Multiple Response System (MRS) Evaluation Report to the North Carolina Division of Social Services (NCDSS)

Submitted by
Center for Child and Family Policy
Duke University

June 30, 2009

Table of Contents

Executive Summary

At the request of the North Carolina Division of Social Services (NCDSS), the Center for Child and Family Policy at Duke University evaluated the Multiple Response System (MRS) reform for families reported to child welfare in the 10 MRS pilot counties and in 10 counties who started MRS in 2004 (wave 2 counties). The evaluation included data collection and analyses to address issues relating to child safety, timeliness of response and case decision, frontloading of services, contributory factors and implementation of key MRS family-centered strategies, specifically: the redesign of in-home services; Child and Family Teams; Child Welfare-Work First collaboration; and Shared Parenting. The study design combined multiple methods to assess the impact of these strategies on the two primary foci of child welfare practice: keeping children safe and providing services to families in order to prevent future problems.

For this evaluation, quantitative and qualitative analyses were performed using data from state administrative data systems and original data collected by evaluators. Data sources included Child Protective Services (CPS) reports, Services Information System (SIS) Data, focus groups with county DSS staff and other community-based organizations, Child and Family Team meeting surveys and caregiver telephone surveys. Interrupted time series analyses were used to examine changes in administrative data over time and at the point of MRS implementation. This type of analysis allowed evaluators to look for changes in the data level or trajectory that occurred at about the same time as MRS implementation began. To control for changes not related to MRS, the 10 pilot counties were compared with 9 matched controls. A second set of analyses examined pilot counties and 10 wave 2 counties to determine if MRS changes in pilot counties were replicated in wave 2 counties.

Major Findings

Dual Track Distribution of Assessments and Case Decisions

There was a significant shift overtime in the use of the Family Assessment track in both pilot and wave 2 counties with the sharpest increases occurring in the first twelve months of MRS implementation. Both county groups experienced a subsequent leveling off as they became more adept at utilizing this track.

The use of findings Services Needed and Services Provided (CPS no longer needed) remained relatively constant over time with very similar rates in both sets of counties.

Significant differences were found between pilot and wave 2 counties in their use of the findings Services Recommended and Service Not Recommended. Pilot counties were more likely to use the Services Recommended finding which may indicate improvements in family-centered practice evidenced by a greater numbers of families participating in voluntary services.

Child Safety

Child safety as measured by overall rates of assessment and rates of substantiated maltreatment, have not been adversely affected by the implementation of MRS.

Repeat assessments decreased following MRS implementation in both pilot and wave 2 counties.

Timeliness of Response

MRS temporarily disrupted the time to initial response in pilot counties. The slowed responding was minimal and short-lived, however, and has subsequently returned to previous levels. This effect was unique to pilot counties; no such disruption was found for wave 2 counties.

Timeliness of case decision for all counties has declined in recent years regardless of the date of MRS implementation.

Frontloading of Services

The data indicate that all counties have shown an increase in the number of frontloaded minutes over time.

Consistent with the findings in the 2006 report, increased levels of frontloaded services reduced the likelihood of a re-assessment within six months.

Contributory Factors

Administrative data indicate that across all categories (caregiver, child and household), domestic violence and caregiver drug abuse emerge as the two predominant contributory factors in child maltreatment cases.

The highest re-assessment rates occurred for cases where child physical disability, hearing impairment, or visual impairment were listed as contributory factors.

Child and Family Teams

Data obtained from focus groups with social workers, supervisors and community partners suggest that there are numerous positive outcomes associated with this key MRS strategy, however, there are also significant barriers to consistent implementation. Data from surveyed CFT meetings showed that respondents overwhelmingly agreed or strongly agreed that meetings adhered to model fidelity; that they were engaged in the process; they were satisfied with the meeting; and understood the purpose of the meeting. Development of strategies to overcome some of the barriers associated with CFT meetings would help to ensure more consistent implementation of this strategy.

Shared Parenting

Data obtained from focus groups and caregiver phone surveys indicate that when implemented, Shared Parenting is an effective tool in forging relationships between foster parents and birth parents.

Five of the twenty participating counties indicated that they were not utilizing Shared Parenting suggesting a need for additional support in helping counties to overcome the barriers associated with this MRS strategy and to reach full implementation.

Child Welfare-Work First Collaboration

Focus group and caregiver phone interview data suggest that Child Welfare and Work First are effectively collaborating through information/data sharing, collateral contacts, and joint case planning or case coordination in situations where there are mutual clients. It appears that the instances where families are involved with CPS and Work First concurrently are relatively few.

Redesign of In-home Services

Social workers and supervisors provided important feedback about the challenges associated with required case contacts as they relate to case load management issues. Focus group participants suggested a need for increased flexibility in case contact requirements until a more appropriate risk assessment tool is put into place. Additionally, it was suggested that counties improve processes for how cases are assigned.

Collaboration with Community Partners

Feedback from community partners obtained in focus groups suggests that participating counties are effectively collaborating with other agencies and community based organizations in serving the needs of families. Areas noted for improvement include the need for enhanced follow-up and greater clarity about what types of information can be shared with community partners to ensure strong collaborations continue.

Blended Case Loads

Focus group data suggests that while many social workers and supervisors believe blended case loads represent best practice, this structure has little support among these groups due to logistical, staffing and administrative challenges. The majority of families that participated in the caregiver phone survey supported the idea of one social worker for the life of a CPS case. These findings have important implications for improving family-centered practice and warrant further exploration and development of strategies to address the challenges associated with a blended case load structure.

Family Satisfaction/Experience

Family satisfaction with the overall CPS experience was gauged through caregiver phone surveys and the findings show that families expressed more positive feelings about their overall interaction with CPS later in the process as compared to initially. This may indicate that negative perceptions about the role of CPS are beginning to change.

Just over one-third of participating families indicated that they would not change anything about the way that CPS works with families.

Recommendations

The following recommendations are based on the findings from the administrative and qualitative data included in this report.

Practice/Policy Recommendations

- Provide mentoring and coaching opportunities for social workers in the implementation of CFT meetings including preparing and engaging families in the process.
- Increase the number of trained, dedicated CFT facilitators across the state.
- Encourage counties to develop more formalized agreements with community partners to ensure greater participation in CFTs by direct service providers.
- Increase accountability, supervision, and training in the implementation of Shared Parenting.
- Facilitate ongoing dialogue with counties on case contract requirements and case assignment procedures in an effort to develop new strategies for addressing the challenges associated with case load management and improve the quality of the contacts within in-home services.
- Facilitate ongoing dialogue about blended case loads that aims to address barriers and ideally increase the use of this structure among counties.

Supervision

- Enhance supervision and monitoring of social workers in implementing key MRS strategies.
- Develop a supervisor training curriculum that focuses on mentoring and coaching of social work staff.

Collaboration with Community Partners

- Encourage on-going outreach and education to community agencies and other stakeholders specific to MRS policies and practices.

Evaluation

- Continue evaluation efforts with a focus on: adherence to MRS standards and policies, the success of MRS strategies in improving child safety, permanence and well-being, and fostering continuous improvement.
- Work with counties to ensure more consistent data entry of the MRS tracking form (5106) including data on the transfer of cases from one social worker to another.
- Work with counties to ensure more consistent data entry of caregiver, child and household contributory factors (form 5104).
- Ongoing training and support for counties in utilizing existing queries within the Client Service Data Warehouse for the purposes of helping counties to track their own progress on key measures.

Multiple Response System (MRS) Evaluation Report to the North Carolina Division of Social Services (NCDSS)

Introduction

Purpose

This report presents the findings of the 2006-2009 evaluation of the Multiple Response System (MRS) reform of family support and child welfare services. As part of continuous improvement efforts, the North Carolina Division of Social Services (NCDSS) has supported ongoing evaluation to ensure that child safety is maintained, that families continue to receive timely response and needed services, and that local human service agencies are working together to accomplish these goals. In 2004, at the request of NCDSS, the Center for Child and Family Policy (CCFP) undertook a comprehensive evaluation of MRS to examine these issues. The initial findings were presented in report dated June 30, 2006. As a continuation of those efforts, the current evaluation examined MRS as implemented in twenty counties across North Carolina. The selected counties included the 10 MRS pilot counties (Alamance, Bladen, Buncombe, Caldwell, Craven, Franklin, Guilford, Mecklenburg, Nash, and Transylvania) and 10 sample counties selected from the 42 second wave counties (Alexander, Brunswick, Chatham, Durham, Harnett, Haywood, Iredell, Jackson, New Hanover, and Pasquotank). The evaluation focused on the following dimensions of MRS reform:

- Case distribution: choice of two approaches to reports of child maltreatment,
- Safety: rates of assessment and repeat assessment,
- Timeliness of response and case decision,
- Frontloading of services,
- Contributory factors,
- Redesign of in-home services,
- Implementation of Child and Family Teams,
- Collaboration between Child Welfare and Work First,
- Shared Parenting activities,
- Feedback from families.

This report describes the quantitative and qualitative sources and methods used to assess these aspects of MRS reform, present the findings in each area, and makes recommendations based on the conclusions.

Evaluator

The Center for Child and Family Policy at Duke University conducted the evaluation of the Multiple Response System to families reported for child maltreatment.

The Center for Child and Family Policy (CCFP) brings together scholars, policy makers, and practitioners to solve problems facing children in contemporary society by undertaking rigorous social science research and then translating important findings into policy and practice.

Kenneth Dodge, Ph.D., who has served as the Principal Investigator for this evaluation, is the William McDougall Professor of Public Policy, Professor of Psychology and Neuroscience, and the Director of the Center of Child and Family Policy at Duke. For the past 25 years, Dr. Dodge has published over 250 scientific articles and has been the PI on research grants totaling over 35 million dollars, several involving multi-site collaborations. He is the recipient of a Senior Scientist Award from the National Institute on Drug Abuse to study the development and prevention of drug use in youth. Most recently, he has been concerned with translating knowledge from prevention science into effective public policies for children, youth and their families.

The evaluation team included staff members of CCFP with expertise in the areas of data management, statistics, project coordination, and program evaluation. Nicole Lawrence, M.P.P.A., assisted by Anastasia Maddox, M.A. and Lorlita Spann, served as the Research Coordinator for this evaluation. Ms. Lawrence has more than 10 years of experience in program development and evaluation specific to programs and services designed for children zero to five and their families. Christina Christopoulos, Ph.D. provided oversight and consultation for the project. Dr. Christopoulos has more than 20 years of experience conducting research in the areas of prevention and intervention related to antisocial behavior and child abuse. Adele Spitz Roth served in an advisory capacity for this evaluation. Spitz Roth has over 20 years of experience in organizational, systems and project management in health and human services delivery systems. Shayala Williams, M.P.H., served as the statistician for this evaluation. Katie Rosanbalm, Ph.D., provided statistical supervision. Dr. Rosanbalm has worked as a program evaluator and statistician for numerous state and federally funded initiatives and research studies, including statewide pilot implementation of previous DHHS programs in North Carolina. Claire Osgood, assisted by Matt Edwards, was responsible for the data management and programming needs for this evaluation. Together, they have over 20 years of experience in data management, programming, and technical report writing.

Background

North Carolina's Multiple Response System (MRS) began with a mandate by the North Carolina General Assembly (Session Law 2001-424, Senate Bill 1005, "Appropriations Act of the General Assembly"). This mandate required that the North Carolina Division of Social Services pilot an alternative response system for child protection with selected reports of suspected child neglect. Ten pilot counties began preliminary field-testing of MRS in 2002, and implementation in those counties began in earnest in January 2003. MRS was expanded to 42 additional counties in 2004 (wave 2), following the passage of legislation in mid 2003 that increased the number of counties allowed to implement an alternative response system in child protection. As of January,

2006, all one hundred North Carolina counties are implementing the Multiple Response System.

MRS Strategies: A Family-Centered Approach

The Multiple Response System reform aims to increase family involvement in assessment and planning to address child welfare concerns and prevent future harm to children. The goal is to respond not only to the specific incident that brought a particular family to the attention of DSS, but to understand and address the broader spectrum of needs that might have undermined the caregivers' ability to parent effectively. Using a team approach, social workers work with the family to explore these needs and identify the available strengths and resources that will help them improve their lives and better care for their children. The MRS assessment process sets a more cooperative tone and is designed to be more open and transparent than the traditional forensic assessment. The purpose is to engage the family and gain a more complete picture of their circumstances so that appropriate assistance can be offered and concerns remedied. When services are deemed necessary, the case planning process includes strategies to facilitate family participation and cooperation. When placement of children outside the home is required, MRS reform extends to the relationship between foster and birth parents, promoting interaction that supports a more seamless transition of childcare and reunification as soon as possible.

North Carolina's Multiple Response System policies outline seven key strategies for carrying out a family-centered approach to child protection, including:

1. A strengths-based, structured intake process. Emphasis is placed on family strengths along with needs. Includes structured intake tools with consistent screening criteria for identifying child abuse, neglect, and dependency reports.

2. A choice of two approaches to reports of child abuse, neglect, or dependency. Allows a differential response to child neglect and dependency reports that provides a more tailored approach for each family, facilitating a partnership among local agencies and communities to address all needs of the child and family. Definitions of the Family and Investigative Assessment Tracks and their respective findings follow:

> A **Family Assessment track** is followed for dependency cases and cases of suspected neglect that might be better served by service delivery than by an investigative response. Social workers and supervisors may however, choose to place a neglect or dependency case into the Investigative Assessment track if they feel that this approach is needed to ensure the safety of the children. The Family Assessment track follows a strengths-based approach that attempts to engage the family in determining needs and finding solutions. By accessing extended family and community resources and facilitating a team approach to address identified needs, the Family Assessment track aims to stabilize the family and enable the parents to better care for their children. Initial interviews of parents and children are scheduled with the parents, parents are informed about collateral interviews, and no perpetrator is identified. This track focuses on total child well-being,

assessing all of the family's needs, rather than solely investigating a specific reported instance of neglect.

For the period evaluated there are four possible findings following a Family Assessment:

(1) **Services Needed**, indicating that child protective services are required;

(2) **Services Recommended**, indicating that services are voluntary but recommended;

(3) **Services Not Recommended**, indicating that no service need has been identified.

(4) **Services Provided, Child Protective Services No Longer Needed**, indicating that appropriate services were provided during the assessment phase and Child Protective Services intervention is no longer needed. This finding option was added in February 2006 to address ambiguity in how counties recorded situations when services were provided during the assessment period and were no longer needed at the time of case decision.

An **Investigative Assessment Track** continues to be followed for cases requiring an investigative response, including all reports that meet the definition of abuse as well as the following special types of reports:

- Abandonment
- A child fatality when there are surviving children in the family
- A child in custody of local DSS, family foster homes, residential facilities, child care situations, and reciprocal investigations
- A child taken into protective custody by physician or law enforcement, pursuant to N.C. General Statue 7B-308 & 500
- The medical neglect of disabled infants with life threatening conditions, pursuant to Public Law 98-457 (Baby Doe)
- A child hospitalized (admitted to hospital) due to suspected abuse/neglect.

Following an Investigative Assessment, there are two possible findings:

(1) **Substantiated**, indicating that the reported incident occurred and child protective services are required, or

(2) **Unsubstantiated**, indicating that the reported incident cannot be proven, though services may be recommended if a need is identified.

Both assessment approaches (Family Assessment and Investigative Assessment) are family-centered and work with families to meet the safety needs of children.

3. Coordination between law enforcement agencies and child protective services for the Investigative Assessment approach. County Departments of Social Services continue to work closely with law enforcement agencies, particularly in investigating and, when appropriate, prosecuting cases on the Investigative Assessment track. The development of formal Memoranda of Agreement facilitates this process.

4. A redesign of in-home services. Redesign allows for a continuum of services of varying intensity depending on the needs of the family and the concerns for safety of the children. This continuum addresses the three core child outcomes of safety, permanence, and well-being. Family involvement, cultural relevancy and individualization of case plans are priorities of the redesign.

