on public assistance and child support. In addition, respondents in rural counties have been more likely to report that their children have learning difficulties, act aggressively and are absent from school due to sickness, and they have reported higher rates of mental retardation or developmental disabilities among their children.

## Part 5. Family 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:

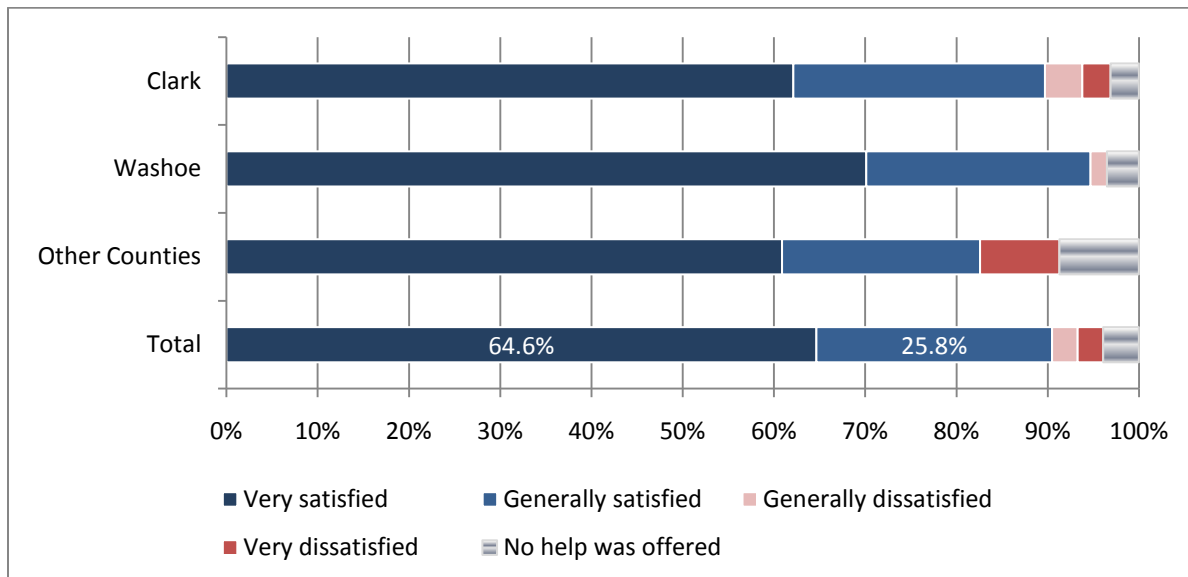
- 1) How satisfied are you with the way you and your family were treated?
- 2) How satisfied are you with the help you received or were offered?
- 3) Overall, is your family better off or worse off because of this experience?

The first question, of the relative satisfaction of families with how they were treated, is perhaps the core attitudinal measure. Family satisfaction is considered a program outcome measure that the Children's Bureau has come to expect on demonstration projects it supports and funds. Based on family respondents thus far, the satisfaction among Nevada families who have received the DR-family assessment is very high. Over 95 percent said they were satisfied, with 80 percent reporting that they were highly satisfied with the way they and their families were treated. Less than 5 percent said they were dissatisfied; less than 2 percent said they were very dissatisfied. When respondents from different counties were compared, there was no statistical difference in their answers. **Figure 15** shows the results of the survey to date. All family respondents combined are included in the total at the bottom of the graph. Response rates are also shown for families from Clark County, Washoe County and all other and more rural counties combined.



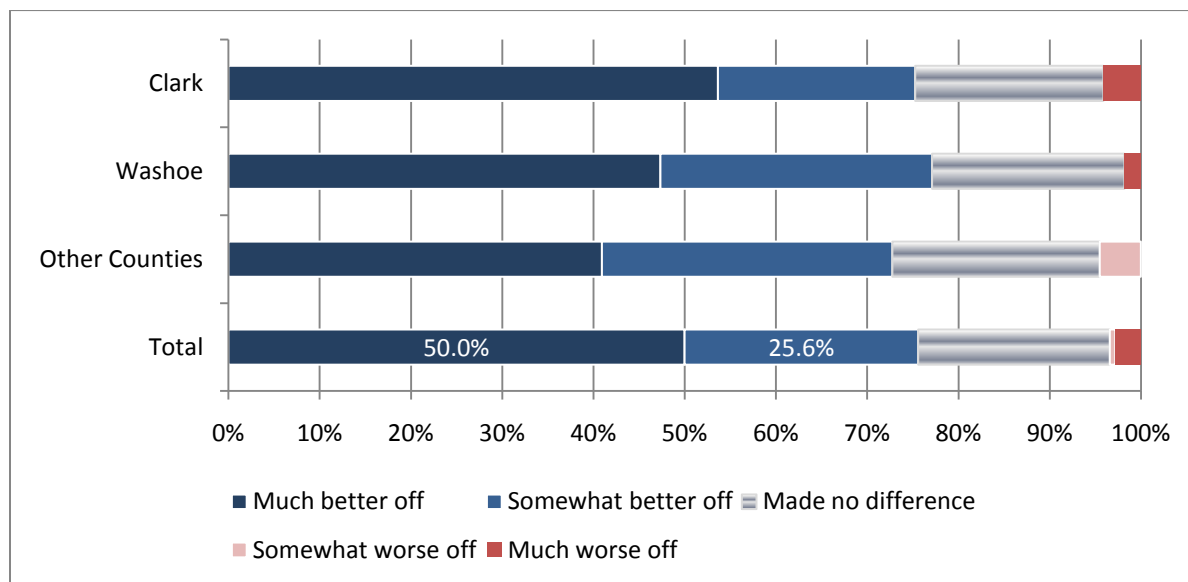
**Figure 15. Level of satisfaction with treatment among DR families**

A very high percentage of family respondents said they were satisfied with the help they had received (90.4 percent); two of three (65 percent) reported that they were very satisfied. The other families said they were either dissatisfied (7 percent) or were not given or offered any help (3 percent). It is not surprising to find some families reporting that no help was provided as it is sometimes the case that no outside assistance is required by such families. Differences among counties was again too small to be statistically significant. (See Figure 16).



**Figure 16. Level of satisfaction with help received or offered.**

The last question in this series asks whether families view 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. Most of the rest (21 percent) said it had made no difference and a few (3 percent) said they were worse off now. Again, the difference among families from different counties was not significant. (See **Figure 17.**)



**Figure 17. Respondent sees family as better off or worse off**

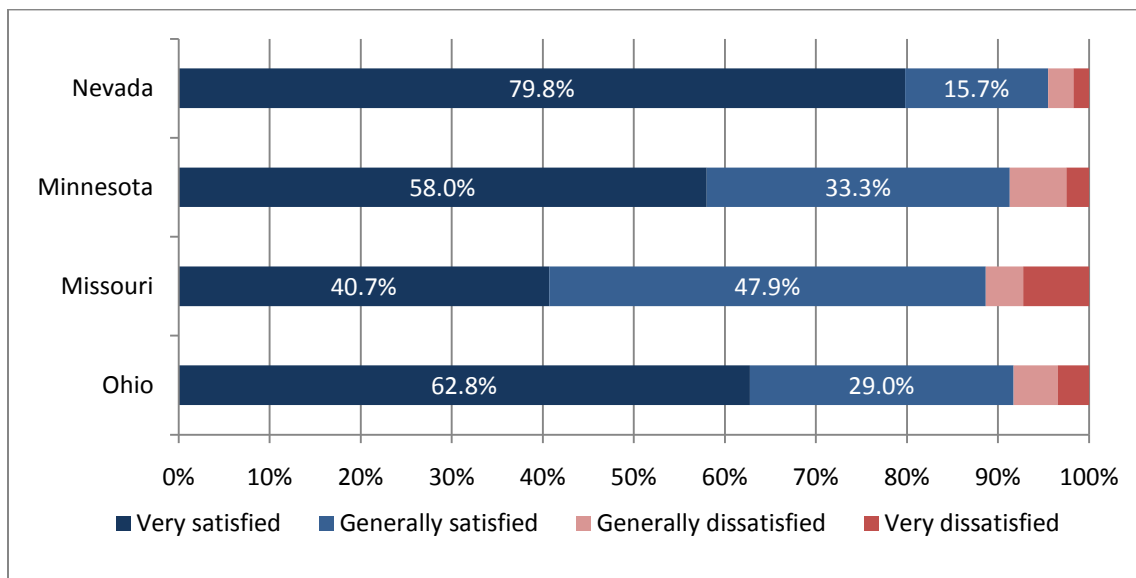
**Comparison of Family Responses in Other States.** Because as yet we do not have the responses from a control or comparison group of Nevada families, we lack a frame of reference for the reactions of families we have just reported. There is no doubt that the response to DR family assessments has been 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. Two of these evaluations are completed and part of the public record. These were studies of the DR programs in Minnesota and Missouri. The results of those studies were positive, that is, they achieved their objectives: families responded positively to the new family assessment approach, 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. The third DR project in which families are being surveyed is in Ohio. As in Minnesota, the Ohio project has an experimental design with a randomly chosen control group. That project is still underway,

however, and only preliminary outcome data are available. Nonetheless Ohio families form part of the backdrop before which the responses of Nevada families may be viewed.

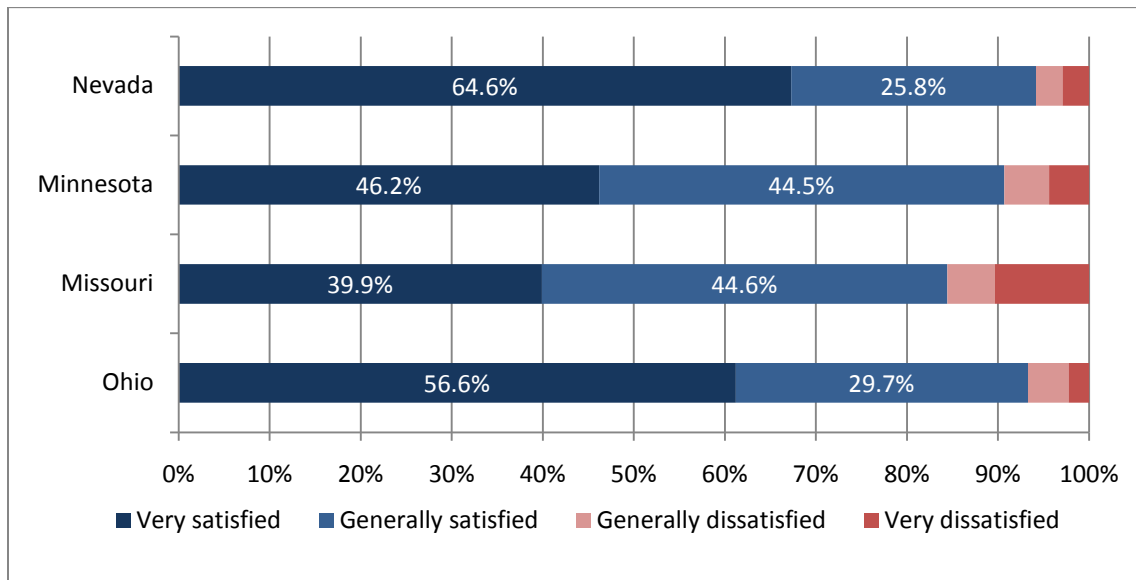
In each of the three other studies, families were asked the same three questions that have been used as barometers for assessing family satisfaction in this study: 1) How satisfied are you with the way you and your family were treated? 2) How satisfied are you with the help you received or were offered? 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 response thus far of Nevada families.

A review of the data displayed in the three graphs (**Figures 18, 19, and 20**) 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 18**, 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 has been the case in other states. The same is true, or nearly so, in the responses of families to the other two questions.