5. Implementation of Child and Family Team (CFT) meetings during the provision of in-home services. Child and Family Team meetings are used as a part of in-home services to bring all involved agencies, community and/or family resources and supports to the table. A CFT is a group of people who have been identified by the parent and social worker who work together as a team to assist in achieving the desired outcomes for their children and families. The common threads of this group are that everyone knows the family (possibly in different contexts) and can honestly discuss the situation, identify needs, problem-solve, and reach consensus on a service plan. A Child and Family Team meeting is a process that occurs "with," not "about," the family.

6. Implementation of Shared Parenting meetings and activities in child placement cases. When a child is placed in foster care, a Shared Parenting meeting is held within seven days for the social worker, birth parents, and foster parents to discuss the care of the child. Ongoing interaction is encouraged between the birth and foster parents to enhance the child's care, to facilitate mentoring of caregivers, and to improve chances for family reunification.

7. Collaboration between Work First Family Assistance and Child Welfare. Child Welfare works closely with Work First Family Assistance programs to share information, coordinate planning with families, and provide financial, employment, and community services to caregivers to help them become self-sufficient and prevent future child maltreatment.

The elements that cut across these seven strategies include:

- Family involvement in all phases of intervention
- Focusing on family strengths
- Respect for families' values and cultural traditions
- Individualized/targeted services to address needs
- Providing assistance earlier to reduce risk
- Collaboration with other agencies and community partners
- Mentoring of parents
- Promoting safety through greater cooperation.

Although many of these elements had been known or partially incorporated into practice prior to the MRS reform, the initiation of MRS was meant to bring the pieces together, standardize them, and formalize them within the context of a cohesive family-centered approach to child welfare. This evaluation offers an opportunity to assess how far implementation has come and what impact the reform has had on children and families.

Method and Sources

The following sections describe the selection of county samples and the sources of data used for quantitative and qualitative analysis of MRS strategies. Quantitative data, drawn from administrative sources, were used to measure case distribution by track, child safety, frontloading of services, and timeliness of response and case decision. Qualitative data from focus groups, telephone surveys of families, and surveys of Child and Family Team meetings were used to assess the quality of implementation related to a number of strategies: redesign of in-home services, Child and Family Teams (CFT), Child Welfare-Work First collaboration, level of collaboration with community partners, blended case loads, and Shared Parenting. The focus groups were designed to solicit feedback from social workers, social work supervisors and community partners. The telephone survey data were used to gauge family satisfaction with MRS and assess the process. The CFT meeting survey was used to gain insight into key areas of CFT implementation from the different perspectives of those who participate in such meetings.

Selection of Counties

Administrative Data

For the quantitative analyses using administrative data, the pilot counties were contrasted with control counties that did not implement MRS until 2006.[1] Each pilot county was matched to a control county based on similarities in the following quantitative criteria:

- Total population
- Child population
- Reported rates of child maltreatment – all assessments and substantiated assessments.

Mecklenburg County does not have a comparison county. Due to its size and population, there is no county in North Carolina that can be appropriately matched with Mecklenburg. Therefore, for the purposes of analysis and comparison, only nine control counties were used.

[1] All of the control counties began implementing MRS in 2006. As a result, comparative analyses only incorporate data through the end of 2005.

Note that this method of evaluation (contrasts between pilot and control counties over time) cannot provide the most rigorous analysis possible of the effects of MRS because alternate interpretations of findings will always be plausible. Changes across time may be due to some other important event (such as a change in the economy) rather than the introduction of a new system. Differences between the MRS counties and their control counties may be due to intrinsic characteristics that led the MRS counties to be selected in the first place (such as readiness for reform) rather than the MRS system. This is known as selection bias. A true experiment with random assignment of counties would be needed to provide a more rigorous test of the effects of MRS.

One way to assess the impact of selection bias is to look at the effects of MRS in a second group of counties. If selection bias is not responsible for identified effects in pilot counties, then one would expect later adopters of MRS to show similar changes after MRS implementation. To compare pilot findings with those of later MRS adopters, wave 2 counties were added to the current analyses. The 10 wave 2 counties were selected from the 42 that began MRS implementation in 2004 using a stratified sampling method accounting for geographic location within the state, county size, child population and assessment rates.

Original Data

During the 2006-2007 fiscal year qualitative data collection including focus groups and family phone interviews were completed in each of the ten pilot counties. Similarly, in the 2007-2008 fiscal year data collection occurred in the selected 10 wave 2 counties, all of which began MRS implementation in 2004. Child and family team meeting surveys were added to the evaluation in 2007-2008 and therefore data from the pilot 10 counties are not available for that measure.

Data Sources

Data for this evaluation were assembled from state data systems and through original data collection as described below.

Child Protective Services (CPS) Reports

The North Carolina Department of Health and Human Services (DHHS) collects data regarding accepted CPS reports of child maltreatment from each county. The data from these reports are entered into the Central Registry and stored in the Client Services Data Warehouse. Data for 10 pilot counties, 9 control counties, and 10 wave 2 counties were extracted from the Data Warehouse, providing information on individual children that included report and assessment dates, the type of maltreatment reported, and the case finding. Additionally, data collected by counties and reported on the 5106 form (Multiple Response System tracking form) were also extracted from the Data Warehouse and used in analyses where the amount of available data was sufficient to do so. See Appendix A for a detailed description of the CPS report data used in this evaluation.

Services Information System (SIS) Daysheet Data

Like the CPS reports, DHHS provides SIS Daysheet data via the Client Services Data Warehouse. These data include information about the type of social service provided for each case, as well as the number of minutes that the service was provided. Data for 10 pilot counties, 9 control counties and 10 wave 2 counties were extracted from the Data Warehouse, providing information on dates of service and the number of minutes of service for children with CPS assessments. See Appendix A for a detailed description of the SIS Daysheet data used in this evaluation.

Focus Groups

Sixty focus groups were facilitated in 20 counties including 10 pilot and 10 wave 2 counties. Each of the counties accommodated three separate focus groups that included social workers, community partners and supervisors. Each group was scheduled for approximately 1.5 hours and was comprised of an average of 15 participants. The key areas addressed during the focus groups include: 1) collaboration/interface between CPS and Work First, 2) Child and Family Teams – quality and impact, 3) redesign of in-home services, 4) Shared Parenting, and 5) practice variations in social worker assignment – keep or transfer cases after case decision is reached. The guiding questions used to facilitate the focus groups are available for review in Appendix C.

Child and Family Team Meeting Surveys

In an effort to further understand variations in the implementation of Child and Family Team meetings, CCFP utilized a revised version of an existing survey tool that is part of the ongoing System of Care evaluation. The survey was designed to examine multiple factors related to CFT meetings including fidelity to the model, level of participation, satisfaction, and knowledge of the process/purpose. The survey tool was administered by the participating counties at the end of CFT meetings during four specified months within the fiscal year. Counties were instructed to request that the survey be completed by all meeting participants including parents, relatives, children, DSS staff, court staff, school staff, mental health staff and community agency representatives. A total of 343 CFT meetings were surveyed yielding 1,463 individual surveys. The survey tool is available for review in Appendix D.

Family Telephone Surveys

To gain additional feedback from caregivers, CCFP conducted a telephone survey with 411 respondents. CCFP requested that agency staff in all twenty counties (10 pilot and 10 wave 2) collect consent forms and contact information from caregivers willing to share their recent experience with DSS in a confidential telephone survey. Evaluators received a total of 890 consents from twenty counties. Three-hundred seventy-three consents were excluded for various reasons including disconnected or wrong numbers, respondent refusal to participate, or incorrect/inappropriate respondent (e.g., contact information was for kinship care providers). Of the 517 remaining consents, 72% were

successfully contacted and participated in the survey. In a 15 to 30-minute telephone interview caregivers were asked about their involvement with DSS, including how the social worker treated them, what services they received, whether their ideas were incorporated into plans, whether the help they received improved their parenting, overall level of understanding about MRS and satisfaction with the interaction. The telephone survey protocol is included in Appendix E of this report.

Administrative Data

The following sections present the findings from the quantitative analyses of administrative data. For all administrative data, the fiscal year was used as the timeframe for analysis. In county groupings (e.g., pilot counties), each county contributes equally to the numbers reported in the analyses. For a full explanation of this process and detailed information on the analytic methodology and statistical findings, refer to Appendix A.

Dual Track Distribution of Assessments and Case Decisions

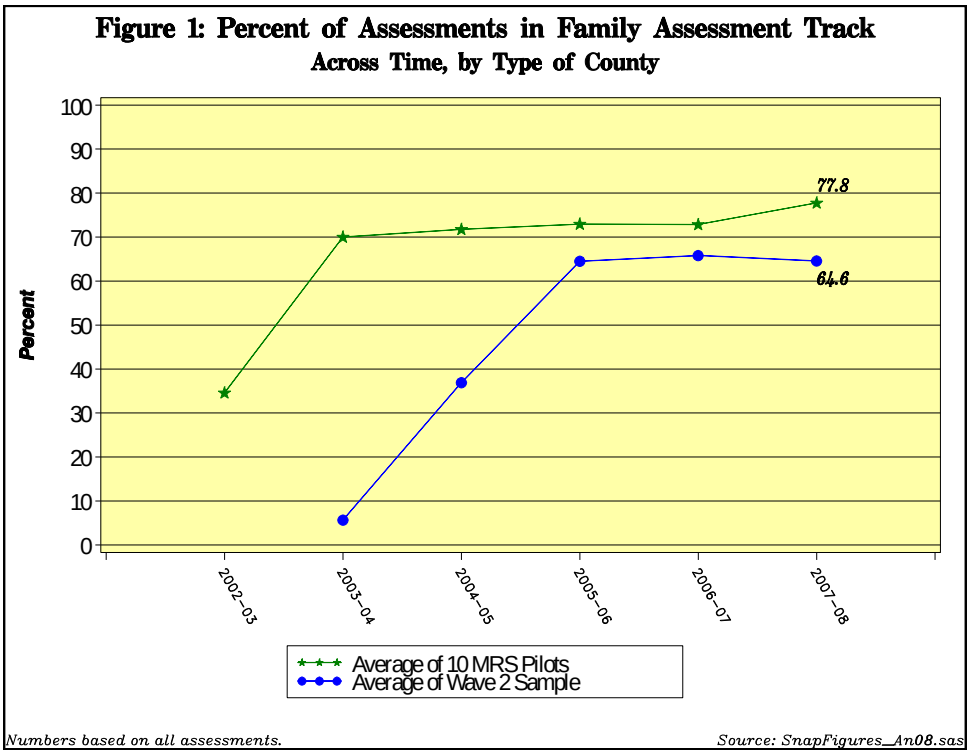
In 2002 and 2004, respectively, the 10 MRS pilot counties and 10 second wave counties implemented two major changes in their practices: 1) a dual response mode to assessments (Family Assessment vs. Investigative Assessment), and 2) a new system of case decisions for the Family Assessment Track (Services Needed, Services Recommended, Services Provided and Services Not Recommended). The Investigative Assessment Track continued to use the pre-existing case decision system (Substantiated vs. Unsubstantiated).

It is important to examine how these changes affect case flow over time. To that end, this section presents an overview of the distribution of assessments and case findings for the 10 pilot and 10 second wave counties.

Has the number of cases in the Family Assessment track changed over time as MRS has become more established?

Figure 1 shows the average[2] proportion of DSS cases handled in the Family Assessment track, comparing pilot and wave 2 counties over time.

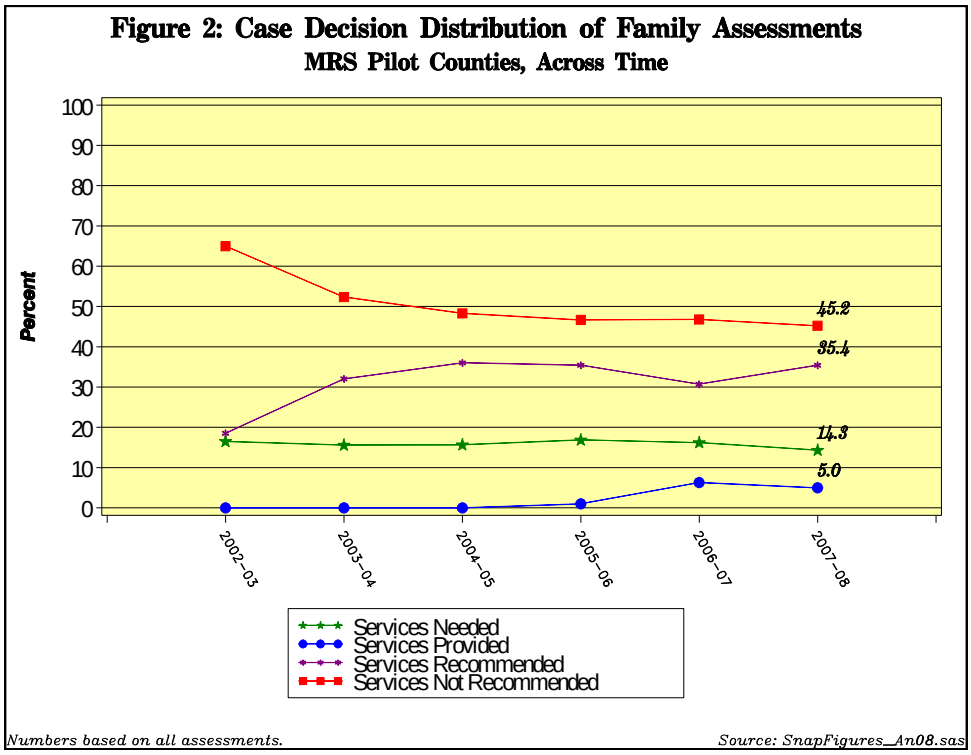
[2] In the body of the report 'average' is used as the equivalent of 'mean.' A mean is calculated as the sum of all observations, divided by the number of observations.

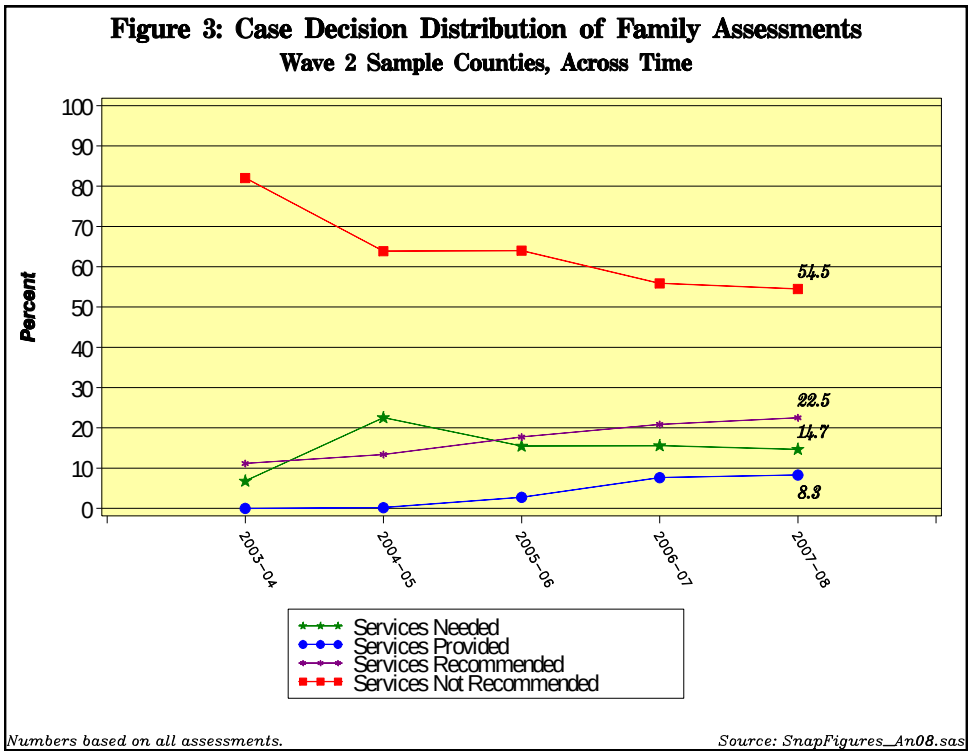


As would be expected, a significant shift was seen in the use of the Family Assessment track over time, with the sharpest increases occurring when counties were in the first twelve months of implementation. Both groups experienced a subsequent leveling off at around 70% Family Assessment cases as they became more adept at utilizing this track. Though both pilot and wave 2 counties showed a similar trend, pilot counties have consistently assigned a significantly higher proportion of cases to the Family Assessment track. This may be attributable to selection bias: those counties with the most interest in MRS were included in the pilot group, and thus may have more comfort with the Family Assessment track. The difference is not large, however, and is unlikely to have much impact on MRS functioning within these counties.