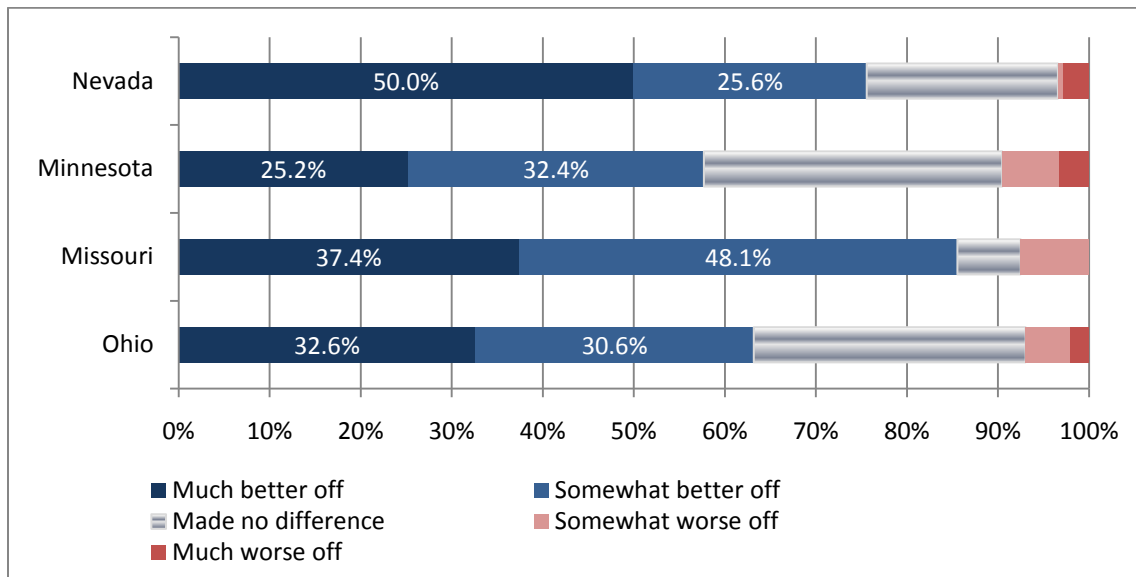


**Figure 18. Question: How satisfied are you with the way you and your family were treated by the worker(s) who visited your home?**





**Figure 19. Question: How satisfied are you with the help you received or were offered?**



**Figure 20. Question: Overall, is your family better off or worse off because of this experience?**

**Comments of Families.** In the survey instrument, families are asked to provide any comments they may have about their experiences with the FRC DR worker. Many respondents did, and their comments generally reflect the largely positive tone of the data in the previous

figures, although with a more personal touch. Some of the comments were mixed or negative in tone, often with specific criticisms. A representative set of family comments is provided below.

#### Sample of positive comments of family respondents

- “I’m very happy to have met [the DR worker] from the \_\_\_\_\_ program. They helped me a lot to be a better parent for our children. I’ll miss them a lot.”
- “The staff was very well trained, have good people skills, and overall helped my family very much.”
- “I am dealing with being a single mother, it’s an adjustment for me and my son. [The DR worker] was great to work with. She gave me a lot of inspirational advice.”
- “I’m glad she came into my life with my son. He is now doing better and his outlook on things is much better.”
- “We had just become homeless. [The DR worker] was awesome and met all of our needs.
- “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 was overwhelmed as a divorced mother of 5. I have kidney failure and am sick a lot. My kids hated school, their teachers. The social 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.”
- “Our worker was the best. He was always trying to help and check up on us. Without Christmas help we couldn’t have had a Christmas.”
- “The ladies that came to see my son and I know what they are doing. We are doing well after so long.”
- “I would like to thank the caseworker that helped me. [The DR worker] did a good job. She was a good person. She was like a big sister to us, and I’m grateful for the help.”

#### Sample of other comments of family respondents--mixed and negative

- “The worker didn’t explain things well to my husband.”
- “The social worker never met with my daughter, who was the topic. It was like her feelings didn’t matter.”
- “The worker offered services, then never fulfilled her promise to call about services.”
- “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.”
- “Very poor communication. Made promises that weren’t kept.”

- They should respect people's privacy and they shouldn't call after working hours. Worker called at 9pm and this is when I was resting.”
- “I wasn't ready to close the case. My daughter avoided the social worker, and now I believe she needs a social worker more now than ever.”
- “My social worker contacted people in my family that were totally inappropriate. She had no reason to do that. She knew my phone number, but always seemed to call everyone but me. She needs to be more professional. “
- “It was good, until the end when the social worker sat in my home and told me I had to medicate my child or he would take my minor children. Upon talking to my son's doctor, I do not have to medicate him.”

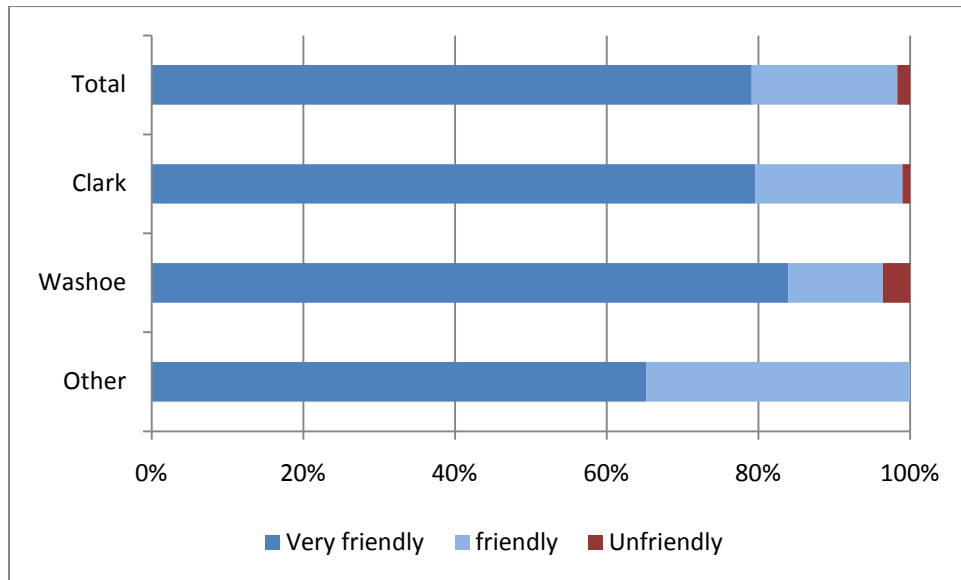
## Part 6. Practice Shift and Model Fidelity

The family survey instrument also addresses the issue of the DR-family assessment approach. A set of survey questions ask about the protocol that distinguishes a family assessment response from an investigation, a core element of differential response. These survey questions are:

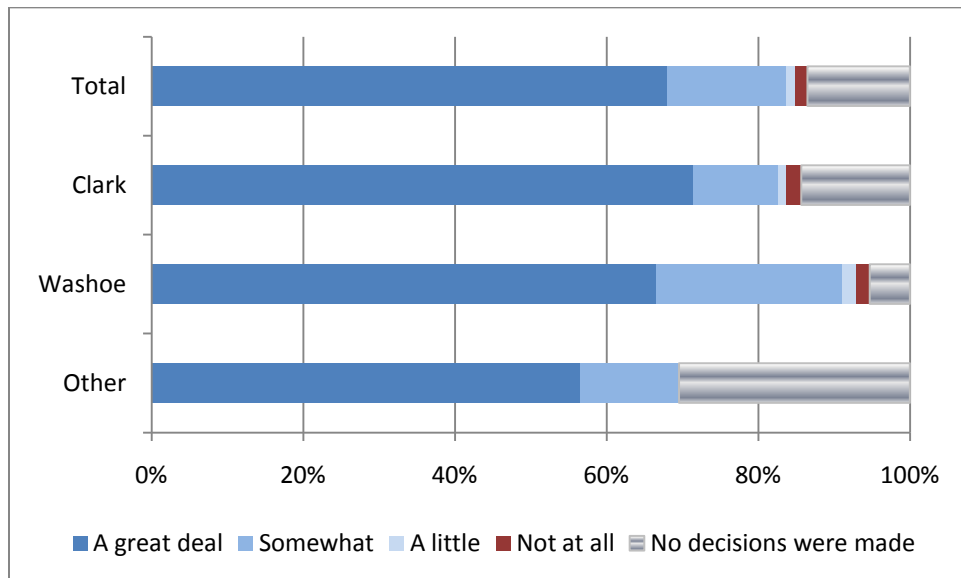
- 1) Overall, were you treated in a manner that you would say was friendly?
- 2) Were you involved in the decisions that were made about your family and children?
- 3) Did the worker who met with you listen to what you and other family members had to say?
- 4) Did the worker who met with you try to understand 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 ask families to give their judgment or assessment about various aspects of their encounter with an FRC social worker during a DR family assessment. In response to each of the questions families that returned the survey questionnaire were very positive. A very high percentage (98.3 percent) said they were treated in a friendly manner; 79 percent described the treatment as “very friendly.” A very high percentage (92.7 percent) said the DR worker who met with them listened “very much” to what they and other family members had to say; only 1 percent said the worker had not listened to them and 2 percent said the worker had listened only “a little.” Asked whether the worker tried to understand their family’s situation, 86.4 percent said the worker had “very much” done so and another 9.6 percent said the worker had tried “somewhat” to understand them; 2.3 percent said the worker had “not at all” tried to understand their situation. Finally, 10 percent of the family respondents said that there were matters important to them that were not discussed during the family assessment, while 90 percent said everything of importance had been discussed.

Each of these five items can be viewed as a successful measure of the extent to which the DR family assessment protocol was in fact implemented. Differences in the responses of families from different parts of the state were not statistically significant. **Figure 21** shows family responses to the question of whether they were treated in a friendly manner. **Figure 22** displays family responses when asked if they were involved in decisions made about the family or children.

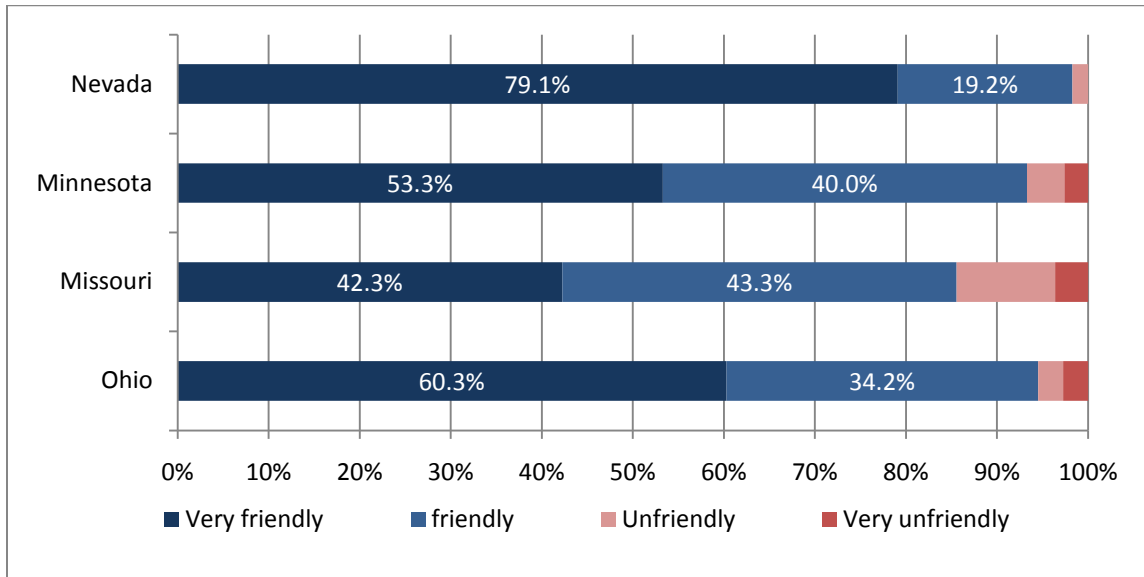


**Figure 21. Question: Overall, were you treated in a manner that you would say was friendly or unfriendly?**



**Figure 22. Question: Were you involved in decisions made about your family or children?**

Again, 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 23** 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 23. Question: Overall, were you treated in a manner that you would say was friendly or unfriendly?**

A key aspect of the family assessment approach involves approaching the family as a unit. This means that whenever possible, and whenever the safety of children does not dictate otherwise, the objective is to meet with the family as a unit. Although only about one-third of the Nevada families surveyed were two-parent households, most of the time (96.3 percent) when there were two parents, both were present for the family assessment visit. Respondents reported that one or more children were present during the initial assessment visit 70.0 percent of the time.

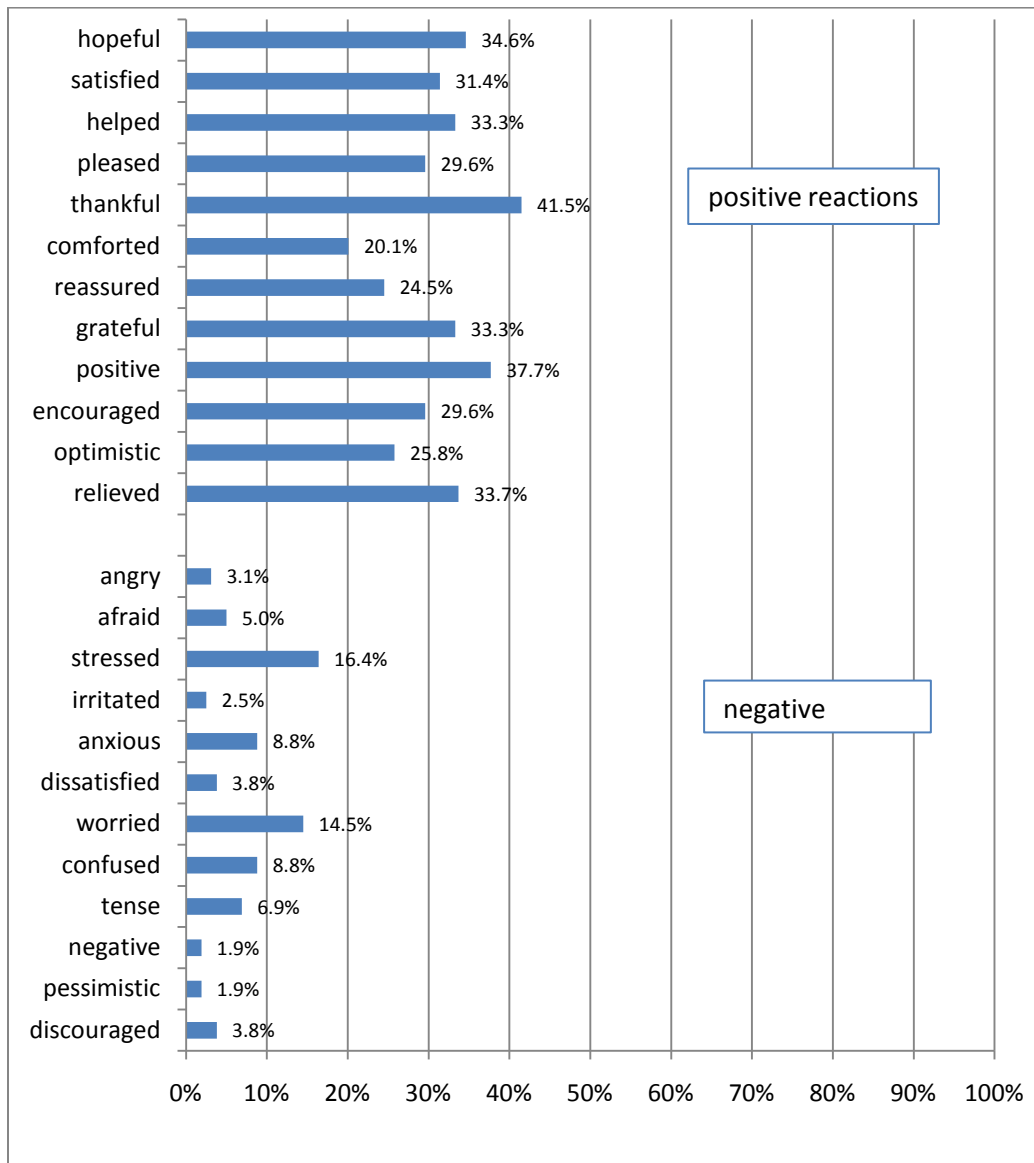
**Family Comments.** As before, open-ended comments of family respondents reinforced their answers to survey questions related to the family assessment approach and protocol. Below are representative comments of respondents that are related to the relative friendliness of DR workers, their openness and willingness to listen to what family members had to say, and their involving them in the assessment and planning process.

## A Sample of Comments

- “This was a hard situation to have someone from an 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 listened to me. Overall this experience was supposed to be very uncomfortable and high stress, but she made it the complete opposite. I’m thankful for that.”
- “I was so scared about this situation. An experience like this is very stressful. [The DR worker] made me feel comfortable and relaxed and was very respectful.”
- “[The DR worker] was very pleasant and told me clearly why he was there to talk with me.”
- “I appreciated the intervention and supervision of the social worker. I got the impression that he was sensitive of my situation and attentive to my needs.”
- “She was very attentive and listened to what my children had to say.”
- “For me, the worker was excellent person. She was very friendly and respectful.”
- “[The DR worker] was very friendly.”
- “... an asset to your organization.”
- “[The DR worker] made my family feel less stressed.”
- “She was very nice and helpful.”
- “She was kind and friendly, very easy to talk to.”
- “[The DR worker] is a great person. She gave me much time, she's like my sister.”
- “The initial visit with my wife was horrific. She felt pressured that if we did not cooperate in how everything should be handled, that we would be turned into CPS. However, after the initial contact with my wife, we had a very positive and proactive experience. *The worker* became positive and helpful in dealing with the situation. Her demeanor changed dramatically.”
- “\_\_\_\_\_ was our worker and she is just a wonderful woman who really cares about her clients and families she helps. She was very friendly and offered all the help and assistance we needed. 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 on our own.”
- “I would like to thank [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.”
- “My worker was very helpful and was always there for advice and what I should do next. She was very understanding while giving accurate information.”
- “The worker was extremely helpful. Wish I had met her a little sooner. The help was timely.”
- “Our worker is just a wonderful woman who really cares about the families she helps. She was very friendly and offered all the help and assistance we needed. She came into our home to help with one problem and ended up helping us with so much more.”

**Emotional Response.** One of the ways we are measuring the approach of workers in the family assessment is through the emotional reaction of families to what can be a difficult experience for them. A method we are using, and used in other studies, is to ask 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 scrambled.

The list of descriptive words from the family survey instrument, grouped by those that are positive and those negative, can be seen in **Figure 24**. This figure shows the percent of



**Figure 24. How families respondents described their emotions following the initial family assessment visit**

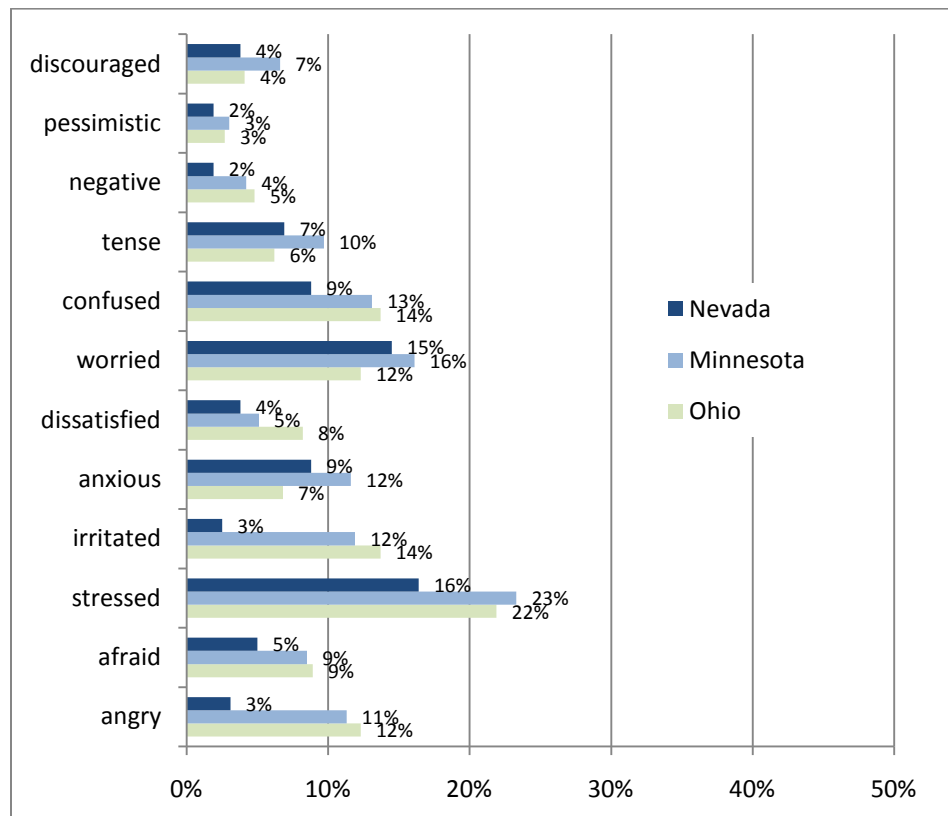
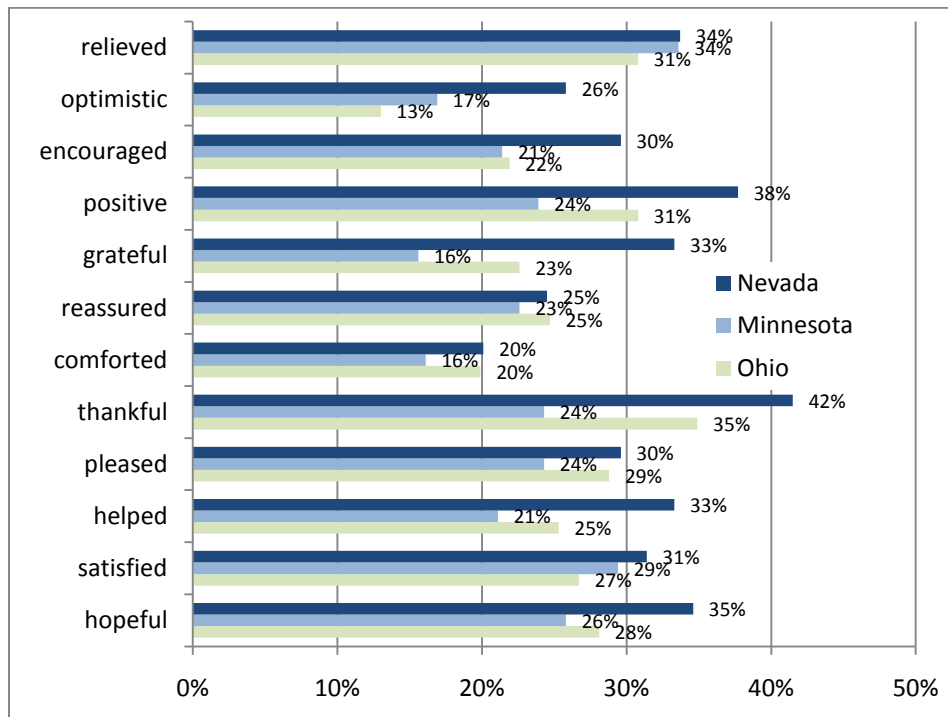
family respondents that selected each descriptor. As can be seen, reports of positive feelings have outnumbered those of negative feelings by a large margin. Families most frequently reported feeling thankful and positive (about 4 in 10). One in three reported feeling helped, grateful and relieved. The most frequently selected negative feelings were stressed and worried. However, these negative descriptors were selected by fewer families than reported any specific positive feeling.

We are not yet able to compare these family reactions to those encountered in traditional investigations. However, these results compare favorably with our findings in the evaluation of the Minnesota differential response pilot project. In our evaluation of that program, we found families who received a family assessment to be significantly more likely to report positive reactions and less likely to report negative reactions ( $p < .05$ ) than those receiving traditional investigation. We are also currently using the same family instrument in our evaluation of Ohio's DR pilot program. And the response from Nevada families compares very favorably to Ohio DR families as well.