Has the distribution of case decisions in the Family Assessment track changed as MRS implementation has matured?

Figures 2 and 3 depict changes in the distribution of case findings within the Family Assessment track over time for the pilot 10 and wave 2 sample counties.



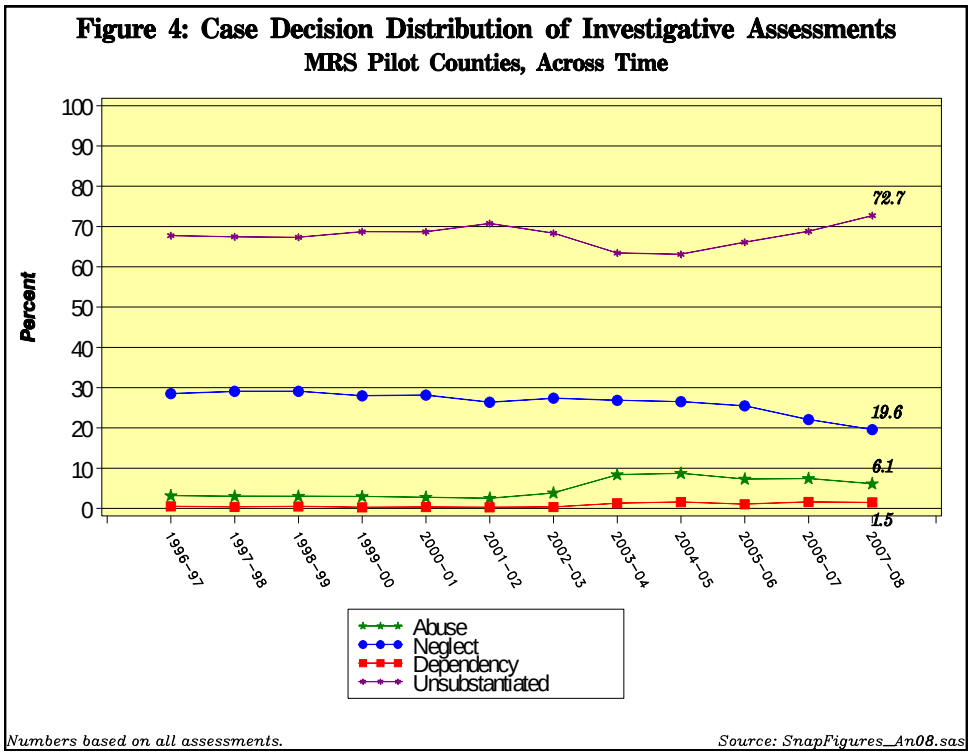


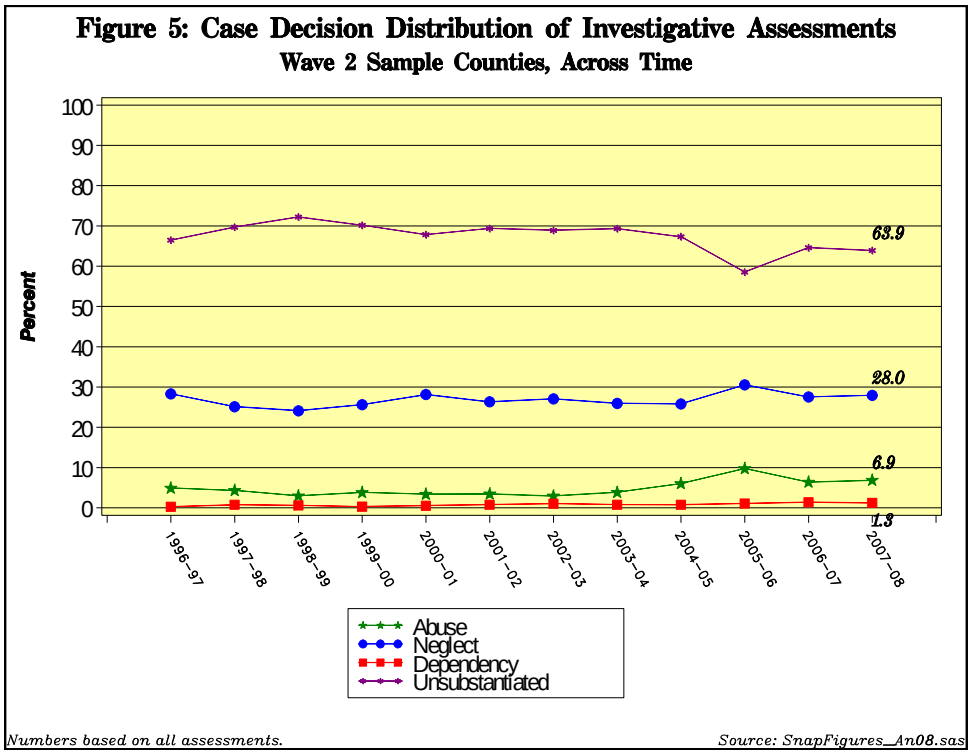
The use of findings Services Needed and Services Provided (CPS no longer needed) remained relatively constant over time with very similar rates in both sets of counties.

Notable are the significant differences in frequency of the Services Recommended and Services Not Recommended findings in pilot versus wave 2 counties. In wave 2 counties, over 54% of cases had a finding of Services Not Recommended in 2007-08, whereas only 22.5% of cases had a finding of Services Recommended. Pilot counties had a lower proportion of Services Not Recommended findings (45%), and instead were more likely to use the Services Recommended finding (35%). Growth in the Services Recommended category is an ideal outcome as workers continue to master the tenets of family-centered practice and expand the numbers of families who participate in voluntary services. Clearly wave 2 counties demonstrate a lower usage of the Services Recommended finding. This finding has a level of subjectivity, so usage differences may reflect variation in county-level norms or thresholds for parenting behaviors. Differences in the available service array may also affect the use of the Services Recommended finding, as counties with fewer resources may use stricter guidelines for referrals. More generally, discrepancies in usage of the Services Recommended finding may reflect differences in underlying comfort with MRS, which again is to be expected given the self-selection of the pilot counties.

Has the distribution of case decisions in the Investigative Assessment Track changed as MRS implementation has matured?

Figures 4 and 5 show the distribution of findings within the Investigative Assessment track.





The changes in case findings for the Investigative Assessment track were quite small over time, indicating that both pilot and wave 2 counties were able to maintain a fairly consistent use of investigations for more serious maltreatment cases. Both sets of counties showed slight changes in finding distributions immediately following MRS implementation. Specifically, the proportion of cases with abuse substantiations increased, while the proportion unsubstantiated decreased. This is an expected change as the absolute number of cases in the Investigative track decreased substantially. As less severe cases were transferred to the Family Assessment track, a higher proportion of the remaining, more severe, cases were substantiated. In recent years these proportions are returning to baseline, however, demonstrating a reduction in substantiations overall (as will be noted in the Child Safety section below).

Child Safety

The safety of children is a primary goal of NCDSS and therefore an important focus in the MRS evaluation. The ongoing concern has been whether the family-centered approach introduced by MRS will alter the likelihood that children remain safe in the future. Safety can best be measured by examining trends in rates of child maltreatment over many years. In examining data to assess child safety, the evaluators analyzed the rates of assessments, substantiations, and repeat assessments.

Similar analyses were conducted in the 2006 report, but have been enhanced to include additional years of data, the 10 wave 2 counties, and the use of interrupted time series analyses. Interrupted time series analyses are useful in examining longitudinal data

(data collected over a long period of time) when there is some change in policy or procedures at a given time point. The data are analyzed to see if there is a change in either the level or the trajectory of the data at the time of the policy change, or "interruption." For example, children's test scores might be tracked across a school year. Mid-year, their teacher might implement a new teaching method. The start of this new method is the "interruption" for the purposes of data analysis. If the new teaching method is effective, one would expect to see: (1) a sudden jump in child test scores following the date of implementation (i.e., change in "level" of the data), and/or (2) a gradual increase in test scores beginning at the time of implementation (i.e., change in the "trajectory" of the data). Either or both of these changes would show that students began improving their scores after the new teaching method was started.

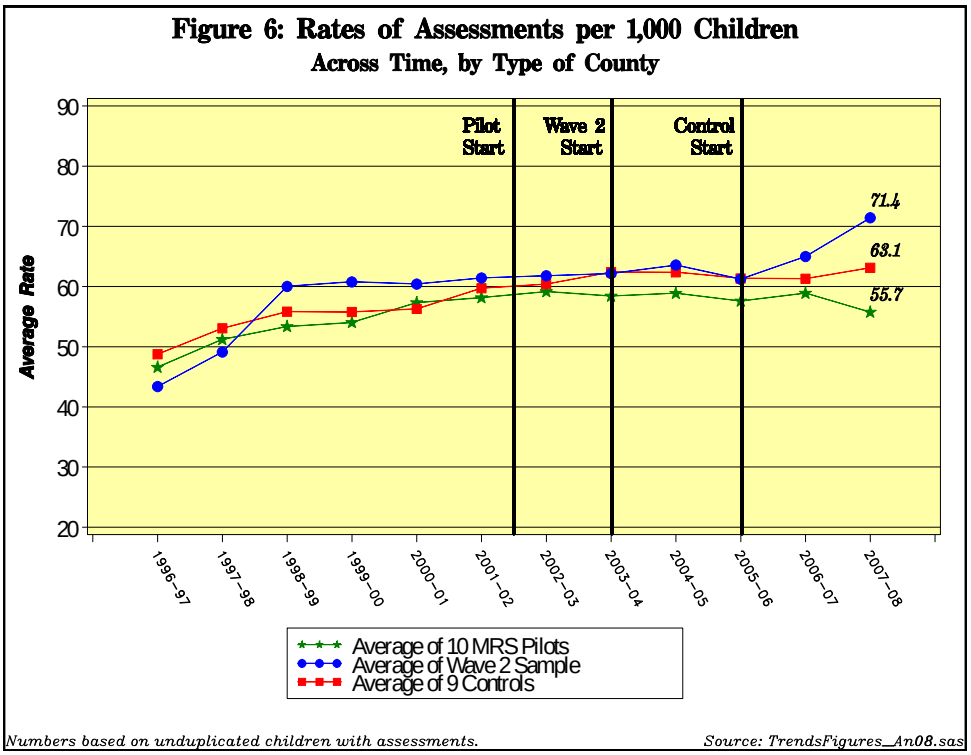
In the current evaluation, interrupted time series analyses were used to look for changes in data level or trajectory that occurred at about the same time as MRS implementation. To control for possible changes over time that are unrelated to MRS (e.g., changes in the economy), one set of interrupted time series analyses were conducted comparing pilot counties with their 9 matched control counties. These analyses show whether pilot-county data changed more than did control-county data. A second set of analyses examined pilot counties and wave 2 counties separately, to determine whether changes occurring with MRS in pilot counties were replicated in our sample of wave 2 counties. Data are summarized in the sections to follow, along with figures depicting average rates over time in each county group (with vertical lines to show the start point of MRS in each group). Detailed statistical findings and figures showing interrupted time series results are presented in Appendix B.

Has MRS altered child safety as evidenced by changes in the rate of assessments?

A primary measure of child safety is the rate of assessments. If MRS is impacting the system by creating a less safe environment for children, one would expect a greater number of children to be reported and assessed after MRS was initiated.

On the contrary, in pilot counties the trajectory for assessment rates declined following MRS implementation, going from a yearly increase pre-MRS to a more stable level after MRS began. A similar slope change was evident in the control counties and the wave 2 counties beginning mid-2002. The trajectory for wave 2 counties did not change in 2004 when MRS was implemented in those counties.

Looking at these data as a whole, it appears that all counties showed a leveling of assessment trajectories in mid-2002 whether they were implementing MRS or not. One possible explanation is the introduction of the state-wide structured intake process within the same year. It is unclear what other factors may have influenced this trend. Regardless, **there is no evidence that MRS decreased child safety across counties**. MRS has neither increased nor decreased overall assessment rates. There is a jump in assessment rates in wave 2 counties in the past year; this possible trend should be monitored to see if it continues or is a temporary increase. Pilot counties have maintained a stable trajectory (see Figure 6).

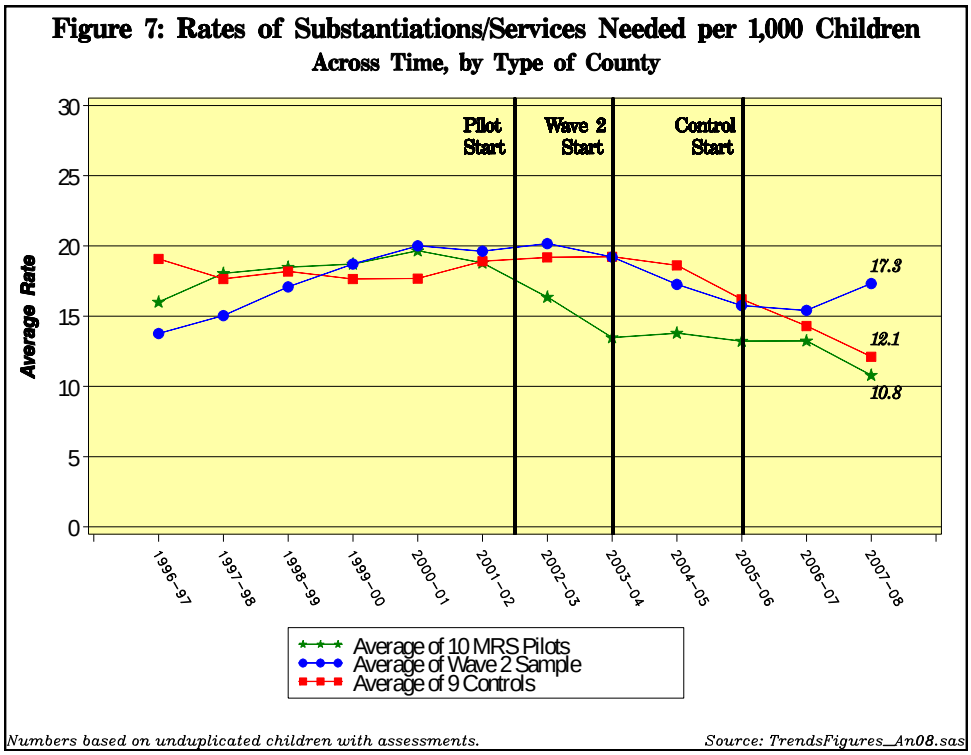


Did MRS alter safety as evidenced in changes in the rate of Substantiated Maltreatment and Services Needed findings?

Another measure of child safety is the rate of substantiations, acknowledging that substantiated maltreatment is arguably the most severe finding, and thus represents the children with the greatest safety concerns. If MRS with its family-centered approach creates a less safe environment for children, one is likely to observe an increase in the rates of substantiated maltreatment. Following the implementation of MRS, substantiation rates in these analyses include both findings of substantiated maltreatment (for the Investigative Assessments) and findings of Services Needed (for the Family Assessments).

Figure 7 shows the rates of substantiation over time in pilot, wave 2, and control counties. Following the implementation of MRS, the level of substantiations dropped significantly for pilot counties as compared to control counties. It is probable that this change is due to new definitions for case findings. For example, many families that would have traditionally been substantiated for neglect instead received services that sufficiently met their needs, and thus had findings of either Services Recommended or Services Provided (CPS no longer needed). Again, the structured decision-making process may have impacted this finding because it made case decision choices more standardized and clear. However, the change in rates occurred only in the MRS counties, and rates have continued to drop over time. Wave 2 counties also showed a trend of declining rates of substantiation after MRS implementation, though the slope was less dramatic. These

findings provide further evidence that **child safety was not adversely affected by the introduction of MRS, and indeed may have been enhanced**.

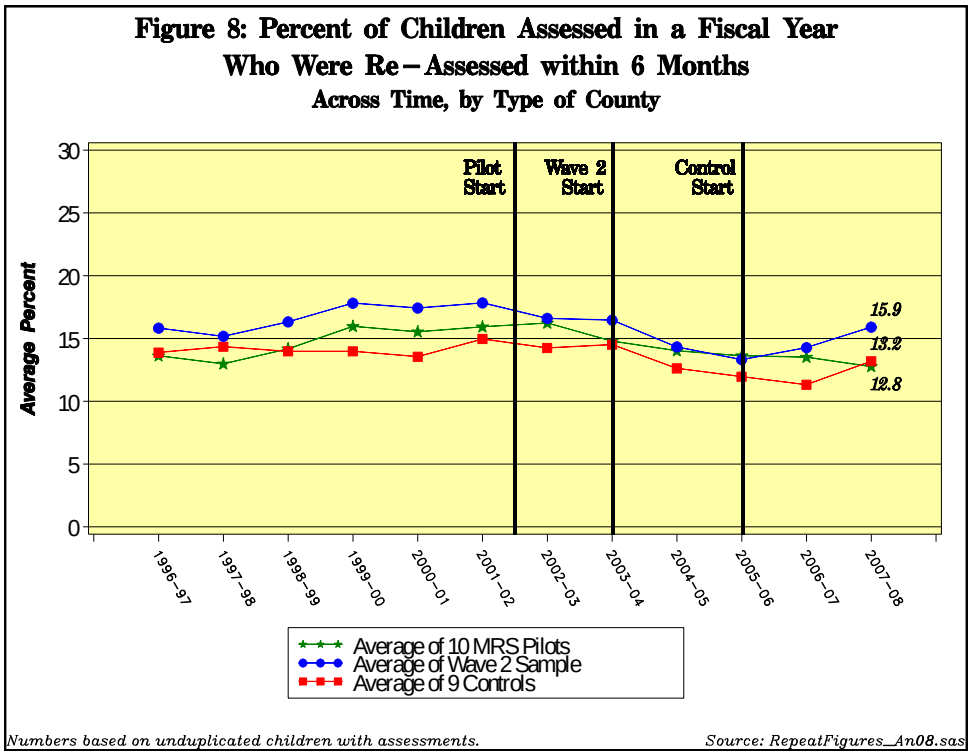


Did MRS alter child safety as evidenced by changes in the rate of repeat assessments?

Another measure to evaluate child safety is the rate of repeat assessments for children with previous CPS involvement. If the MRS system is not effectively addressing the safety and security needs of children and families, these children and families may return to the attention of CPS. The proportions of previously assessed children who returned to CPS within six months for another assessment were computed for the years preceding MRS and those after MRS implementation began.

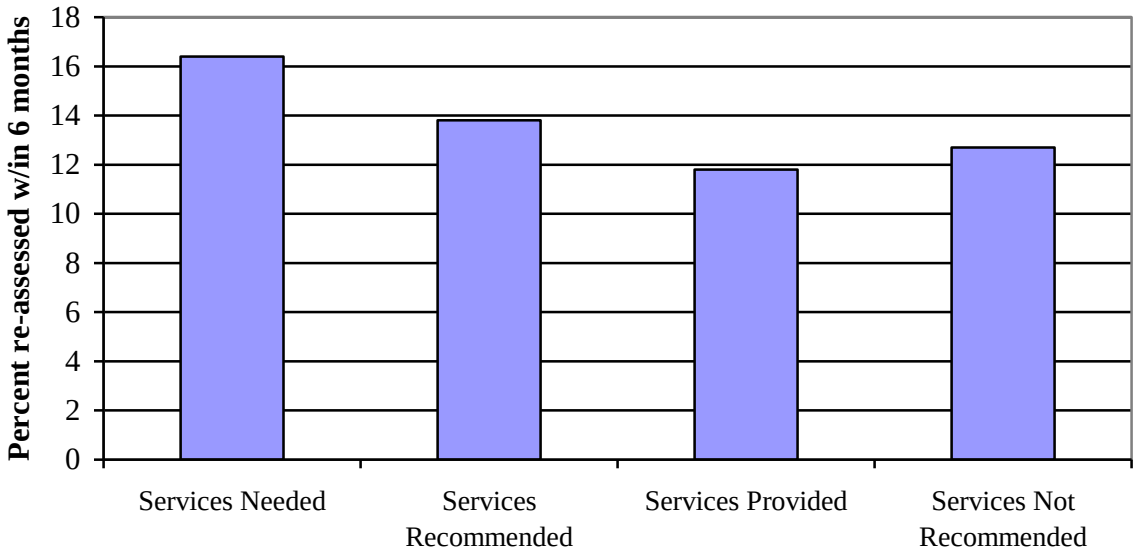
Figure 8 shows the rates of repeat assessments for pilot, control and wave 2 counties over time. The trajectory for repeat assessments shifted significantly after MRS implementation in the pilot counties. Relative to the control counties, pilot counties showed an increasing repeat rate prior to MRS, and a *decreasing* rate following MRS implementation. Similarly, wave 2 counties showed a drop in the average number of repeat assessments following MRS implementation. Though these percentage changes were not large, they were statistically significant and represent a large number of children across counties. Rather than decreasing child safety, these numbers suggest that **MRS is *improving* child safety by meeting families' needs at a level sufficient to keep them from returning to CPS with maltreatment concerns**. Only pilot counties have maintained this downward trajectory in repeat assessments in recent years, however, again

reflecting the enhanced effectiveness of MRS in counties with early enthusiasm for this child welfare reform.



To look even deeper into child safety with MRS, we examined the repeat assessment rate separately for each case finding within the Family Assessment track. It is possible that a finding of Services Recommended, where families are demonstrating some challenges but are not at a level severe enough for mandated services, would be given out too liberally. If this were the case, families with Services Recommended findings would be more likely to return to DSS with another maltreatment report. Looking at all cases within the pilot counties after the initiation of MRS, Figure 9 shows the repeat assessment rates for each Family Assessment finding.

Figure 9: Repeat Assessment Rate
by Family Assessment Case Finding



As may be expected based on the likely case severities, family assessments with findings of Services Needed were the most likely to return within six months with another report of maltreatment. Families with findings of Services Provided (CPS no longer needed) were the least likely to return for a second assessment within six months. These numbers suggest that the use of Services Recommended and Services Provided findings is not detrimental to child safety.

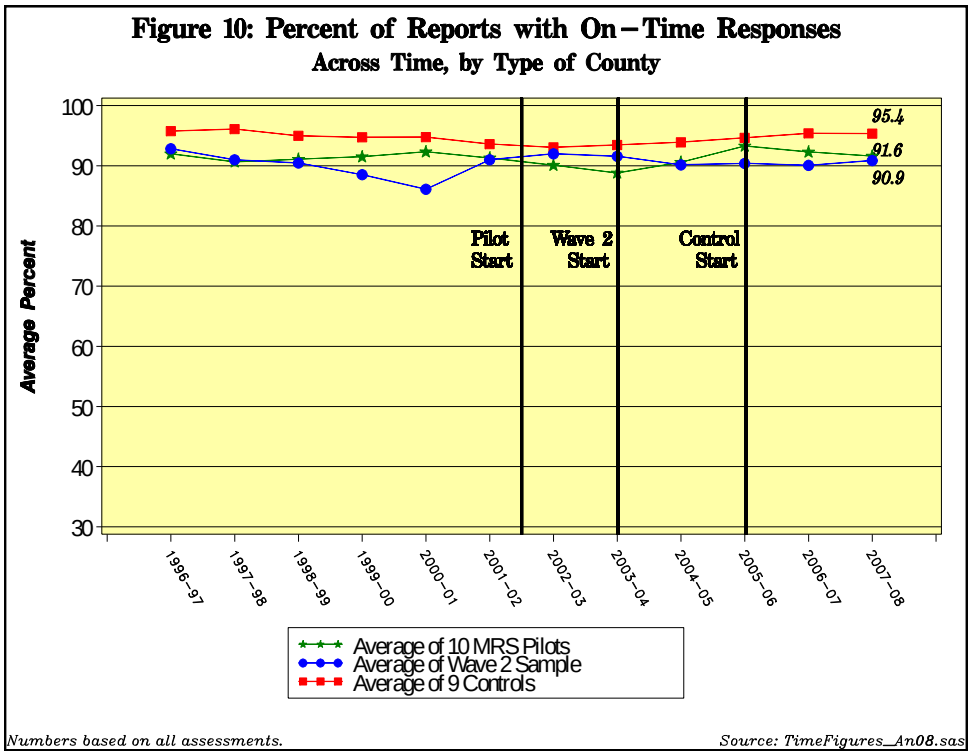
Timeliness of Response

A second concern with MRS implementation has been that changes in protocols will decrease the timeliness of initial case response and of overall assessment completion. To examine this possibility, analyses addressed both the length of time taken to initiate an assessment following a report of maltreatment and the length of time taken to reach a case decision.

Has MRS altered the timeliness of initial response to accepted reports of child maltreatment?

County Departments of Social Services are required to initiate a response within a maximum of 72 hours following receipt of an accepted report (dependent on the type of allegation). When a report is accepted for assessment, it is called a "case." The Priority Response Decision Tree tool is used for all accepted reports to determine if the required response time will be immediate, within 24 hours or within a 72 hour timeframe.

Again, using interrupted time series analyses, evaluators found that the timeliness of initial case response did drop significantly at MRS implementation as compared to control counties. In other words, **MRS temporarily disrupted the time to initial response in pilot counties**. The slowed responding was minimal and short-lived, however, and the rate of on-time responses has subsequently returned to previous levels. This effect was unique to pilot counties; no such disruption was found in timeliness of case response for wave 2 counties (see Figure 10).

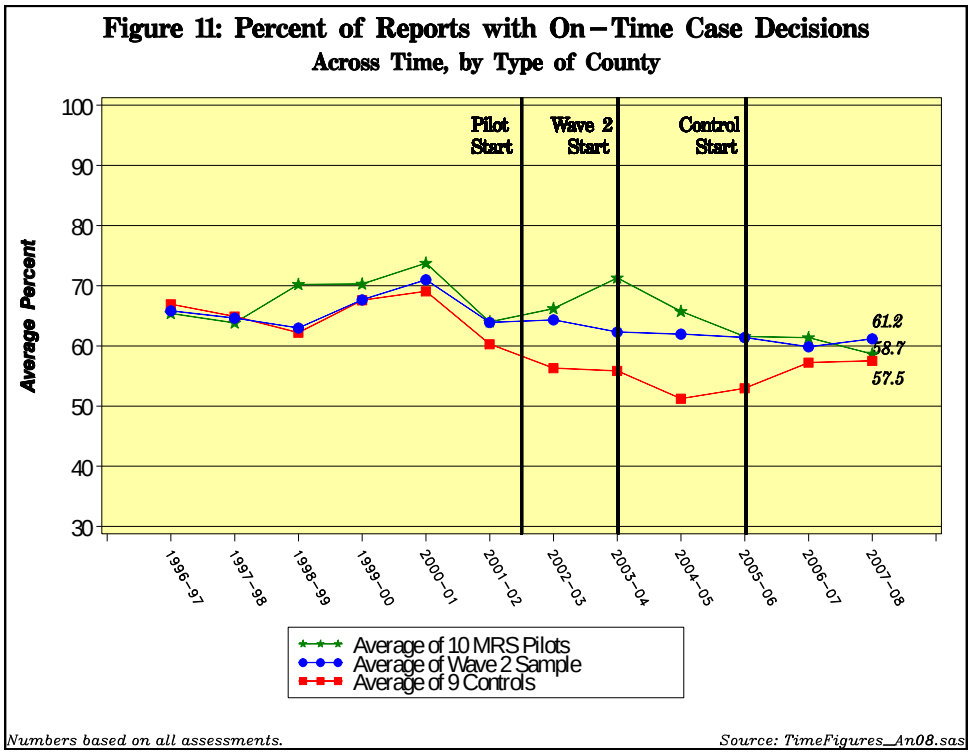


Has MRS altered the percent of on-time case decisions?

A second aspect of timeliness is the time taken to complete an assessment and to reach a case decision. Before the introduction of MRS, all counties were required to complete their investigations and to reach a case decision within 30 days from the report date. On August 1, 2002, a new policy was implemented for the Family Assessment track only. In order to allow social workers to put services in place during the assessment period without compromising child safety, the time frame for the completion of Family Assessments was extended to 45 days. Investigative Assessments were still to be completed within 30 days.

Figure 11 shows the proportions of cases for which case decisions were reached within their respective time requirements for each year from fiscal year 1996-1997 through fiscal year 2007-2008. Timeliness of case decision appears to have begun dropping just before pilot MRS implementation, regardless of county type. **MRS implementation, itself did not seem to result in any changes in timeliness of case decision for either pilot or**

wave 2 counties. A number of factors may have influenced this cross-county decrease in on-time case decisions, including increasing case loads and high levels of social worker turnover in many areas across the state. Additionally, focus on frontloading services may increase time spent in case assessment.



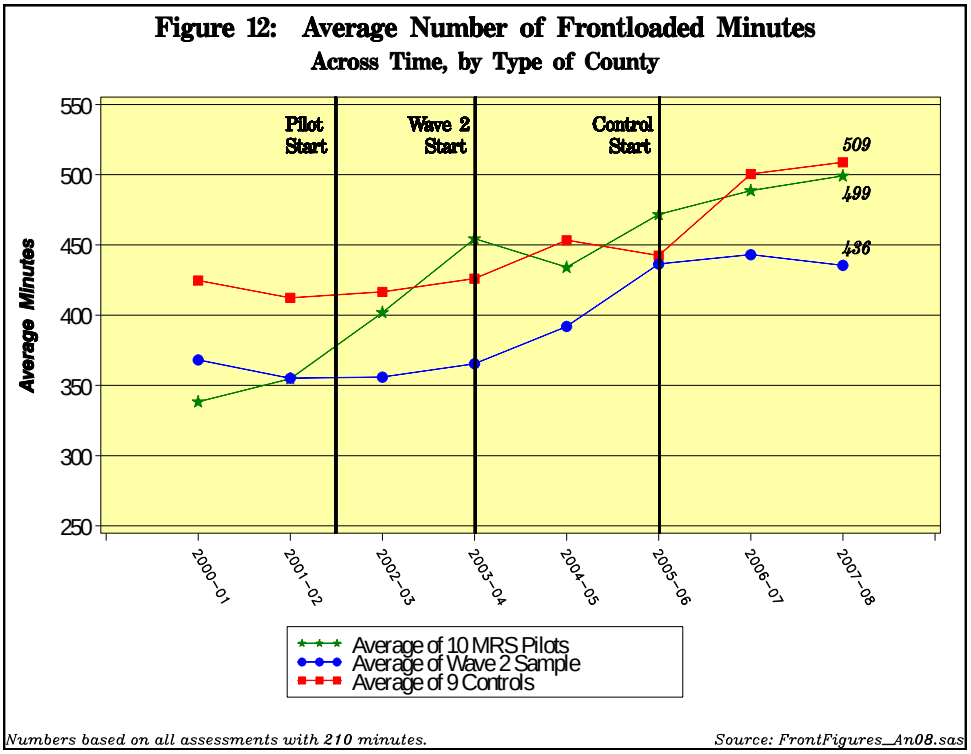
Frontloading of Services

One of the major premises of MRS is that a family should be offered services that will support their ability to keep their children safe and stable as early as possible in the process. The frontloading of services may effectively reduce the length of time that DSS is involved in the lives of families. For example, if a family is offered services early in the assessment process and those services effectively address the family's needs, the social worker and supervisor have the option to decide that no additional services are needed and that DSS no longer has to monitor the safety of the child. Of course, such a decision is always weighed against the risk to child safety and maltreatment re-occurrence. Again, interrupted time series analyses were used to examine trends associated with frontloading of services after the initiation of MRS.