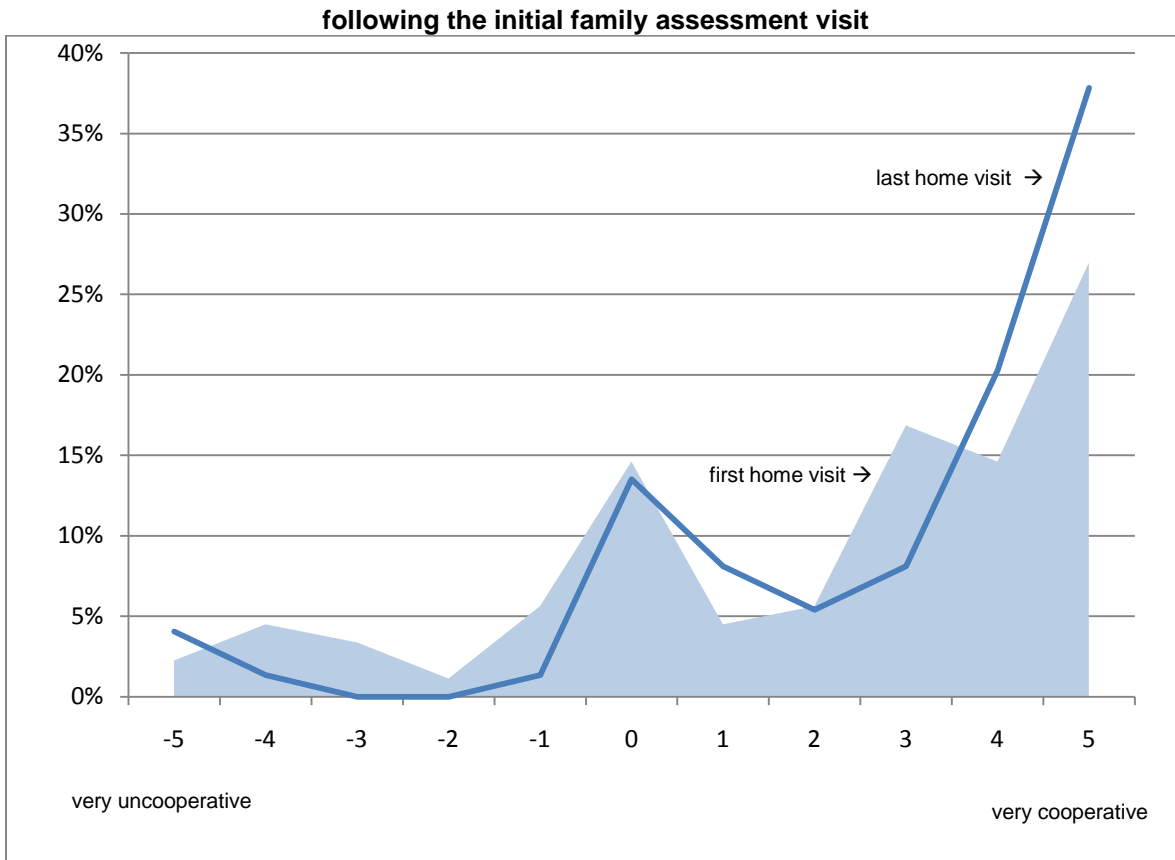
In fact, as can be seen in **Figure 25**, the response of Nevada DR families tend to be even more positive and less negative than families in the other two states. Why is this? Two possible reasons seem most likely. 1) There are differences in screening criteria that affect the types of reports selected for a family assessment. 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. 2) Nevada relies on community organizations to conduct family assessments. FRC workers bring a fresh, social worker perspective to their encounters with families. This second program feature probably plays the larger role.

**Worker Perception of Family Cooperation.** Another indication of the reaction of families to the DR family assessment is their cooperation with workers. In the case reviews completed by workers, they are asked to rate the level of cooperation of family members during the first and last home visits. The rating is done on a scale from -5 to +5, with -5 representing "very uncooperative" and +5 signifying "very cooperative." For a majority of cases (68.5 percent) thus far, workers have said the families were cooperative (that is, a rating of +1 to +5) during their first visit, while 16.8 percent of the families were rated as uncooperative (a rating of -1 to -5); 14.6 percent of respondents gave a neutral rating (0). According to the worker ratings, families were even more cooperative the last time they met with them; 83.1 percent were rated as cooperative at this point compared with just 5.6 percent who were rated as uncooperative and the 11.2 percent rated as neutral. Figure 26 shows these data graphically, and the increase in perceived cooperation during the last visit between the worker and the family can be seen. As will be noticed, ratings of cooperation for both the first and last visits have tended to cluster at the positive end of the rating scale.





**Figure 25. Feelings reported by families in Nevada, Minnesota and Ohio**



**Figure 26. Ratings given by workers of family cooperation during first and last home visits**

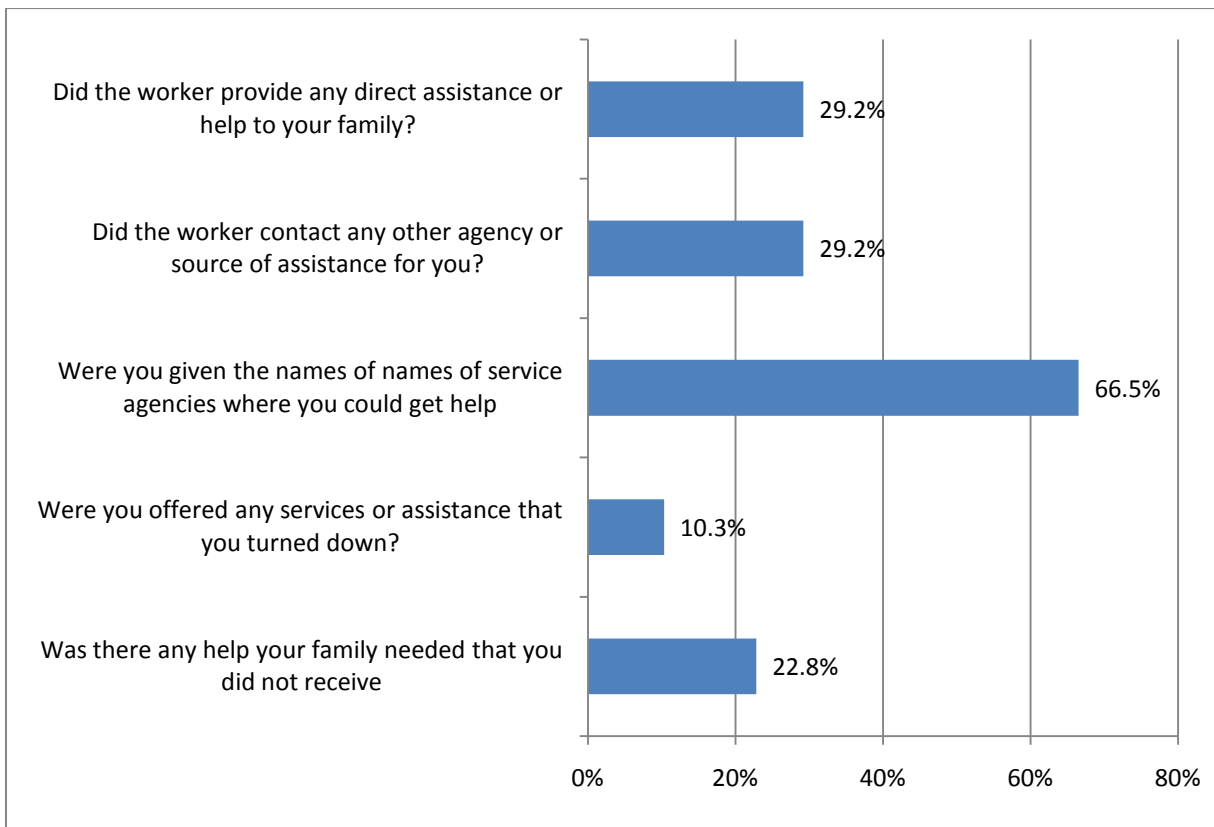
## Part 7. Services

The second core element of the DR-family assessment approach is the provision of needed services or assistance. This element has two parts. First, the provision of assistance to families who often do not receive services in traditional CPS; and, second, providing assistance across a wide service spectrum aimed at addressing the specific needs (chronic or immediate) of individual families in order to foster the longer-term wellbeing of children and their families.

Information about services being provided to families is being obtained through the family surveys as well as through the case reviews being completed by DR workers.

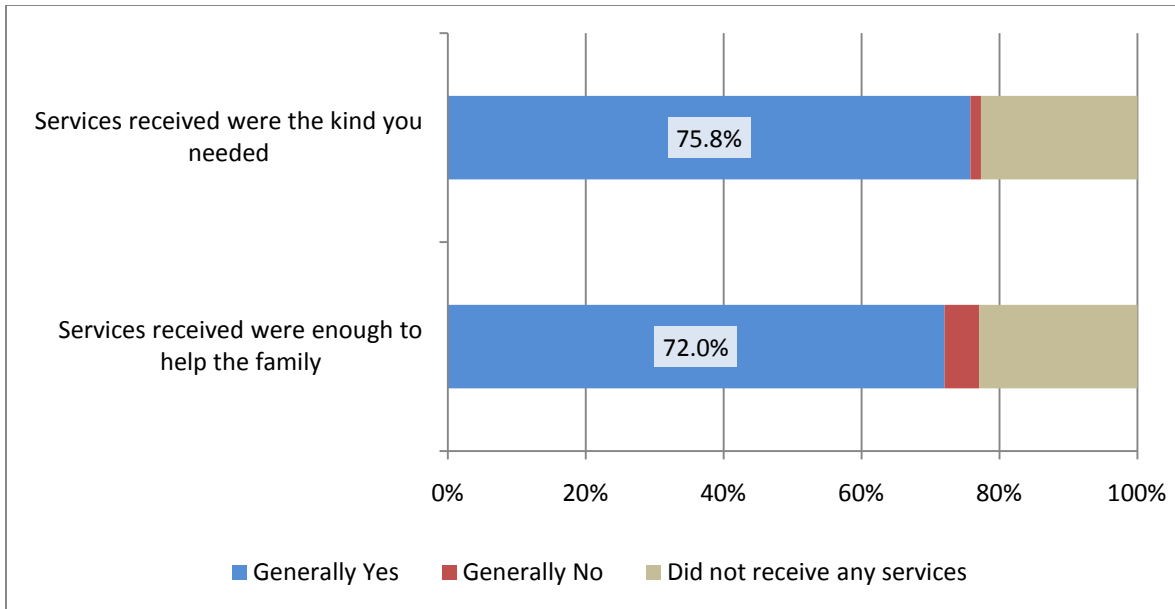
**Reports of Families.** Two out of three (67.4) family respondents have reported that the DR-family assessment worker helped them or another family member obtain some service or assistance they needed. Two of three (66.5 percent) family respondents said the DR worker had given them the names of service 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. According to the families, workers themselves sometimes (29.2 percent) helped the family directly; that is, the worker herself/himself was the source of assistance. About a quarter of the families (22.8 percent), said there was help of some kind that they needed but did not receive. And 1 family in 10 said they were offered services that they turned down. (See **Figure 27.**)



**Figure 27. Nature of assistance provided by DR workers according to families**

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. Only a few (1.5 percent) said the help they got was not what they needed. Similarly, a high percentage (72 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 and a few said the services they received were not enough to help them. (See **Figure 28.**)