For evaluation purposes, frontloading of services was defined as the number of minutes of services provided subsequent to an accepted report of maltreatment and before

a case decision was made.[3] The Services Information System (SIS) Daysheet records from the Client Services Data Warehouse were utilized in these analyses (see Appendix A). Minutes of frontloaded services were not available electronically from the Client Services Data Warehouse before the middle of 1999. Consequently all analyses were based on data beginning in 2000.

Figure 12 shows the average number of minutes of frontloaded services provided for each year from fiscal year 2000-2001 through fiscal year 2007-2008. Pilot counties showed a jump in the level of frontloaded minutes at the point of MRS implementation. As noted in the 2006 report, control counties were frontloading services at higher average rate than were pilot counties pre-MRS. It is unclear why frontloading was so discrepant in these counties initially, but the implementation of MRS in the pilot counties effectively increased the average number of frontloaded minutes to the same level found in control counties. MRS increased frontloading in wave 2 counties as well, with a clear shift in the trajectory of frontloaded minutes following MRS implementation. Overall, **MRS does appear to increase the frontloading of services**, and all counties have continued to increase frontloading over time.

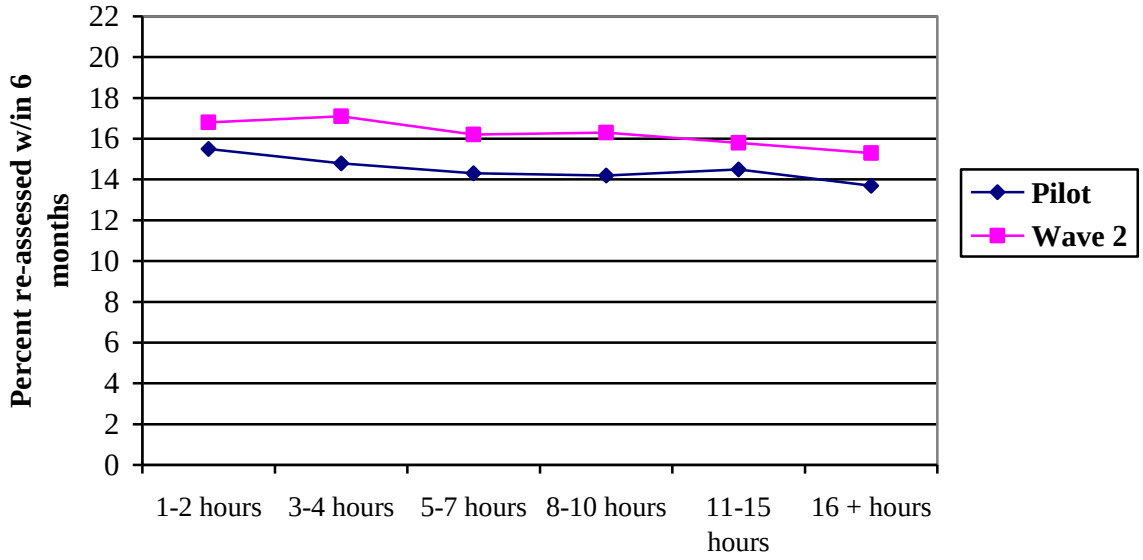


In the 2006 MRS evaluation, analyses suggested that the frontloading of services reduced the probability that a child would return to CPS for a re-assessment within six months of a report. In the current evaluation, this question was again addressed, focusing on pilot and wave 2 counties from fiscal year 2000-2001 to 2007-2008. Consistent with

[3] Frontloading minutes included both time spent in assessment activities as well as the facilitation of service implementation during the assessment period.

2006 findings, analyses showed that frontloading significantly decreased the probability that a child with an accepted report would return to CPS attention. In other words, **families that received more frontloaded services during their assessment were less likely to be re-assessed for maltreatment in the next six months than were families that received fewer frontloaded services**. This is true for both pilot and wave 2 counties, and both before and after MRS implementation. To demonstrate this effect, Figure 13 shows the probability of re-assessment associated with different levels of frontloading in both pilot and wave 2 counties following the implementation of MRS.[4]

Figure 13: Average Percent of Cases with Re-Assessments by Number of Hours of Frontloaded Services Received
Post-MRS, by Type of County



Contributory Factors

In 2006, after all 100 counties began implementing MRS, several data fields were added to the Central Registry to be collected on CPS cases. Among these were fields listing primary contributory factors at the caregiver, child, and household level. Contributory factors describe family characteristics that are thought to have contributed to child maltreatment, and should be entered for all cases that are given a finding of Substantiation or Services Needed.

A better understanding of the factors contributing to child maltreatment may be useful for service development and prevention activities. To get a broad picture of risk factor prevalence in North Carolina, data on contributory factors were collapsed across all

[4] Hour intervals are grouped so that the number of records is equally distributed across the categories.

three county groups (pilot, wave 2, and control) for cases with Substantiation/Services Needed findings from January 2006 through June 2008. Though all of these cases should have at least one contributory factor listed in the Central Registry, contributory factor data were identified for only 53.5%. This proportion of missing data is consistent across calendar years; experience in entering these data has not improved the entry rates over time.

Of those cases with contributory factor data available, 69.4% listed a caregiver contributory factor, 31.1% listed a child contributory factor, and 57.5% listed a household contributory factor (contributory factors may be listed in more than one category). Figures 14 through 16 show the prevalence of each type of contributory factor across counties. Across all categories, domestic violence and caregiver drug abuse emerge as the two predominant contributory factors in child maltreatment cases, emphasizing the ongoing importance of building the capacity and effectiveness of services in these areas.

Figure 14: Caregiver Contributory Factors
Across all Substantiated/Services Needed Cases
Pilot, Wave 2, and Control Counties, January 2006-June 2008

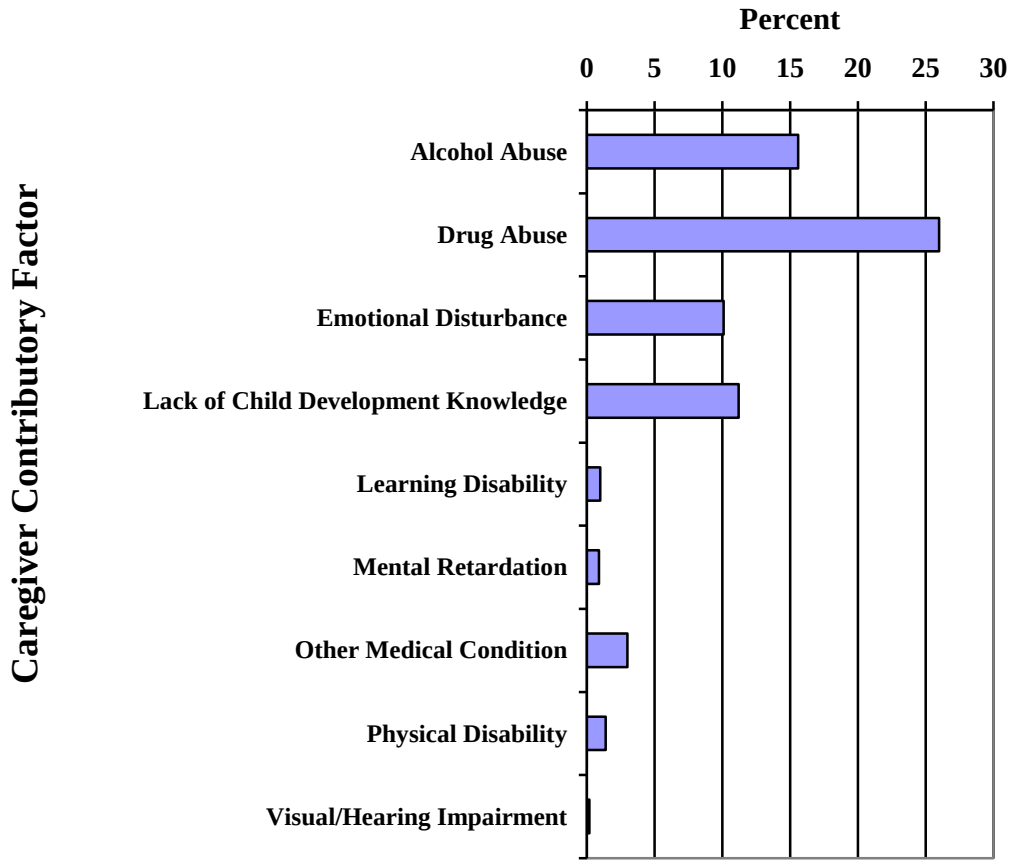


Figure 15: Child Contributory Factors
Across all Substantiated/Services Needed Cases
Pilot, Wave 2, and Control Counties, January 2006-June 2008

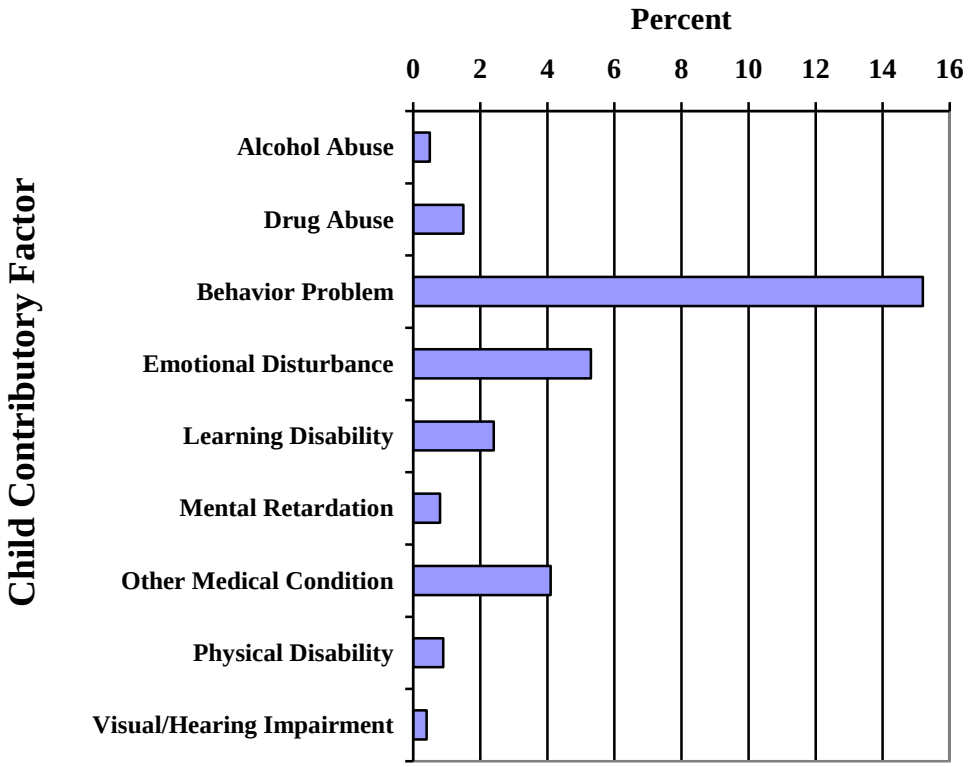
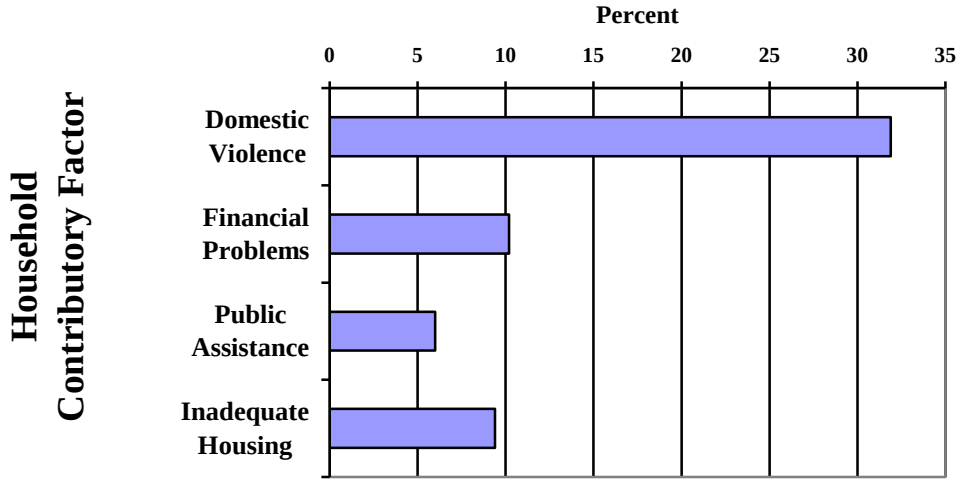


Figure 16: Household Contributory Factors
Across all Substantiated/Services Needed Cases
Pilot, Wave 2, and Control Counties, January 2006-June 2008



Contributory factor data may also provide information on which cases are most likely to return to CPS with repeat reports of maltreatment. To explore the risk of ongoing child maltreatment, we examined the rates of repeat assessment (a second assessment within 6 months) for each type of contributory factor. These data are presented in Figures 17 through 19. Across categories, the highest re-assessment rates occur for cases where child physical disability, hearing impairment, or visual impairment are marked as contributory factors. Though there are relatively few cases that identify these specific contributory factors, those that do may require particular care in case management. In-home workers will need to identify appropriate services and parent support resources that can alleviate the burden of these chronic stressors and hopefully reduce risk of future maltreatment.

Figure 17: Average Percent of Cases with Re-Assessments by Caregiver Contributory Factor

Pilot, Wave 2, and Control Counties, January 2006 to June 2008

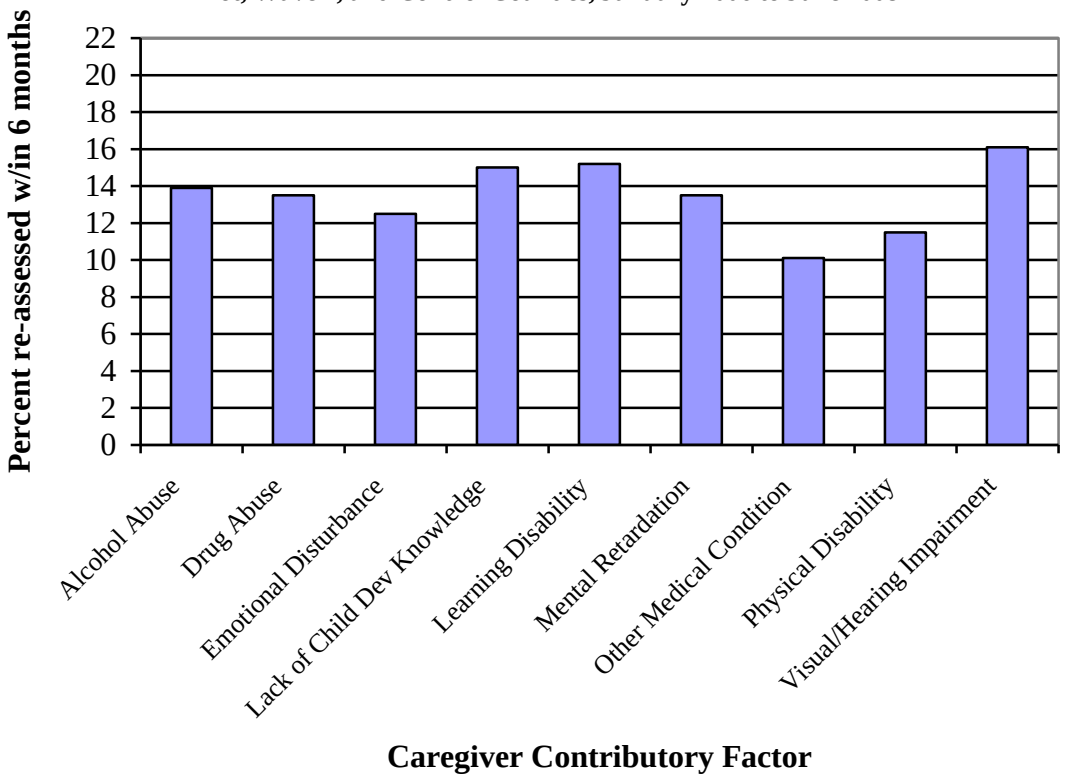


Figure 18: Average Percent of Cases with Re-Assessments by Child Contributory Factor

Pilot, Wave 2, and Control Counties, January 2006 to June 2008

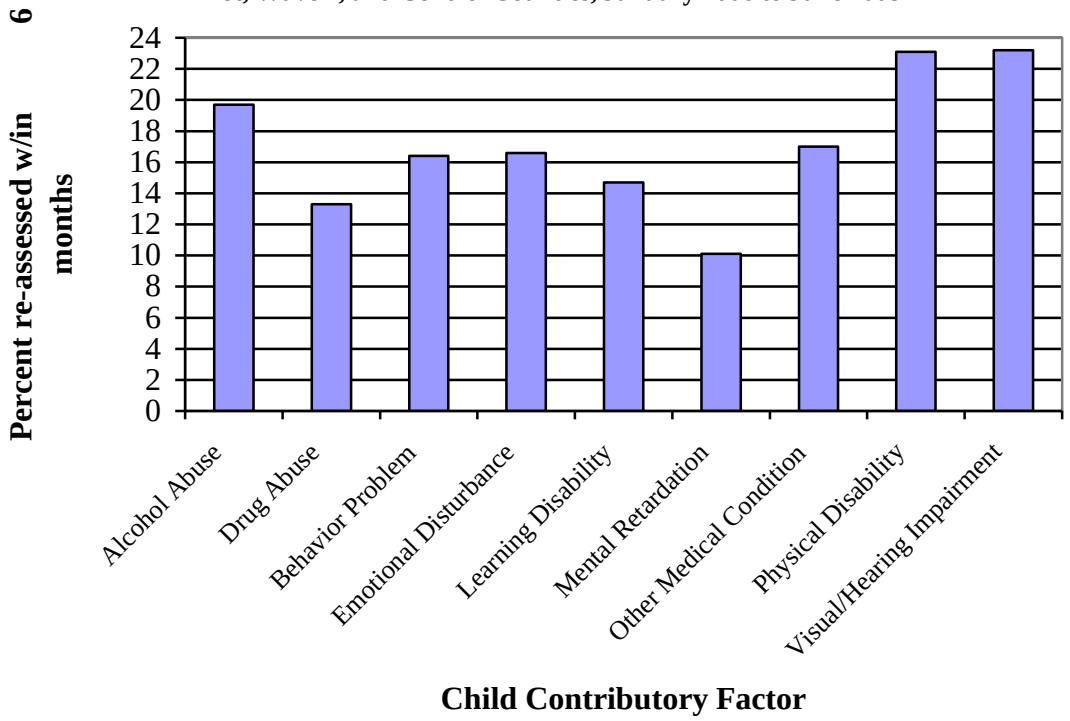
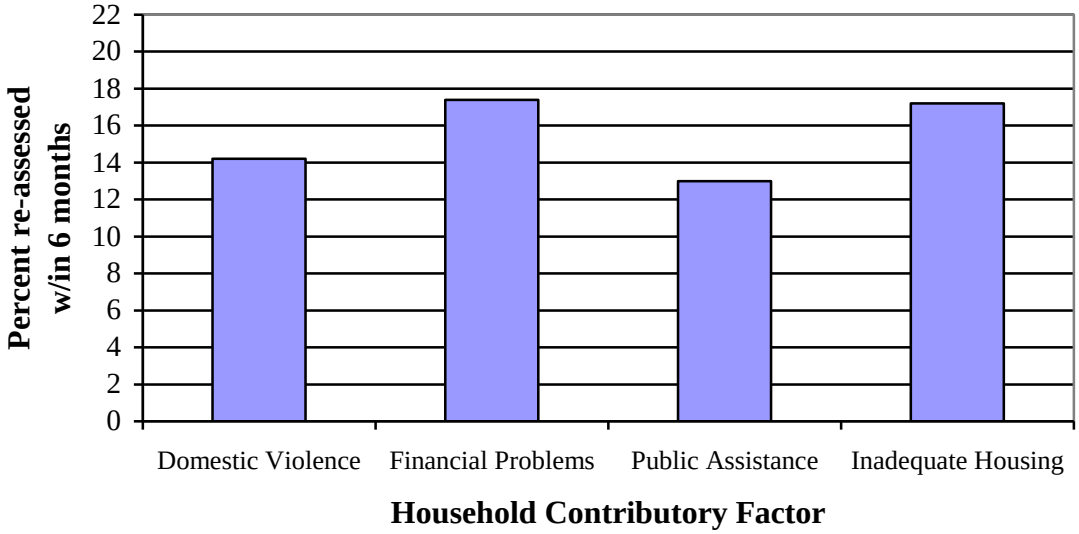


Figure 19: Average Percent of Cases with Re-Assessments by Household Contributory Factor

Pilot, Wave 2, and Control Counties, January 2006 to June 2008



Blended Case Loads

Blending case loads is the practice of social workers conducting investigative and/or family assessments as well as in-home case management activities for cases with findings of Services Needed or Substantiation. From a services perspective, blended case loads are considered ideal because a single social worker can remain with one family throughout the life of the case. This social worker can become very knowledgeable about the family's situation, strengths, and needs, and can provide continuity with consistent targeted services for the family. On the other hand, blended case loads bring with them considerable logistical and practical challenges. It is therefore important to understand the true benefits of this practice so that counties can gauge the necessity of attempting to overcome these challenges.

The current evaluation attempted to examine the benefits of blended case loads both in terms of service provision and child safety. Specifically, we sought to determine whether the use of blended case loads predicted: (1) frontloading of services and (2) risk of repeat assessment. Blended case load status was analyzed at the level of the individual case, utilizing data entered on the Multiple Response System tracking form (5106) regarding case transfer. Unfortunately, these data have not been consistently entered to date. As a result, case transfer data was available on only 6% of the cases seen across counties during fiscal year 2007-2008. With such a small proportion of data available, no valid analyses on blended case load effectiveness could be conducted. Enhanced training and supervision on data entry using the MRS tracking form may improve use of this data collection tool. If transfer data become available on a more consistent basis, blended case load analyses would be a valuable addition to our understanding of effective MRS practices.

Original Data

Data from focus groups, caregiver telephone surveys and Child and Family Team meeting surveys provided qualitative information to assess the extent to which counties are complying with the goals and standards for MRS practice and highlight the associated challenges and successes. The qualitative findings, while illustrative, cannot be considered conclusive due to the limitations inherent in focus group discussions, administration procedures used for the Child and Family Team meeting surveys and self-selection by the caregiver respondents to the telephone survey. Nevertheless, these findings point to areas where MRS strategies have successfully permeated DSS practice and ways they can be implemented more effectively going forward.

Focus Groups

County-level focus groups were an important component of the broader MRS evaluation. Each of the 20 participating counties was asked to host three separate focus groups during the 2006-2007 (Pilot 10 counties) and 2007-2008 (10 wave 2 counties) fiscal years: one for social workers, one for supervisors, and one for community partners. A total of 60 focus groups were conducted across the state. Two social worker focus groups were

conducted in Mecklenburg County because of the size of the county and to ensure inclusion of workers from different geo districts. Evaluators were unsuccessful in attempts to schedule a community partner focus group in Durham County. Both sets of counties were in or very near the fourth year of MRS implementation at the time of the focus groups.

The focus group for social workers included CPS, Work First and Foster Care line workers. The supervisors' group had the same representation but included only those who serve in a supervisory capacity. The community partners' group included broad representation from various other county agencies such as the Department of Juvenile Justice, the health department, the public school system, law enforcement, mental health, family court, and guardian ad litem representatives. These groups also had significant participation by representatives from various levels of community-based organizations, such as Smart Start, domestic violence support centers and other family advocacy agencies. The focus groups typically had between 10 and 20 participants, but attendance varied widely based on the size of the county. In many instances the supervisor focus group was considerably smaller (some counties only have one or two CPS supervisors, one foster care supervisor and one Work First supervisor). Each of the focus groups was approximately 1.5 hours in duration. The guiding questions developed to facilitate focus groups' discussions are provided in Appendix C.

Seven key topic areas were covered within the focus groups: Child and Family Team meetings, blended case loads, Shared Parenting, relationship and collaboration with community partners, frontloading of services, in-home services, and Work First/CPS collaboration. Not all the topics were discussed with the community partner groups because many of those participants would not have the in-depth knowledge necessary to discuss specific domains (e.g., Work First/CPS collaboration). Out of the seven topic areas, four topics related to MRS implementation emerged as the most relevant and tended to generate more dynamic discussions. These areas included Child and Family Team meetings, blended case loads, Shared Parenting, and collaborative relationships with community partners.

Transcripts were developed from focus group recordings and were coded and analyzed using Atlas.ti qualitative software. The topic areas and the associated themes are presented below. In most cases a few examples of the ideas and opinions expressed are provided; however, a more comprehensive presentation of the comments made by discussion topic is available for review in Appendix C. Recommendations stemming from focus group findings are presented at the end of each section.

A. Child and Family Team Meetings

Focus group discussions specific to Child and Family Team meetings centered around examples of staff experiences and attitudes toward the process, barriers to implementation, and strategies used in implementation. A number of key themes emerged from the data and are presented by category below.

Positive Experiences/Outcomes

Out of the 184 comments coded as "attitudes" or "outcomes" related to CFT meetings, 80% were categorized as positive, focusing on the benefits gained by holding CFT meetings with each family. Overall, participants reported that CFT meetings are beneficial because they provide a unified forum for problem solving, with the family as a central participant. As a result, effective CFT meetings can provide:

- Improved communication and trust with families, who come to see the team as a support system rather than a group of accusers;
- Enhanced transparency of the process, leading to better inter-agency collaboration; and
- Improved case plan development, resulting in higher levels of adherence and better outcomes.

In addition, CFT meetings can improve compliance with county- and state-level policies by providing opportunity for social workers to complete multiple collateral contacts simultaneously and meet other documentation requirements.

The comments below exemplify some of the positive experiences and attitudes about CFTs as expressed by focus group participants:

"I think that if you can get to a place where the parent sees a crisis coming and understands that she/he really needs help, that is good participation. When they call to say that they want to have a CFT you know that the parent understands why they need that team. It is difficult to get to that point." (Social Worker)

"I think any time you can get everyone to the table, you can stop that triangulation of communication that can occur. Parents trying to say - this person said this, and this one said that. When you have everyone together, it produces the best outcomes. In my unit, there are some low risk cases that don't have a CFT every month. Anything that is high risk or where there are lots of providers involved, I believe that they should have one every month because they are invaluable in terms of getting positive outcomes."(CPS Supervisor)

"CFTs make the system more user friendly with the family being the user. It is almost a shift in mindset with the realization that placing kids does not help. Fixing families, if you can, by helping them with resources, helping them with coping skills, that is what helps children." (Community Partner)

Barriers to Implementation

In addition to the positive comments described above, a number of barriers to effective CFT implementation were identified. Two of the key themes were the difficulty in managing the practical logistics of CFT meetings and family preparation. Challenges include:

- Difficulty accommodating the schedules of both families and community partners;
- Low levels of participation by community partners due to low school personnel availability, inability of service providers to bill for time spent in CFT meetings, the "after hours" time frames of many meetings, and inter-agency conflicts;
- Lack of dedicated facilitators to support and manage the process; and
- Lack of family preparation, engagement and understanding of the process.

The following quotations highlight some of the barriers related to CFT implementation:

"The barriers that I have seen are turf issues. DJJ, schools, mental health and DSS have all signed on to adhere to the CFT system of protocol which is a really nice, family centered strength based approach to facilitating Child and Family Teams. The two people that I have the hardest time getting to the table were therapists, mainly for issues of pay and billing (and if I were in their shoes, might have difficulty coming), and schools." (CPS Supervisor)

"CFTs won't be fully implemented unless you have a person (facilitator) who is dedicated to doing it and you can hand it over to them." (Social Worker)

"I think one of the biggest barriers is getting families to involve other people. It is their choice as to who they want to have at the team meeting. They may not want their probation officer or grandma to be there or to be privy to the information we have to share." (Social Worker)

"Scheduling is the hardest thing, getting everybody's time right. Nothing is going to prevent that because it will always be difficult to try to manage the logistics and make sure that everybody can be at one place at one time." (Community Partner)

Strategies Used in Implementation

There were not a large number of implementation strategies offered by focus group participants, but those that were exemplify creativity and efforts around engaging families and incorporating the principles of family-centered practice. The following comments provide examples of some of the common themes.

"You have to think outside the box. Can that teacher or doctor write something up if they can't attend? Also, can they join the meeting by speaker phone?" (CPS Supervisor)

"I like to ask the family to tell me about a time when they felt like things were going well with their family and they communicated and solved their own problem. I think people are responsive to that." (Social Worker)

"I have noticed that some of the families come in angry and we need to allow a little venting time during the first part of the meeting."(Community Partner)

Overall, CFT meetings are seen as very beneficial by social workers, supervisors, and community partners alike. Identified barriers may decrease effective implementation, however. To address community partner participation and logistical challenges, counties may need increased interagency dialogue. The collaborative development of meeting strategies or perhaps more formal agreements between county Divisions of Social Services and other agencies/providers within their communities may alleviate some of these concerns.

CFT meetings will also be more effective if families bring their informal support network to the table. However, social workers feel that families are reluctant to include extended family members or other supports in the meetings because they do not want others to be aware of their involvement with CPS. Additional preparation and explanation about the goal of the meetings may help to lessen this concern for families. In addition to ongoing efforts to build trust with families, case workers should emphasize the value and purpose of including informal supports in the meetings: to build an ongoing support network for the family so that CPS can have limited or, ideally, no further involvement.

B. Blended Case Loads

Blending case loads, the practice of social workers conducting assessments as well as in-home case management activities, was a contentious topic in some counties across the state. Twelve of the twenty participating counties indicated that they were not currently blending their case loads, with eight counties reporting that they currently utilize a blended structure (though the specifics of blended case load policies vary considerably).

The focus group discussions with both social workers and supervisors centered on the pros and cons of blending case loads and whether or not one social worker for the life of a CPS case produces better outcomes for families. Of the 206 comments coded for this topic, 83% were categorized as negative compared to only 17% positive. Overall, most participants seemed to see the value in blending from a family perspective and recognized the positives associated with the continuity that such a structure would provide, but felt it presented too many challenges in implementation. A number of ideas were captured though the discussion and are presented below.

Positives

The positive comments expressed, while relatively few, centered on a three key themes. Blended case loads can effectively:

- Reduce or eliminate transitional issues for both families and social workers;
- Provide on-going opportunities for workers to build rapport, trust and relationships with families; and
- Broaden the skill levels of social workers.

Examples of some of the positive comments or "pros" expressed by focus group participants are highlighted below.

"Everybody loves not having to transfer the cases. Having been here a long time, I love that there is not, "It is not my job" or "It has not made it off your desk, so I don't have to do anything with it." You don't hear that. There is more ownership. But the poorer workers just cannot do it."

"I am not saying that it always works best, but I am saying that it does work. To have one worker on a case is possible - it is possible for a worker to follow that case all the way through. You go from bad to good with a client anyways. Foster care workers don't take in-home services case being the "good guy" just because we did not do the investigation. The fact is, you are with DSS and families don't really care. You still stick it out. I am not saying that with the case loads we have that it would work best in this agency. I am just saying that it is possible."

"Blended case load really kick up the skill level of the workers."

"For many families it is better to keep the same worker because they have developed a rapport with that worker and often they don't want a new worker. I think it is better for the family to keep one worker for the entire process."

Barriers

A number of barrier to implementation were discussed but comments tended to center around the following three themes:

- Case management difficulties associated with the urgent need to respond to new assessments versus keeping scheduled appointments with in-home services cases;
- Difficulties mastering policies and maintaining documentation requirements and visitation standards for each respective area of CPS practice; and
- Social worker specialization and/or preferences for working in one area of CPS over another.

The following quotations are examples of the comments made by social workers and supervisors.