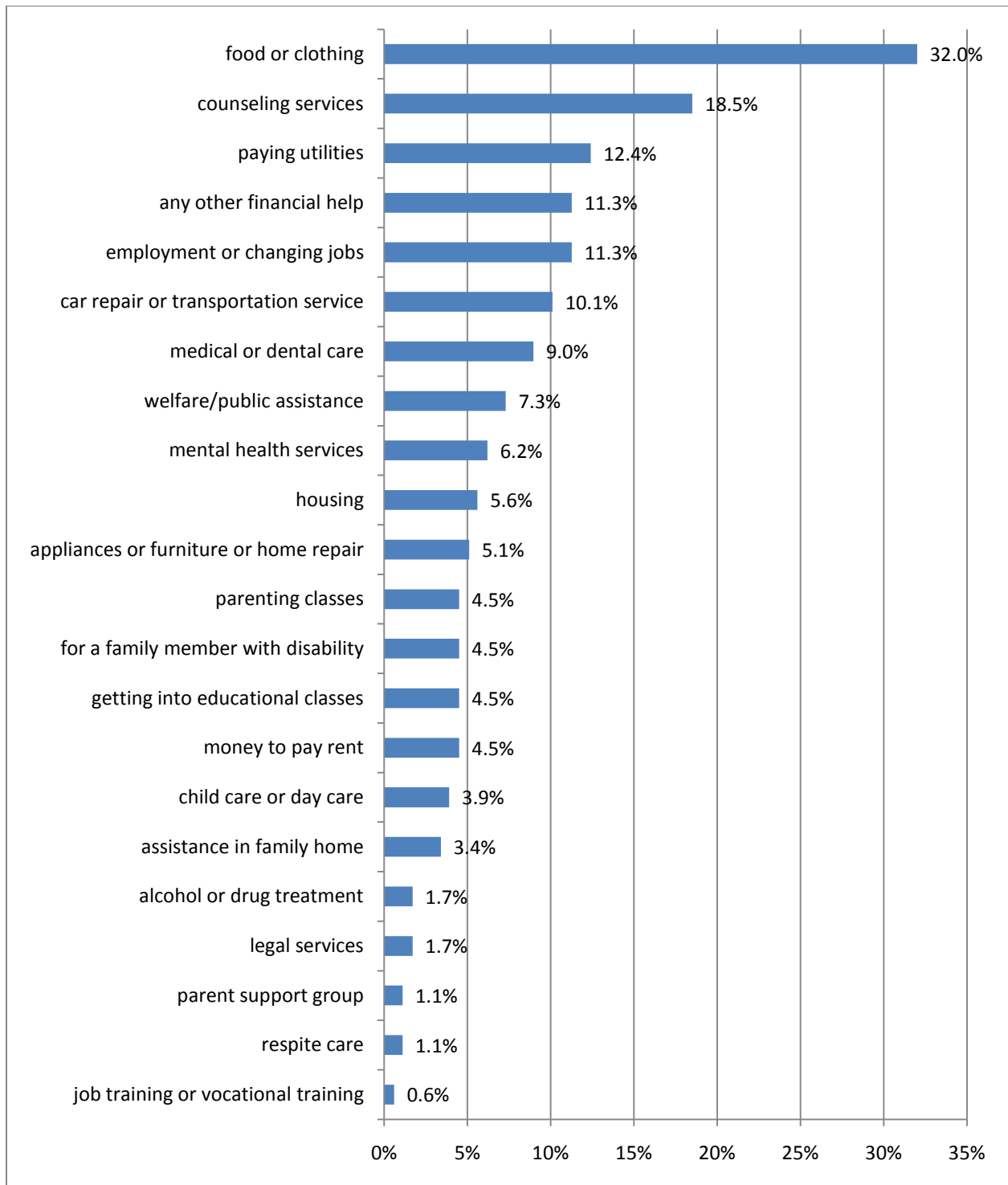


**Figure 28. Appropriateness and sufficiency of services received according to families**

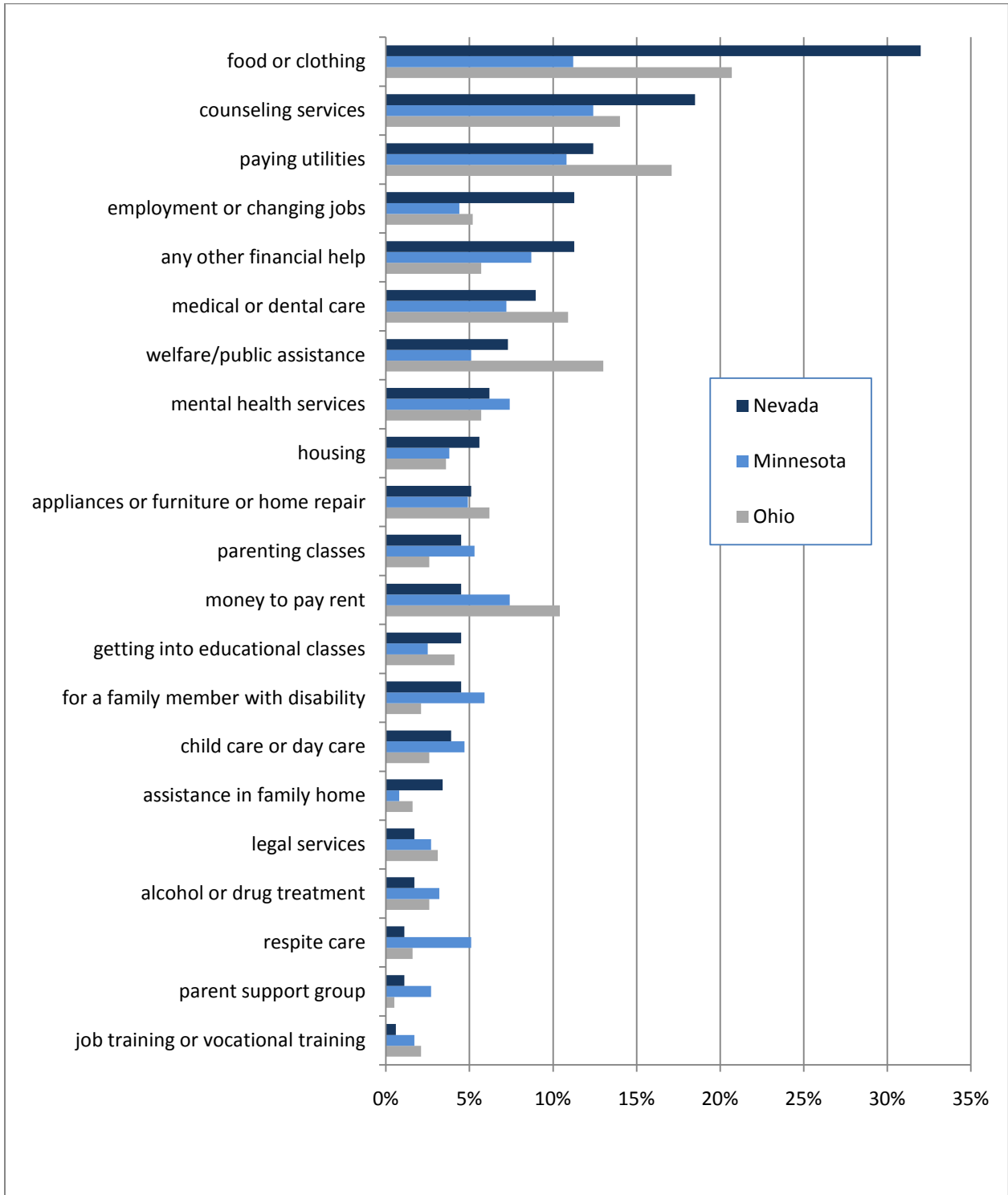
The specific types of services and assistance that families reported receiving are shown in **Figure 29**. The services were varied and often involved some type of practical assistance. In the figure, the services are ranked in order most provided. Nearly one in three (32 percent) families reported receiving food or clothing. This was followed by counseling services (18.5 percent). Approximately 1 in 10 said they received help paying utilities, help finding or changing jobs, transportation assistance including car repairs, medical or dental assistance, or some type of financial assistance not listed. While there were some differences across the state in the provision of particular services, this figure is generally representative of all parts of the state where the Differential Response approach has been implemented

Again, while this information is not available on a group of control families, we are able to compare Nevada families in types of services/assistance received with families in two other states. **Figure 30** is the same as **Figure 29** with the addition of data from families in Minnesota and Ohio. Based on site visit interviews, the pattern of assistance to DR families in Nevada appears, to a large extent, to be a reflection of the kinds of assistance that FRCs are organized to provide.

This may account for the relatively large percentage of families served by these agencies who receive emergency food and clothing and, perhaps, employment assistance. Nonetheless, comparing Nevada to the other two states, the pattern of assistance, with some exceptions, is not dramatically different and the similarities speak to commonalities in the populations served.



**Figure 29. Percent of Nevada DR-FA families who reported receiving specific services/assistance**



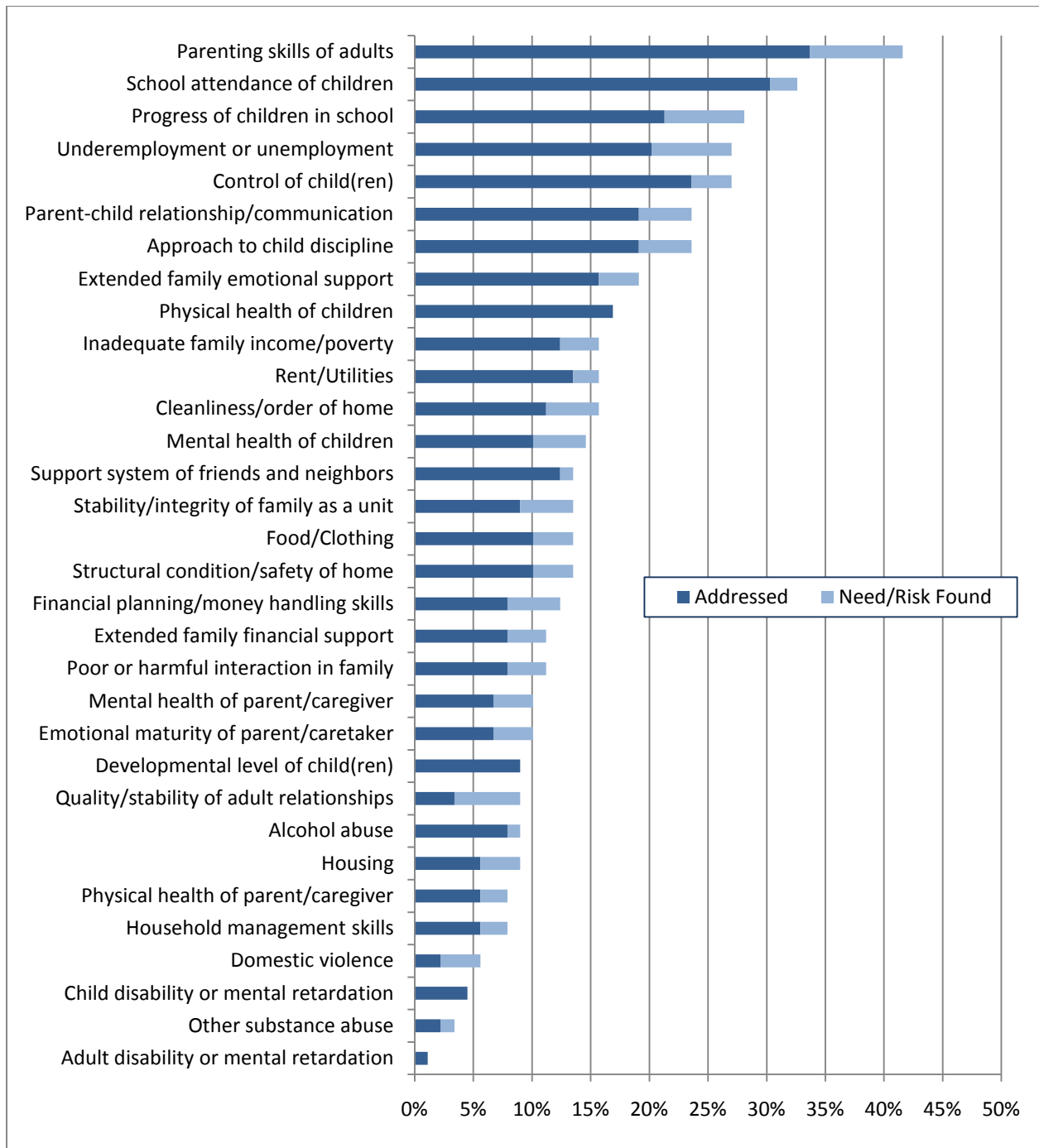
**Figure 30. Percent of DR-FA families in Nevada, Minnesota and Ohio who received specific services/assistance**

**Worker Reports about Services.** In the case reviews, DR workers are providing a wide range of information about the nature of their work with families. Although the current number of completed reviews (95) is not large, the information provided is a useful glimpse into DR interventions and the services and level of assistance being provided to these families. In the case reviews completed thus far, DR workers have reported that they had an average of 4.3 face-to-face contacts with the families they saw. In some instances, about 1 in 6 among currently completed reviews, workers had a single face-to-face meeting with the family. Workers reported an average of 8.2 telephone contacts and 5.5 collateral contacts, either on behalf of families or to obtain additional information about the family or possible sources of assistance.

Overall, the reports of workers have corroborated what families have said, and vice versa. For example, the percentages of families who have reported receiving some kind of services/assistance through FRCs (67.4 percent) is very similar to the percentage of families receiving services/assistance as reported by DR workers (65.2 percent).

The assistance provided to families by DR workers follows an assessment of need, a joint process between the worker and family members. **Figure 31** shows the percent of families in which specific areas of needs or risks to children were identified in the case reviews. The figure also shows the percent of cases in which workers reported the need or risk was addressed while the case was open.

In general, the relative incidence of risks reported by workers is consistent with the frequencies of specific allegations included in reports of concern that were made to CPS. For example, problems related to parenting skills were identified by workers more frequently (42 percent) than any other, an area consistent with allegations of improper supervision. Related problem areas listed with some frequency in the graph are “control of children,” “parent-child communication,” and “approach to child discipline.” Similarly, and as would be expected, workers identified a number of problem areas consistent with reports of educational neglect. These include “school attendance” and “progress of children in school,” the second and third most frequently mentioned issues in the case reviews. Other risk areas frequently reported are consistent with reports of neglect of basic needs, which is consistent with families in or on the edge of poverty. Specific risk areas identified include “underemployment or unemployment,” “inadequate family income,” and problems with basic needs such as food, clothing, rent, utilities, condition of the home. Other areas reported with frequency include those related to health and mental health. All of these problems, in addition to those related to the stability of residence and relationships among others, represent risks to children that, if not addressed, can become ongoing and chronic in nature. These are the types of issues that the family assessment approach was designed to discover and address.



**Figure 31. Percent of families with specific needs/risk present and addressed**

According to the reports of DR workers, when the issues listed in **Figure 31** were identified they were frequently addressed while the DR-family assessment case was open. There



were a minority of cases, generally between 10 and 35 percent depending on the problem area, in which specific needs and risks were not or could not be addressed.

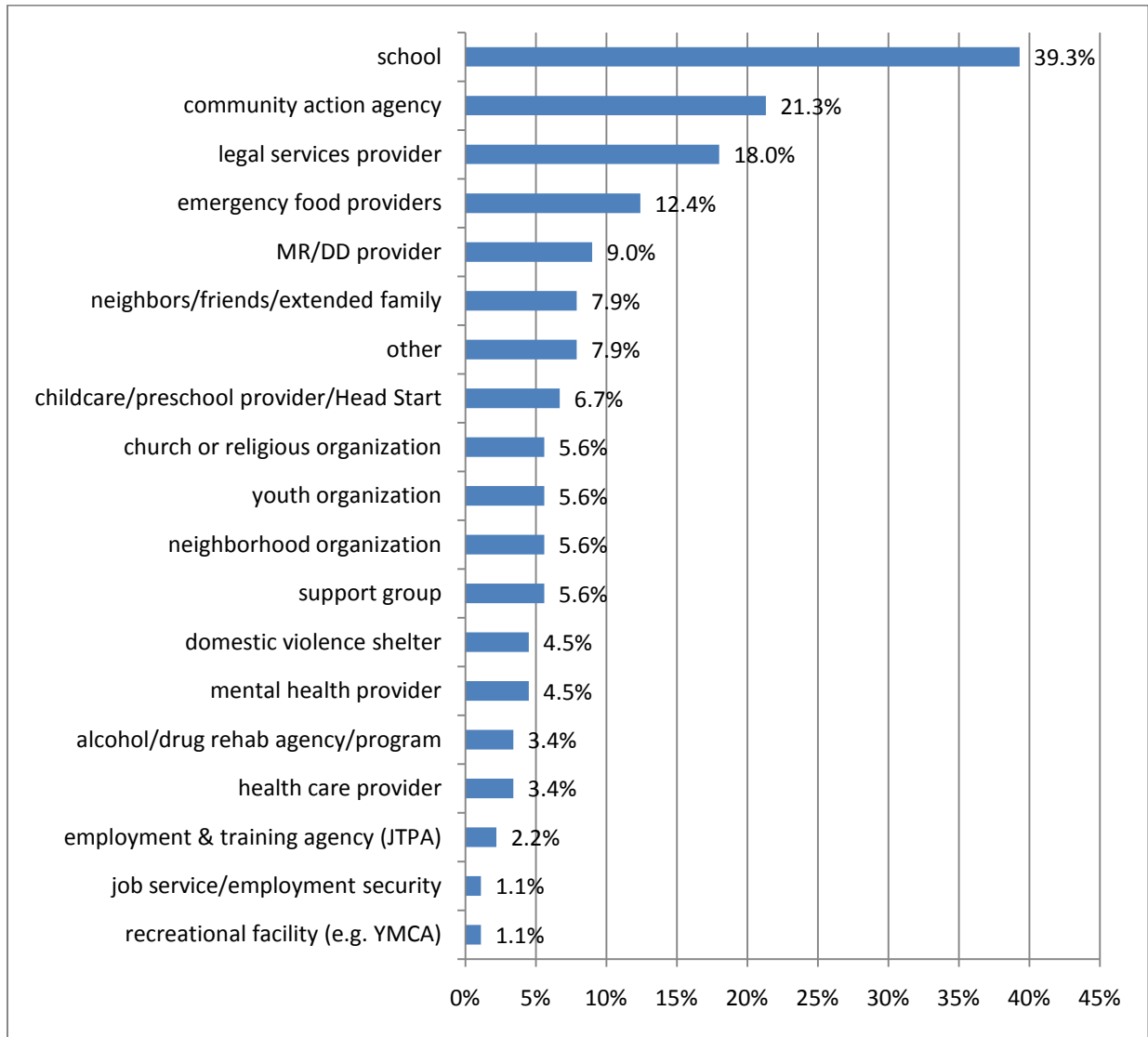
DR workers were asked a variety of additional questions about the sufficiency and effectiveness of the assistance they provided families. Overall, DR workers thought the services provided to the families matched the needs of families, improved the well-being of the children and reduced threats of possible future abuse or neglect. However, the responses of many workers to such questions were often guarded and suggested that many of the families they worked with had complex and multiple needs that were not easily or fully dealt with. For example, the percent of workers who thought that services provided were “well matched” to the needs of families was 43.5 percent. Similarly, just one in four (24.7) percent said they thought the services were “very effective” in solving the problems families faced or in producing needed changes and 47.1 percent said the services were “somewhat effective.” When asked to indicate, on a scale of 1 to 5, where 1 was “not at all” and 5 was “completely,” whether the level of services provided to families was sufficient to reduce threats of possible future abuse or neglect the average worker response was a modest 3.5.

Although family assessment cases in Nevada involve reports on the “less severe” end of the child maltreatment spectrum, half (51 percent) of the families included in the case reviews had prior reports of child abuse or neglect. About 1 in 5 (21 percent) had a prior investigation and 2 percent had a child removed from the home for some period of time. These figures, combined with the types of needs and risk conditions found by DR workers, are an indication of the complexity and level of difficulty that these workers face in many of these cases.

**Utilization of Resources.** DR workers were asked how often the extended family or unfunded community resources (such as churches or community groups) became involved in providing support or assistance to the parents of the children involved in the case. Among the families included in the current sample, workers said the extended family was involved either “extensively” or “moderately” in 38 percent of the cases. More often extended families were involved “not at all” or “very little” (49 percent) or there was no extended family available (13 percent). Unfunded community resources were involved “extensively” or “moderately” in 1 case in 4 (25 percent). In other cases such resources were not involved at all (37 percent) or were involved “very little” (24 percent), or there were none known to the worker to draw upon (13 percent).

DR Workers were asked whether they helped members of the families in obtaining services or assistance from specific community resources. The community resource most frequently mentioned by workers was a school (39 percent). Other resources utilized with some frequency by DR workers were community action agencies (21 percent), legal service providers

(18 percent), and emergency food providers (12 percent). See **Figure 32** for a list of these and other resources utilized by DR workers.



**Figure 32. Percent of families put in touch with specific community resources by DR workers.**

According to DR workers, 60 percent of the families they worked with became aware of community resources they had not know about before. In addition, workers said they helped families access services from such resources by providing information about the resource (52 percent) and/or by direct assistance (22.4 percent).

## **Part 8. Recurrence of Maltreatment and Subsequent Child Removals**

This section provides the first, and still preliminary, report of two key outcomes being tracked in this evaluation: the recurrence of new child maltreatment reports that led to new investigations and any subsequent removals of children from their home. There are two groups of families in the study, the DR families that have been referred to FRCs for family assessments and a group of comparison families chosen for their similarity to the DR families, but who received a traditional CPS investigation. All of these families have an initiating report and intake process that brought them into the study population. The “outcomes” being discussed in this section refer to any new reports that received an investigation and any removals of children from their homes in the period following the initiating report and intake process. Because the DR program was phased in at different times in different locations, the start of the follow-up period varies from place to place, but, for the present analyses, it ended everywhere on August 31, 2009, the closing date of the last UNITY extract. Accordingly, the follow-up period ranges from two years seven months for cases in Clark East and South which implemented DR in February 2007, to less than one month for families entering the study population in August 2009.

The selection of a non-random comparison control group is not an exact science. A researcher faced with a quasi-experimental design can only rely on his judgment, experience and available data to make the best of an imperfect situation. Nonetheless, comparison groups provide a measure of contrast with treatment groups and can be utilized to provide a greater understanding of the import of outcomes achieved by a new program.

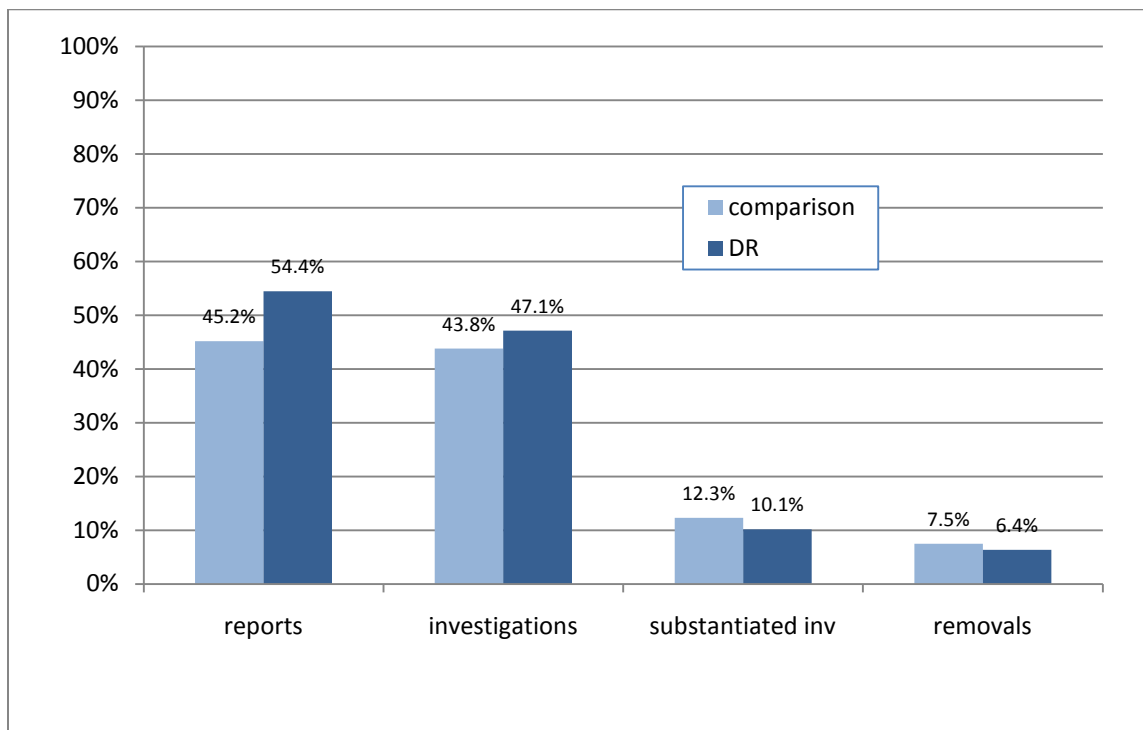
For this evaluation, comparison-group families were selected from the pool of families who might have been selected for a DR family assessment, based on program eligibility criteria, but were not and who instead received a CPS investigation. Among families available for the comparison group were those in locations where the DR program had not as yet been phased in, those who could not be referred to an FRC because its caseload was full at the time the report was received, or those who might have been referred but were not, sometimes because of differences in the judgment of CPS personnel from one location to another concerning the appropriateness of DR for particular families.

This pool of DR-possible families contained several thousand families across the state. Families were selected from the pool for the comparison group based on their similarities to DR families in CPS history and family characteristics. Variables taken into account for matching purposes were previous reports accepted for investigation, previous removals and placements of children, previous reports with the disposition “information only” (IO), previous reports with the disposition “information and referral” (IR), previous reports with another disposition, allegations

associated with past reports, single parent or two-parent family, age of primary and secondary caregivers, number of children in the family by age category, number of girls in the family, number of boys in the family, the county of residence. The selection was accomplished through an iterative, best-fit process in three geographic areas: Clark County, Washoe County and rural Nevada. Throughout the selection process prior contact with CPS remained a key variable because past contact with CPS is the most powerful predictor of future contact.