"I know that I am set in my ways. I did in-home for three years. Personally I don't like long term intervention with clients, I like investigations. There is a reason why people have specialties and many good reasons for having specialties. That does not mean that you can't be holistic and know about other program areas. I am going to be blunt in saying that we already have struggles with people not being able to do what they are expected to do, and when you put another program on them, it increases liability and increases turnover. Some people are not investigators. They cannot go out and get the information.

Some are not nurturing enough to be an in-home worker. So I think that it is a horrible idea. I understand the philosophy but I think we are setting ourselves and our families up for failure." (CPS Supervisor)

"My fear is that because investigations take priority, you will see an increase in cases where in-home services must take a back seat. Suddenly we are going to be in custody situation because in-home services had to take a back seat."(CPS Supervisor)

"The quality of services will fall down. You are trying to wear all these hats simultaneously instead of concentrating on something you are skilled at - the quality of services might fall down. "(Social Worker)

"I found that I was often calling my in-home cases and telling them that I was sorry but I wouldn't be able to make our scheduled meeting. I found it challenging to do that. I am not saying it is impossible, but it felt impossible unless you were absolutely working yourself to death. We get new cases constantly." (Social Worker)

Blended case loads were generally acknowledged as best practice for working with families, however, the logistical challenges in every day practice have prevented many counties from implementing this structure over time. If counties are to effectively utilize a blended case load structure, a number of these barriers will need to be addressed. Open dialogue with counties should be initiated to determine what steps may be required to assist those using a blended case load structure in better managing case loads and the related requirements. Additional supervisory oversight and training may also be an important component in helping individual social workers to manage blended case loads, reducing stress and perhaps turnover rates.

C. Shared Parenting

Discussions regarding the implementation of Shared Parenting focused on the effectiveness of this strategy, the barriers to implementation and success stories. It is important to note that five of the twenty counties indicated that they are not currently utilizing Shared Parenting meetings in foster care cases. A number of key themes emerged from the data and are presented by category below.

Positives

Overall, focus group participants expressed positive attitudes about Shared Parenting as a strategy for engaging foster parents and birth parents. It was suggested that these meetings can be highly useful in achieving numerous desired results for foster care cases by effectively:

- Easing the transition and associated anxiety for children and birth parents;
- Facilitating long-lasting relationships between birth parents and foster parents, often leading to the provision of respite care and/or on-going support for birth parents after the children return home; and

- Reducing time to reunification in some cases.

The following comments are provided as examples of some of these common themes.

"Shared parenting is the best thing that I've seen with MRS. Some of our foster parents are still active with the children that were in their care. These children and their parents still use the foster parents as a resource or for respite care."(Social Worker)

"If the foster parent has bought into the process, it is extremely helpful. The parent knows who has their child. The foster parent puts the parent at ease so that they can focus on what they need to do. In the cases that worked well, they maintain contact when the kids go home. In essence, foster parents have turned that into an ongoing support system."(Social Worker)

"I think it is very beneficial because it allows the parents to know where child is going and it makes the child feel safer and not as upset that they are going to a strange place because mom just gave her blessing that it is okay for the child to go with this person." (Social Worker)

"When foster parents buy into it and are really active at helping the mom and the children, I have noticed the kids are more likely to go home. When the foster parents are more accommodating with visits and include birth parents in holidays and church we have seen higher success rates."(Supervisor)

Barriers

Amid the positive comments expressed about Shared Parenting, a number of barriers to implementation were also discussed. The barriers mentioned centered around three key themes:

- Foster parent resistance related to the desire to adopt and/or difficulties overcoming the familial circumstances that placed the children in care;
- Birth parent resistance due to anger about the removal of their children and/or denial around the issues that created the safety risk; and
- Seven-day time frame for implementation of Shared Parenting meetings creating logistical challenges and impacting the "readiness" of foster parents and birth parents to engage in the process.

Examples of the barriers noted are highlighted in the comments below.

"It is not a waste of time if it is sold to the foster parents effectively and they buy in. The trouble is that most of our foster parents want to be adoptive parents so they don't want anything to do with the birth parents."(Social Worker)

"Some birth parents do not want a relationship with the foster parents. They just feel like the foster parents want their kid(s)."(Social Worker)

"Some foster parents can't get beyond the circumstances that caused the child to come into care in the first place and as a result they don't trust the birth parents with unsupervised visits." (Social Worker)

"Sometimes it is difficult to do within 7 days of placement with some of our families because of safety issues or they are just not ready." (Social Worker)

"Our social workers are not equipped to facilitate developing a relationship between foster parents and birth parents. They have time constraints and are juggling a zillion different things." (Supervisor)

Success Stories

Examples of some of the success stories offered are highlighted below and help to illustrate the belief among focus group participants that this strategy can be effective.

"My best example of Shared Parenting was when we took custody of an infant who was in a homeless shelter with the mom who had a substance abuse problem. The baby had been addicted and was a fussy baby. I continued to see this mother when she would show up to meet with the foster parents. She was amazed that the foster parents would talk with her about the strategies they used to help calm the baby down. She told me that she couldn't believe that the foster parents were willing to help her learn how to care for her child. She had lost custody of other kids in the past but being able to see her looking better and empowered was wonderful. She had hope, something that she did not have before. It gives them the reassurance that their child is not just disappearing into a vacuum." (Supervisor)

"We had a foster family who would allow the teen parent to come over to her house and she spent time mentoring the teen and showing her how to take care of the baby. Another let the birth parent come over on Christmas day. Still another foster parent took the child to the in-home substance abuse program to let birth parent and child visit there. It depends on the trust between the birth parents and the foster parents." (Supervisor)

"I had case involving a Hispanic family and there were two different sets of foster parents involved. The kids all ended up going home. The foster parents didn't speak Spanish but they found resources in the community to help them communicate with the birth parents and are still involved. One of the foster parents was actually a nurse and the baby has a lot of special needs including a feeding tube, so that foster parent has remained very actively involved in helping mom get other resources in the community." (Social Worker)

The success of this strategy appears to be largely dependent on the willingness of foster parents to engage and in some cases mentor birth parents in coordination with social work staff. This suggests a need to enhance curriculum around Shared Parenting within MAPP training completed by all prospective foster parents. Additional training for foster

care workers in facilitating strong relationships between foster parents and birth parents may also improve outcomes.

D. Collaborative Relationships with Community Partners

Focus group discussions related to the nature of the collaboration between county divisions of social services and other agencies or community based organizations focused on two key areas: the level of inter-agency collaboration and concerns.

Inter-agency Collaboration

Discussions about interagency collaboration yielded overwhelmingly positive comments related to how effectively DSS is engaging other agencies in serving the needs of families. The following themes emerged from these discussions:

- DSS agencies have developed strong partnerships with community partners;
- Social workers and supervisors are generally viewed in a positive light; and
- There is a high degree of interaction among and between agencies.

The following quotations are examples of the comments heard across community partner focus groups.

"In spite of some of our cases, our relationship is very good. I think it is exceptionally good with Work First. We get a lot of referrals from them and communication with social work staff is good and they are receptive when we have issue with clients."

"They are very collaborative in the CFT process. We have agencies talking with each other separate of DSS."

"There are a lot of things that could be improved, but we have good social workers in our county and we have a good overall relationship with them. I am not crazy about MRS, but that is what we have been talking about."

"The Guardian ad Litem program work very closely with DSS. Even though we might have different recommendations about what the family needs - especially related to the child, we could not do our job without DSS."

"At the Head Start program we have quite a bit of interaction with DSS when we have child abuse concerns. DSS goes to our Head Start Centers and trains staff on how to report cases."

"Before I became involved as a GAL, I just saw social services as a police agency. Now, I have actually been with these social workers and their clients and I see that they take on the role of coach and are not there to punish. They promote positive ideas. They are really doing social work."

Concerns

While the majority of community partners made positive comments about their working relationships with county DSS agencies, a number of concerns were also noted. Of the concerns expressed, they tended to focus on a four key areas:

- DSS is not holding families accountable or is not doing enough to protect children with the implementation of MRS;
- Lack of feedback or follow-up specific to reports made by community partners;
- Need for greater clarity on what information can be shared with community partners and what can not; and
- High levels of social worker turnover impacting the ability to forge on-going collaborative working relationships.

The following quotations are provided to exemplify some of key themes noted above.

"Social workers are confused between family centeredness and family friendly. That is an issue that needs to be addressed. Your primary focus should be the safety of children and family. You can't just keep pacifying them (families) for the sake of family friendliness - there are certain levels of accountability that you have to hold them to."

"It has been a difficult transition for the community to understand. For so long the community was so aware of the CPS investigation process. You call in a concern and the next thing you know a social worker is at the school initiating an investigation and that has changed now. It is harder for them, especially the school folks to feel like DSS is "doing" something about the situation."

"New employees need to know what can be shared with whom. Some work well but we get frustrated when a case transfers from one social worker to another."

"Getting information back about what's going on, the status of someone referred to them, that's where the frustration is."

"They are never going to be able to fully implement this kind of system reform (MRS) with the current case loads and high social worker turnover rates."

"DSS has so much turnover it's really hard to build those relationships with workers. I've worked in my job for a long time and it is a little harder now to make personal contacts because of the turnover."

These finding suggest that overall counties are doing a good job in collaborating with other agencies and community-based organizations. Some of the concerns expressed could be addressed through clear policy development outlining what levels of information may be shared among and between partnering agencies.

Additionally, the fact that community partners believed that the use of MRS does not appropriately hold families accountable indicates a lack of understanding about the seven strategies of MRS and the principles of family-centered practice that now guide social work in North Carolina. Early in MRS implementation, pilot counties conducted extensive community outreach and education efforts which should remain an on-going process to ensure that such misperceptions do not become deeply rooted. It may also be true that some social workers struggle with being family-centered and strengths-based in their interactions with families while simultaneously holding them accountable and again may point to the need for additional training, supervision and mentoring.

E. Frontloading of Services

Supervisors and social workers were asked about the practice of frontloading services for families during the investigative or family assessment phase of a case. Eighteen of the twenty counties indicated that they believed they were frontloading services more since they began MRS implementation. Two counties indicated that while they may not have referred to the practice as "frontloading," they had traditionally connected families to services prior to case decision and felt MRS implementation had had no tangible effect.

Additionally, participants were asked what services they referred clients to most often and, among the services, which were the most difficult to secure for families. The findings across the twenty counties indicated:

- The most frequently referred and most difficult to secure services were mental health related, inclusive of substance abuse assessment and treatment; and
- Childcare and domestic violence programs were the second and third most frequently referred service respectively.

Consistent with findings from the administrative data analysis, it appears that from a practice standpoint counties also believe that they are frontloading services more since MRS began. They further offer that the most difficult services to put into place were mental health related with many suggesting that mental health reform efforts in the state were responsible for reduced access to services.

F. In-Home Services

Discussions surrounding the re-design of in-home services focused on the challenges associated with the case contact requirements within in-home services primarily due to high case loads. Participants suggested possible remedies to address such challenges:

- Adjust county-level policy to include greater consideration of the number of children involved in a case as criteria in case assignment - similar to the traditional way in which foster care cases are assigned; and

- Allot greater flexibility in visitation intervals for some cases, with supervisor approval and appropriate oversight, as a stop-gap measure until the state adopts a more appropriate risk assessment (currently under development).

The following are examples of the comments heard across supervisor and social worker focus groups.

"I think what is tough about it is trying to keep up with the monthly contacts that we are required to make because of our higher caseloads, and we are trying to get the services in place, coordinate them, do the paperwork, see the kids, see the parents, adjust your hours to the family hours because a lot of our families don't come home until after 5:00 after they pick up their children Yet, our workers have families too, and they have to pick up their own children. That balancing act can be difficult at times." (Supervisor)

"We refer to them as drive-bys especially if you have nonverbal or very small kids. You run by day care just to make sure they are okay but it doesn't allow you the time to spend in the places where you think you really need to spend the time. I wish we had more flexibility and ability to use our judgment about case contacts." (Social Worker)

"You are not catching those warning signs of crisis that are going to brew in families because you have to run out the door. You don't have time to sit with families that really need you because you're running all over. Also, there is too much paperwork, you could sit all day for a week and still not be caught up."(Social Worker)

It is important to note that changes in required documentation instituted as part of the state's movement toward standardized documentation will no doubt improve the quality of contacts within in-home services. For example, the use of the SEEMAPS framework requires workers to address multiple domains and document the outcomes for each contact/visit, effectively reducing the likelihood that workers can just check a box indicating that they saw the family. This framework will likely improve the quality of these contacts, but will not address the time challenges associated with case loads and the subsequent work-family balance issues faced by many social workers.

G. Work First/CPS Collaboration

Focus group discussions related to the level of collaboration between Work First and CPS programs centered on: (1) the use of Work First staff as collateral contacts, (2) the processes associated with determining dual involvement, and (3) the development of joint case plans. The following points highlight the findings:

- Fifteen out of the twenty counties indicated that they currently use Work First staff as collateral contacts when they are aware of common clients;
- The process by which they become aware of common clients varied by county, but in most cases the CPS intake worker was responsible for determining if a family has involvement with other services;

- Sixteen out of the twenty counties indicated that they engage in some form of case coordination to ensure efforts are not being duplicated; and
- The volume of cases simultaneously involved with CPS and Work First is not large.

There were some indications that joint home visits have occurred in several counties, but it was clear that this practice is not a common occurrence. Workers commented that the goals of CPS home visits and Work First visits are often too different and cannot always be appropriately combined.

Focus Group Summary

Overall the focus groups yielded some important information about different aspects of MRS implementation from multiple perspectives including social workers, supervisors and other community agencies. The following points summarize key findings.

- CFT meetings as a strategy for engaging families have broad support among social workers, supervisors, and community partners, but implementation with fidelity to the model presents significant challenges. Issues related to logistics, scheduling, staffing, and participation by community partnering agencies were frequently cited, as well as poor family preparation and engagement in the process.

- A blended case load structure was generally acknowledged as representing best practice for families; however, participants noted a host of logistical, staffing and administrative challenges associated with such a structure.

- Shared parenting was acknowledged by participants as an effective strategy in working with families that have children in care. The structure or formality of Shared Parenting tended to be of less importance, with success hinging primarily on the willingness of foster parents to engage in the process with birth parents.

- Discussions related to the level of collaboration with community partners suggest that DSS is doing a good job of reaching out to other organizations in meeting the needs of families. The concerns expressed were relatively minimal and centered on the need to improve information sharing, communication and social worker turnover rates.

- The practice of frontloading services appears to be more prevalent in counties since MRS implementation began. Mental health, inclusive of substance abuse treatment, was cited as the most frequently referred service and the most difficult to secure for clients.

- Discussion around the re-design of in-home services suggests a need for dialogue and/or re-examination of policy and case assignment strategies at the

state and county levels. Social workers noted a need for greater flexibility in case contact requirements and/or a more appropriate risk assessment tool for assigning risk levels, which ultimately determines contact requirements.

- Discussion related to the level of collaboration between Work First and CPS indicated that social workers are using their Work First counterparts as collateral contacts, and joint case planning and/or coordination is occurring in the majority of the participating counties. It also appears that the instances in which families are simultaneously involved with CPS and Work First are few.

Child and Family Team Meeting Survey

As part of the larger MRS evaluation, a survey tool developed for the "Improving Child Welfare Outcomes through Systems of Care" evaluation was utilized for the purposes of gaining insight into four key areas of CFT implementation including:

- Fidelity – Adherence to the CFT model;
- Participation – Level of engagement and involvement in the CFT process;
- Satisfaction – Level of satisfaction by participants with regard to how the meeting was run; and
- Knowledge – Participant understanding of his or her personal role in the CFT.

The survey tool is provided in Appendix D along with a description of how the items were grouped within four categories for the purpose of analysis. The family-centered meeting survey allowed respondents to choose among four possible response options ranging from strongly agree to strongly disagree.