In the end, 1,055 families were selected for the comparison group. Outcomes associated with these families have been compared to those of 1,271 DR families. The DR family group consisted of all families screened for DR from whom there was no evidence in UNITY that they had been returned to CPS for an investigation or could not be located by the FRC. The DR and comparison family groups were not identical in their characteristics but matched well overall.

**Similarities and Differences.** As noted above, previous contact with CPS is a key variable for matching families. Measures of CPS contact used in matching families included previous reports of child maltreatment (regardless of disposition), previous investigations, previous substantiated investigations, and previous child removals. The percentage of DR and comparison families with any of these can be seen in **Figure 33**. As will be noticed, a higher percentage of DR families than comparison families had at least one report of child maltreatment



**Figure 33. Percent of DR and comparison families with prior CPS contact**

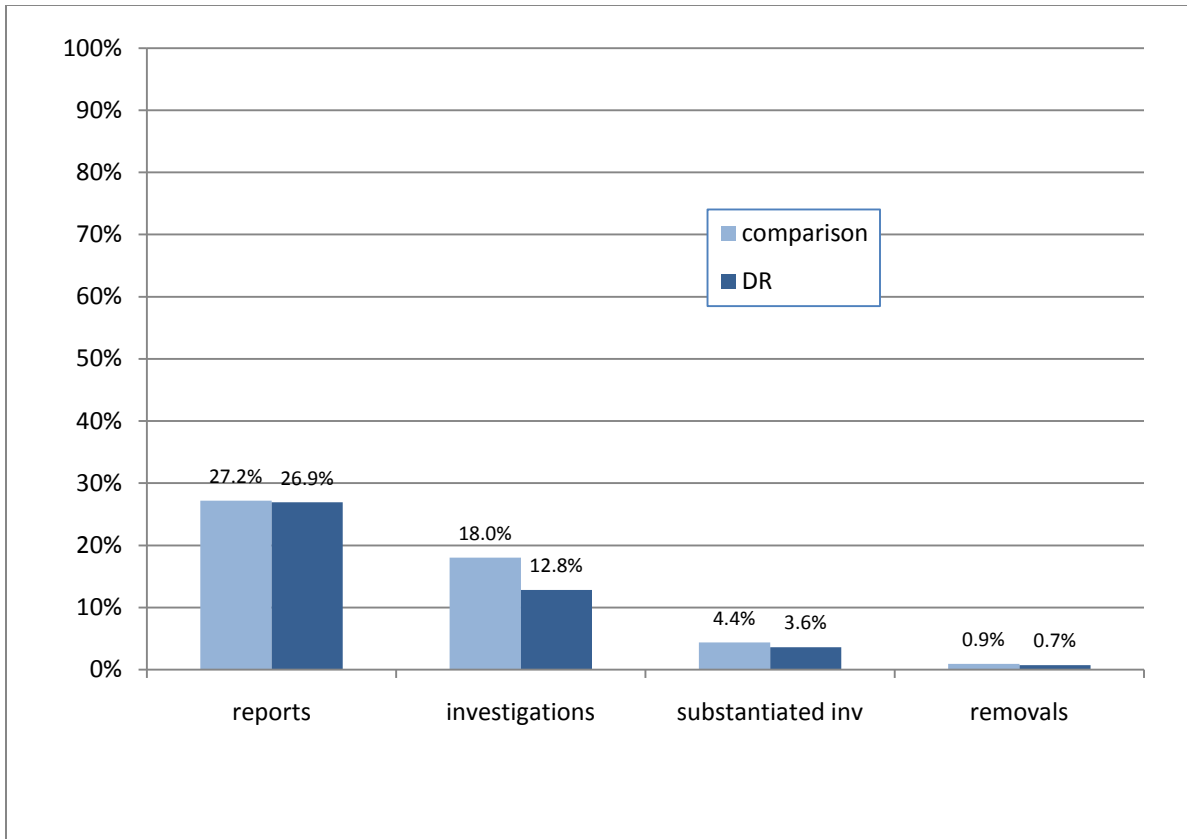
before the report that brought them into the study's population (54.4 to 45.2 percent). DR families were also somewhat more likely to have had a prior report that was substantiated. Comparison families, on the other hand were somewhat more likely to have had a substantiated report and about 1 percent more had a child previously removed.

Allegations associated with past investigations were also examined and matched to the extent possible. Considering the entire DR and comparison groups, no differences were found in past levels of allegations of sexual abuse, severe physical abuse, less severe physical abuse, severe neglect, drug-exposed infants, lack of supervision, educational neglect or parent/family risk characteristics. DR cases were more likely to have had one or more allegations of neglect of basic needs, including environmental, dirty home, lack of necessities and physical neglect. Some differences emerged in the area of family characteristics—in the size of families and number of children and age of the primary caregiver—but the differences were negligible.

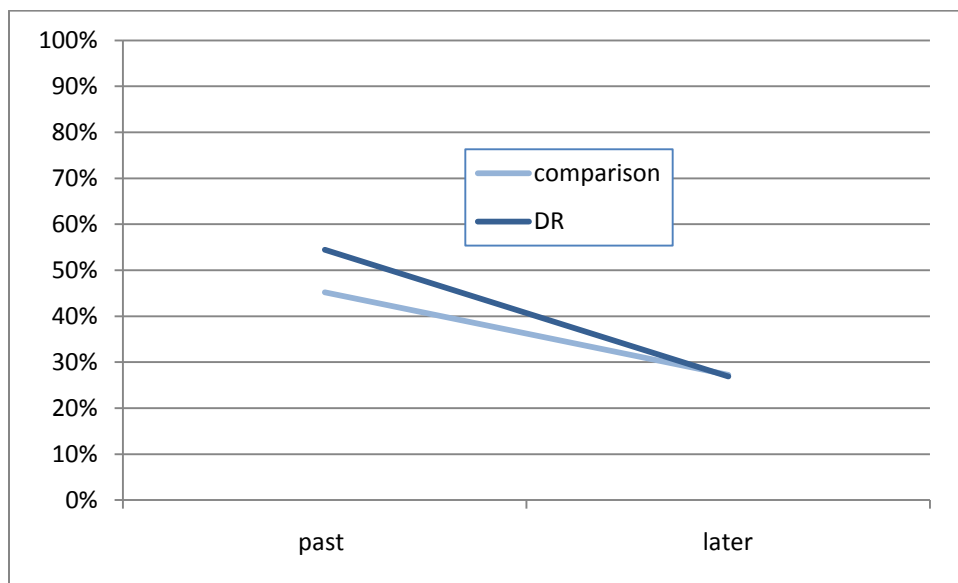
Finally, the average follow-up time for DR families was somewhat longer (336 days) compared with comparison families (309 days). The difference is statistically significant and means that there was a longer “opportunity period” for new reports and new child removals to occur for DR families.

**Recurrence and Removals.** **Figure 34** shows the percentage of DR and comparison families with contact with CPS during the follow-up period. As can be seen, there was essentially no difference in the percent of families with subsequent reports, substantiated investigations or removals of children from the home (of which there were very few among this population overall). There was a significant difference in the percent of families with a subsequent investigation, however. Among DR families 12.8 percent had at least one investigation during the follow-up period, while the figure for comparison families was 18.0 percent.

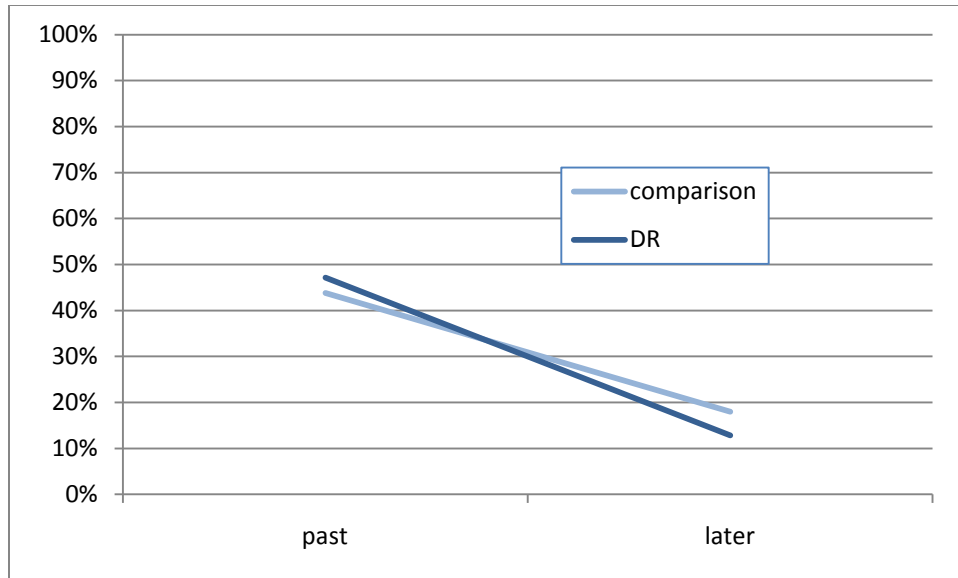
Since we are using a comparison and not a randomly selected control group in this study, it may be useful to add some additional context in reviewing outcomes to this point. **Figure 35** shows the percentage of DR and comparison families who had a previous (past) child maltreatment report and the percentage who had a report in the follow-up (later) period, a before and after comparison. The trend, with the percentage decline among DR families being sharper, suggests the possibility of a difference of consequence (represented by statistical significance) as more families are added to the study and as the follow-up period is extended. **Figure 36** shows the significant difference already found between the two groups of families in the percentage with a subsequent investigation. The crossing of lines in before-after comparisons usually indicates a difference that is statistically significant, as it is here ( $p < .0001$ ).



**Figure 34. Percent of DR and comparison families with CPS contact during the follow-up period**



**Figure 35. Percent of DR and comparison families with previous and subsequent CA/N reports**



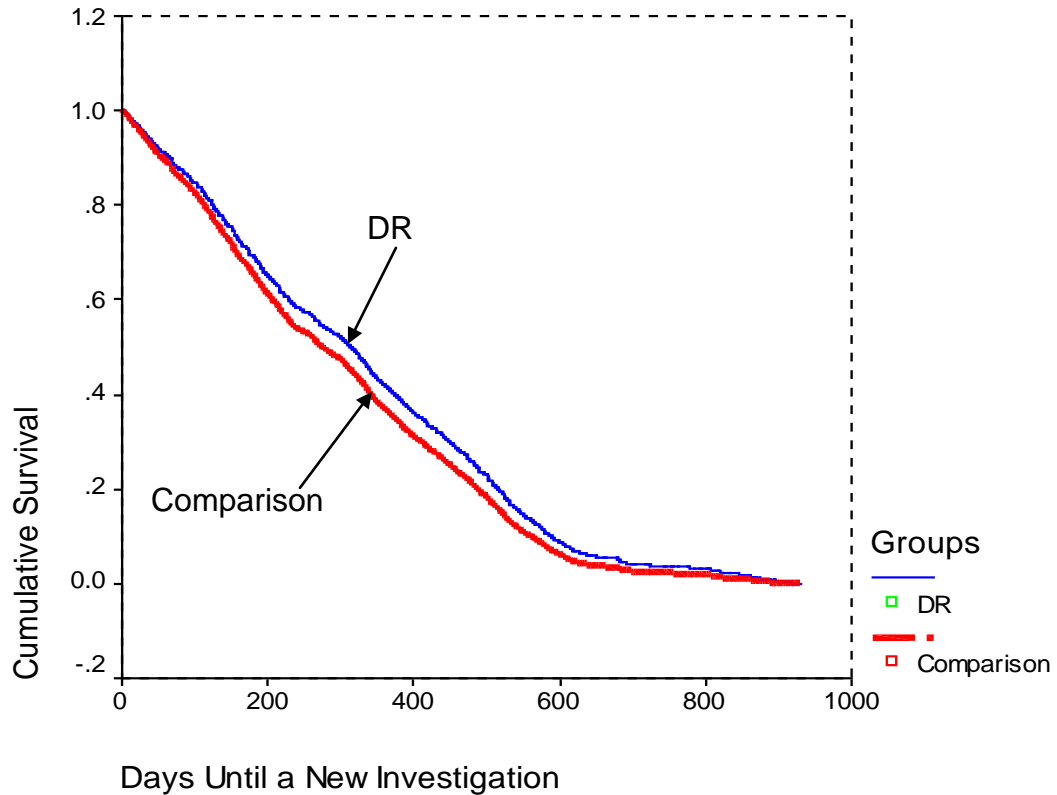
**Figure 36. Percent of DR and comparison families with previous and subsequent investigations**

**Survival Analysis.** As noted above, the follow-up time within the DR group varied greatly for families, from over two years for some to less than a month for others. The perennial problem in comparing cases with varying periods of follow-up times is that it may not be a fair comparison. One can ask, for example, whether it is fair to compare the number of new investigations for a families followed for 2 months with those of a families followed for 24 months. Other things being equal, one would expect the 24-month families to have a greater likelihood of a new report than the 2-month family, specifically 12 times ( $24/2$ ) as great a likelihood. We achieved a certain level of equivalence in the average follow-up time: 309 days for comparison families versus 336 days for DR families. However, this does not fully solve the problem of varying follow-up periods.

Survival analysis is a statistical method for taking such differences into account. The specific method employed was proportional hazards analysis. The results of the analysis can be seen in **Figure 37**. In the graph, the survival line for comparison cases is lower, showing that comparison families have lower survival rates, that is, they had a greater number of later reports and the reports were received on average sooner than for DR families.

This analysis also included another covariate: past investigations for child abuse and neglect. Among families (whether DR or Comparison) with no previous investigations for child abuse or neglect, 9.2 percent had a later investigation. On the other hand, among families with one or more previous investigations, 21.0 percent had a subsequent investigation. Introduction

of the past investigation variable into the analysis was essentially a way of forcing the DR and comparison families to be equivalent in terms of past investigations. This procedure strengthens the validity of the comparison. In statistical terms the analysis shows that, controlling for any differences in past investigations of child abuse and neglect, DR families received fewer subsequent investigations. The analysis showed that the DR families in this comparison were significantly less likely to receive a new report (Wald = 7.8,  $p = .0052$ ).



**Figure 37. Cumulative survival of DR and comparison families until a later CPS investigation**

DR families had slightly fewer later substantiated investigations as well, but this difference was not statistically significant. Future analyses will focus on this and on differences in the total number of reports, including IO and IR dispositions, where a positive trend has been found.



## Part 9. Summary, Conclusions and Considerations

This is the second evaluation report of the Nevada Differential Response program. The program was initially implemented in two service zones in Clark County in February 2007 and operates now in most populated areas of the state. The Nevada model is unique among states with DR programs due to the involvement of Family Resource Centers. Only Nevada employs such community organizations entirely for the family assessment track, from start to finish. FRC's have dedicated DR staff who are responsible for all aspects of family assessment cases, from initial safety and risk assessment, to the provision of services, to closing the case.

DR selection criteria were broadened and simplified during 2009. With the change, any report that is classified as Priority 3 and does not involve a child under 6 may be referred to an FRC for a family assessment. Priority 3 reports are those judged to have no immediate or potential safety risks to children. Typically such reports involve educational neglect, environmental neglect (dirty or unhygienic house), physical or medical neglect, improper supervision or inappropriate discipline with non-severe physical harm. Before the criteria change certain reports were not allowed to be referred for a DR-family assessment 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. State statute continues to require an investigation of any report in which a child younger than 6 is identified as a possible victim of abuse or neglect.

The change in DR selection criteria should be expected to increase the proportion of reports that are referred to FRCs for a family assessment. This proportion increased somewhat during 2009, with 8.8 percent of all reports referred for family assessments; this is up from 6.6 percent at the end of the first program year. This rise in percent of reports screened for DR comes mostly from rural counties where higher percentages of reports are being referred to FRCs for family assessments than is the case in the two urban counties. Overall, however, it is what happens in Clark County, where 70 percent of the state's residents live, that impacts state figures the most, and the percent of reports selected for DR-family assessments in Clark remains low (5.7).

Child maltreatment is not an isolated phenomenon but found within all types of families. However, an analysis of Nevada CPS families shows that, as in most states, the state's child protection caseload is filled with large numbers of poor and working poor families. The household heads of these families are often single parents, frequently single mothers; many have limited education and limited means, are often unemployed or work in the secondary labor market at low-paying temporary or part-time jobs; and many live in temporary homes with a

household membership that changes with some regularity. These are not the only families encountered by CPS, but they are overrepresented in the child protection system. This means that CPS workers not only encounter families with difficult issues related to the care and treatment of their children but families that often face serious, often chronic life situations that are both complicated and complex. It is the very nature of the problems many of these families have that make them appropriate for the differential response.

Results of family surveys indicate that the response to FRC family assessments is quite positive. The level of satisfaction we are seeing among Nevada families compares very favorably with what we have found in other states where we have evaluated DR programs. This includes Missouri, the first full effort to install a two-tack system, Minnesota, whose program has become the model many states have begun to emulate, and Ohio, where the DR pilot study is nearing its conclusion. At least part of the explanation for the positive family response in Nevada appears to arise from the reliance on community organizations to conduct family assessments. FRC workers bring a fresh, supportive, social worker perspective to their encounters with families.

Based on reports of families as well as workers, it appears the DR model has been implemented as intended. Families report that they are being treated in a friendly manner and are involved in decisions being made about them and their children. Families say that DR workers listen to what they have to say and try to understand their situations, problems and needs. Workers report most families cooperate with them. Both families and workers report that about two-thirds of DR families have received some services or helpful assistance that address their problems and predicaments.

As part of the evaluation, outcomes for DR families are being compared to outcomes of a matching group of families who have received a traditional CPS investigation. Comparison families are chosen for their similarity to DR families in all characteristics available to evaluators. As of this report, outcome analyses indicate that, once their cases close, DR families have fewer subsequent reports that lead to investigations than matching families. There is a statistical trend suggesting DR families can be expected to have fewer subsequent reports of any kind. Very few families in either group have experienced the subsequent removal of a child from the home, and no differences have been detected in this as yet.

Site visit interviews with FRC DR personnel and CPS supervisors confirm that the DR program is operating successfully in regard to the families now served. FRC workers have a strong commitment to the philosophy of differential response and are vocal advocates for their families. CPS supervisors recognize the value of DR in providing support to those families that would not normally receive ongoing service through an investigative process. From the DR case

managers' statements, families appear to be responding well to differential response and are benefitting from the help.

At the same time, in a number of locations DR workers are being underutilized. This sometimes arises from a lack of timely communication between CPS agencies and FRCs about the status of current DR cases and/or the current caseload of DR workers. This is a situation that can be remedied easily by re-examining communication practices between CPS and FRCs in each location. Of greater concern is the underutilization of FRCs even after DR selection criteria have been broadened. None of the DR case workers interviewed in recent site visits to the state's urban counties reported carrying full case loads. The number of cases referred to DR varies throughout the year, but workers, especially in Clark County, say they have never held the maximum of 15 cases. Some of this, reportedly, is related to an overall drop in the total number of child maltreatment reports received. But whatever external factors may be at work, undertultization of DR workers is neither programmatically effective nor cost effective. This is problematic in a system with limited resources and a critical mission.

A secondary concern is the legal separation of the community-based DR programs and county/state child protection. Occasionally, cases referred to the community DR workers require that CPS become involved when the family cannot be located or initial contact is difficult. When DR workers encounter barriers to locating a family or obtaining certain information, they are unable to move the case forward until CPS steps in. Given that the relationship between CPS supervisors and the DR sites appears strong, contacting CPS for these types of barriers may be a minor obstacle. However, this is a legal barrier that, from the perspective of DR workers, is not conducive to prompt intervention. If possible, the procedures and authority for locating and interviewing a family should be streamlined for the DR sites.

The introduction of the differential response component of Nevada's child protection system is an important step in a positive direction. However, as pointed out in the previous evaluation report, it has also introduced certain anomalies. In a traditional investigation a report that is unsubstantiated is likely to be dropped from further agency action and many substantiated reports are viewed as not rising to the level of concern that prompts continued intervention. While improvements have been made through the Program Improvement Plan, some of this has been done through the reallocation of resources (such as IV-B) and has robbed Peter to pay Paul. Differential response, on the other hand, is designed to address a broader set of issues than just the immediate allegation and remediate conditions that undermine the future as well as the present safety of children. Ironically, more serious reports and reports involving very young children are less likely to receive the more comprehensive and service-oriented response.

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 that appears to produce improved outcomes. However, as implementation has unfolded, two issues have arisen. On the one hand, relying solely on FRCs for DR effectively limits DR to a relatively small component of the child protection system. On the other hand, current DR capacity, although limited, is not being fully utilized. The result is that many families who could benefit from DR do not receive it.

Given this, two courses of action might be considered. The first involves increasing utilization of DR workers through a more formal downgrading of some reports that are selected for investigations and transferring them, following the investigation, to FRC DR workers as family assessment cases. Currently, all referrals made to FRCs for a family assessment are done following the initial screening of incoming reports. There is no mechanism for track reassignment for a family assessment after the investigation has been conducted.

A model for this is the Wrap program operated by HopeLink FRC in the south service zone in Clark County. The goal of Wrap is to provide case management to families that have unsubstantiated cases but could benefit from additional support services. CPS refers families to Wrap who need and want help and voluntarily agree to participate. HopeLink staff see this program as an excellent way to assist families that could not initially be sent to the FRC as a DR referral but would have been good candidates for a family assessment. This includes, in particular, families with minor allegations but who have children under age six. However, the Wrap program is small, has limited funding and presently has only one part-time case manager. Still, this case manager experiences high demand for her services and carries a case load of 19—well above the average for DR workers. The success and popularity of the Wrap program suggests that there may be an advantage to allowing CPS investigators to downgrade Priority 2 reports (where there is judged to be a potential but not immediate safety threat) after making initial contact with the family. As the DR program is currently operating under capacity, DR workers could potentially take additional cases as referrals from CPS, ideally by way of a “warm hand off” from the investigator. This would allow a mechanism for reports to be serviced through DR that, by statute, are required to be investigated.

Maximizing the benefit of the DR model would involve embracing more fully the idea that not all families who need services also require formal court involvement. In the current system, investigators are likely both to close Priority 2 level cases that could benefit from short-term services and formally open cases that could be serviced effectively through a voluntary agreement. Many of the cases that initially seem to be more at risk, at a Priority 2 level and with small children in the home, are closed without short term support. To boost the potential of

differential response, community-based DR workers could be integrated more fully into the child protection system and utilized for the services they can provide.

The second course of action involves considering the expansion of DR by adding a family assessment component to current county and state CPS operations. This does not mean taking away DR from FRCs, but adding an in-house component to CPS. This was discussed in the previous evaluation report as a way to make DR a larger part of the state's child protection system. As long as DR is the sole responsibility of FRCs, financial and political realities will constrict its role and size within the state's child protection system. Adding a family assessment track to CPS would add function but not necessarily size to the existing system. The underutilization of FRC DR capacity described in this report is an added reason to consider this step. One factor causing fewer referrals cited by CPS supervisors during recent site visits was the reduced number of maltreatment reports overall. It would seem unlikely that CPS workers would refer away the need for some of their positions by sending reports elsewhere, whatever the perceived benefits of DR.

Beyond this, having the family assessment track operating within the same institutional environment as investigations has the potential to improve investigations by imbuing them 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 be served more effectively with a combination of investigatory and 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.

It would be possible, even preferable, to blend these two modifications into a single, revised system with a larger DR program. This would involve establishing a DR track within CPS and utilizing FRCs for ongoing involvement in family assessment cases, at least for Priority 2 reports. This would be similar to the approach employed successfully in certain county programs in Minnesota, California and elsewhere. But it would not and should not relinquish the valued role of Nevada's FRCs. Priority 3 reports could be handled as now, with immediate referral to FRCs.

The DR program has been operating for over two years in Nevada and much experience has been gained. Outcomes and feedback from families and workers have been very positive. CPS professionals have become comfortable with the approach and FRCs have mature DR programs. The structure exists for expanding the role of differential response. Expertise is available inside and outside the state to strengthen existing practice and guide program

development. Like Rome, well-built service systems are not built in a day, but they can only be built by continuing construction on the next hill.