Survey Administration

County DSS staff in the 10 wave 2 counties were instructed to have the survey administered by meeting facilitators at the end of all CFT meetings held during four specified months in the 2007-2008 fiscal year. All CFT meeting participants were asked to complete the survey, but were not required to do so. A total of 343 CFT meetings were surveyed, yielding 1,463 individual surveys. Respondents were asked to identify themselves and their role on the team from a list of 26 options. The 26 roles were collapsed into eight categories for the purposes of presentation, including (1) parent, (2) child, (3) foster parent, (4) informal support, (5) DSS staff, (6) child-serving agency, (7) community partner, and (8) other. Informal supports include relatives, live-in partners, friends and neighbors. Child-serving agencies are comprised of county agencies such as public school personnel, juvenile justice staff, and the guardian ad litem (GAL). Community partners include various service providers such as therapists and representatives of other community-based programs or resources. Figures 14 and 15 illustrate the number of CFT meetings surveyed by county and the breakdown of CFT participants surveyed.

Figure 14

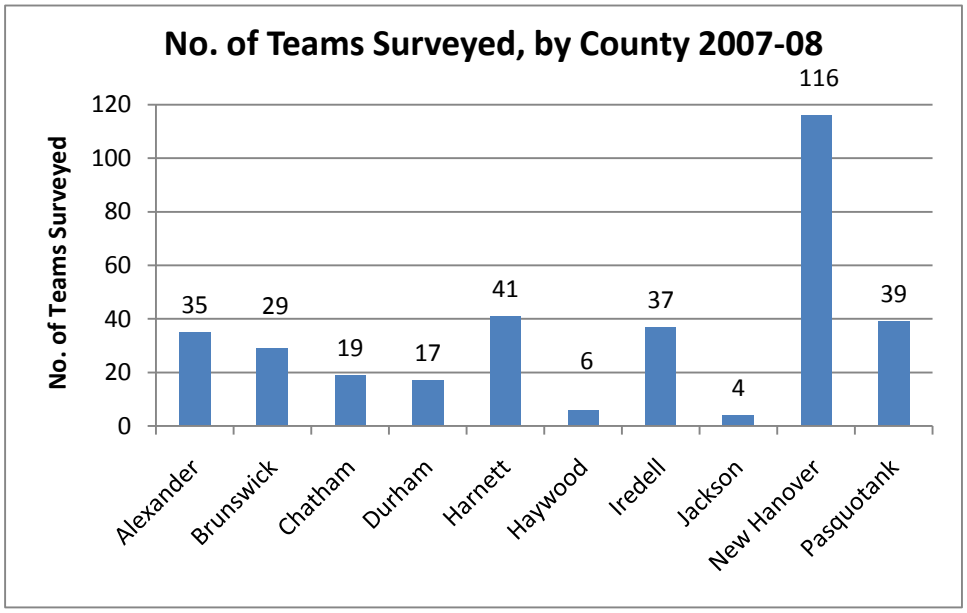
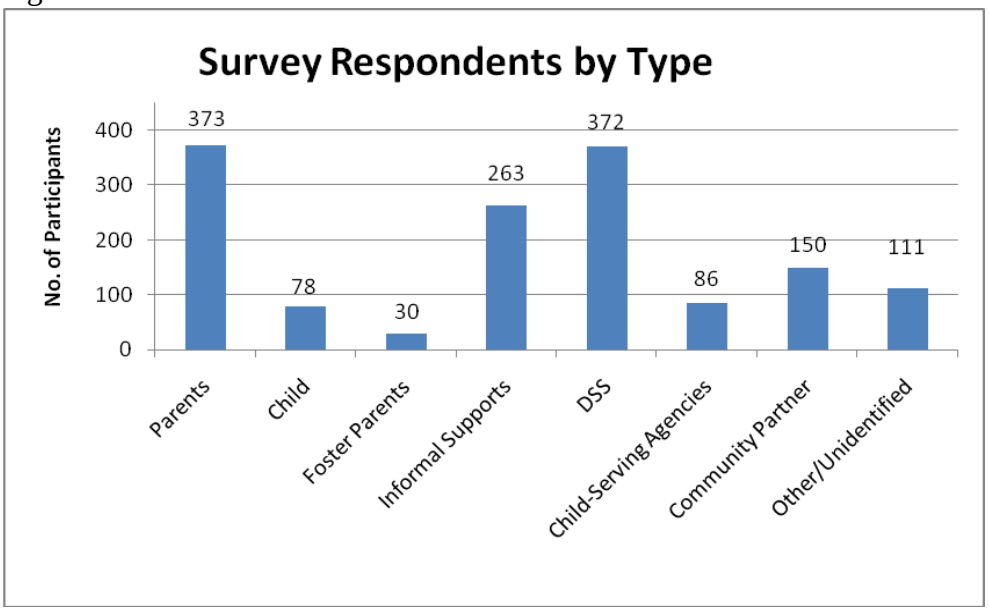


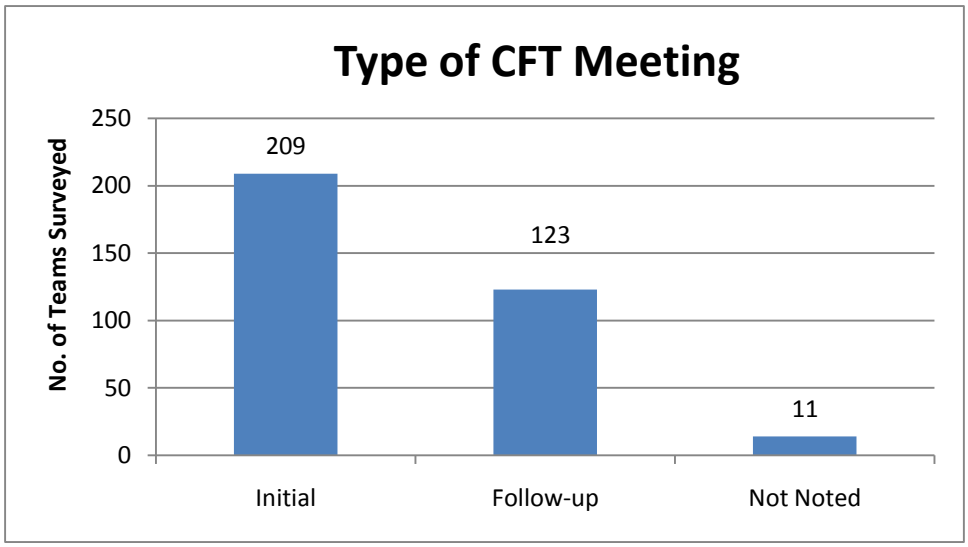
Figure 15



Summary Sheet Data

The CFT meeting facilitators completed a summary sheet and attached it to the completed surveys. The summary sheet collected information about whether the CFT was an initial or follow-up meeting, the length of the meeting, the risk level assigned to the case, and the location of the meeting. Figures 16, 17 and 18 highlight this information.

Figure 16



The location selected for holding a CFT meeting is a key component of incorporating principles of family-centered practice into this MRS strategy. Holding meetings at the family's home, child's school or some other neutral location selected by the family can be a critical factor in engaging families and creating buy-in to the process. The results of the survey indicate that 52% of the meetings surveyed took place at county DSS, 40% at on off-site location and 8% were not noted. It is clear that participating counties are holding CFT meetings off-site; however, these findings suggest there is more work to be done in increasing the number of meetings held at alternative locations.

Figure 17

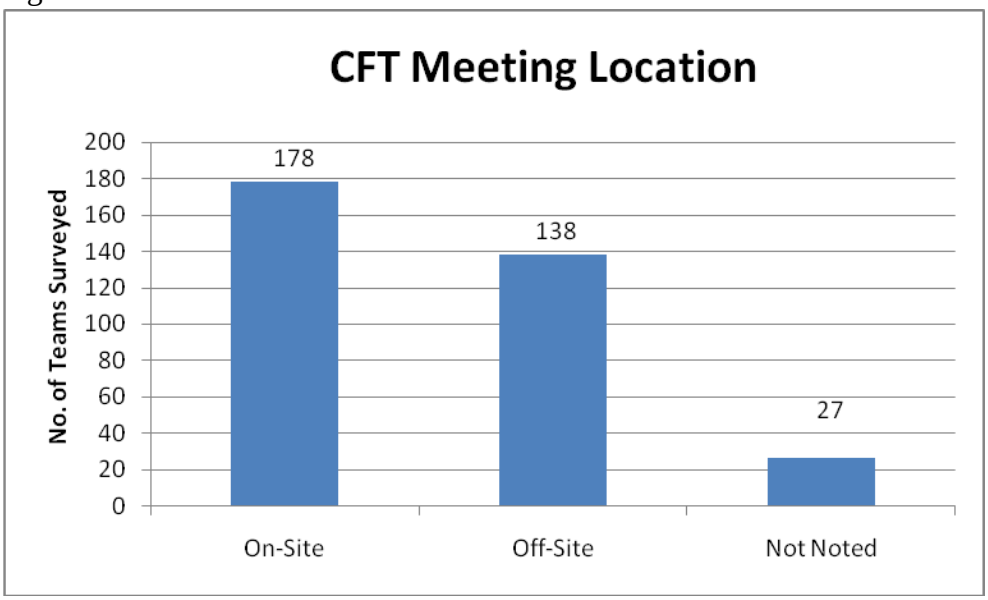
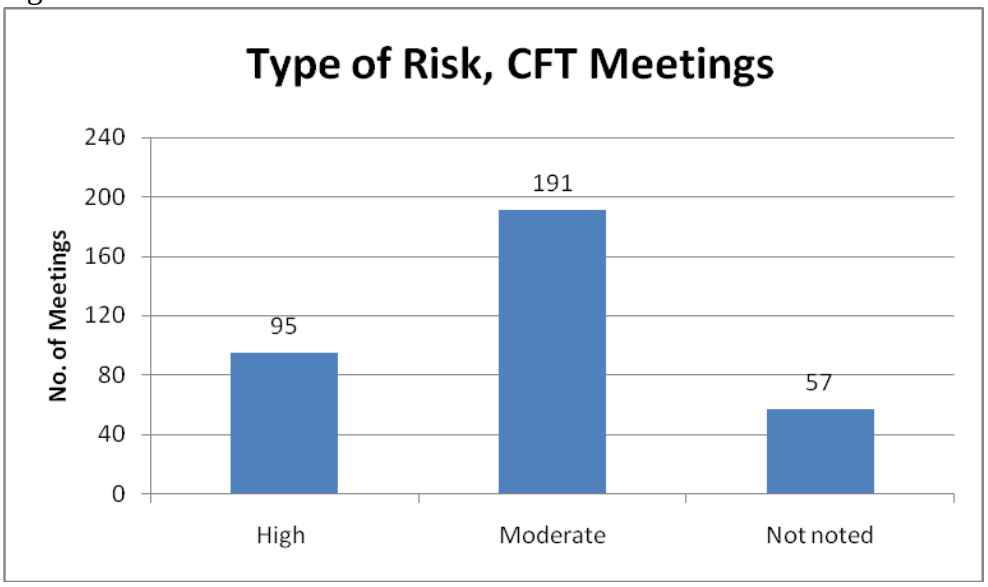


Figure 18

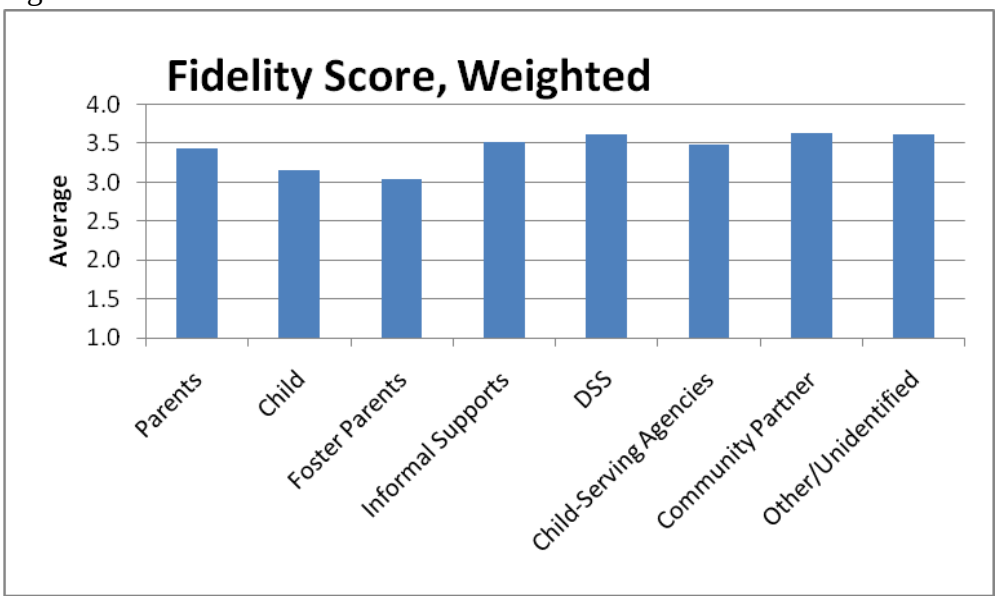


Family Centered Meeting Survey Data

The following tables provide averages for the scores within each of the four key areas of CFT administration: fidelity to the model, participation, satisfaction and knowledge of the process. These averages represent combined, weighted data so that each county contributed equally. There were nine questions in the survey that probed fidelity, five for participation, two for satisfaction and two for knowledge. Appendix C provides a table that lists the survey questions and how they were grouped within the four categories for the purposes of analysis. Item analysis was also run to identify any variability in the mean score for each item independently. No substantial differences were found.

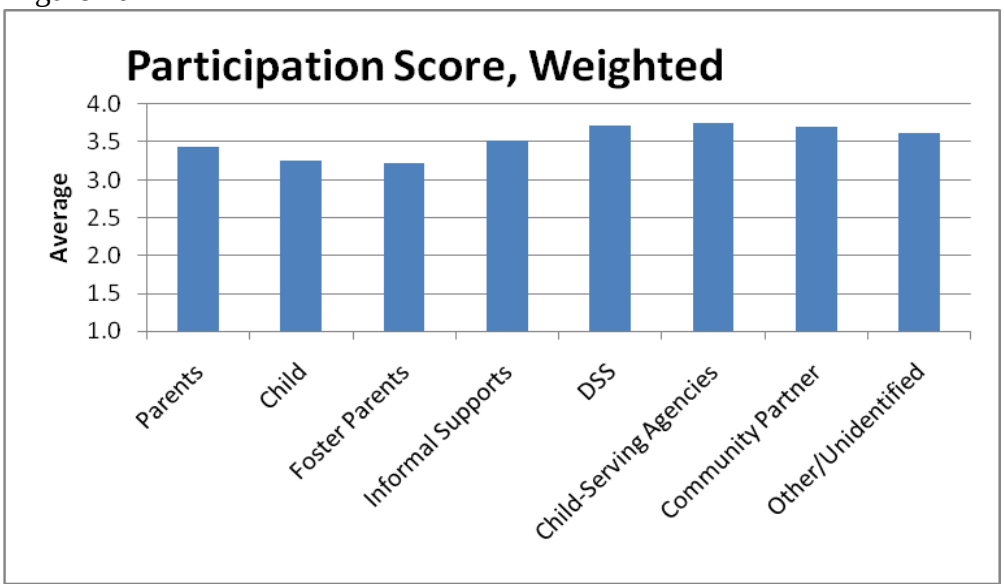
The survey questions grouped within fidelity were designed to solicit feedback specific to how effectively meetings adhere to the CFT model. The average scores indicate that participants had strong levels of agreement that the meetings had model fidelity. Respondents categorized as Community Partners, DSS and "others" had the highest levels of agreement. Respondents identified as foster parents had the lowest levels of agreement with a mean score of 3.0.

Figure 19



The questions grouped within the participation category sought to understand how engaged the respondent felt he/she was in the meeting process. Respondents categorized as "Child Serving Agency" indicated the highest levels of agreement with a mean of 3.7. Community partners had a mean score of 3.6. Parents had a mean score of 3.4, and foster parents again had the lowest mean score at 3.2.

Figure 20



Within the categories of satisfaction and knowledge, DSS staff had the highest average rating across all respondent types at 3.8. Respondents identified as children and foster parents had the lowest average scores for both satisfaction and knowledge.

Figure 21

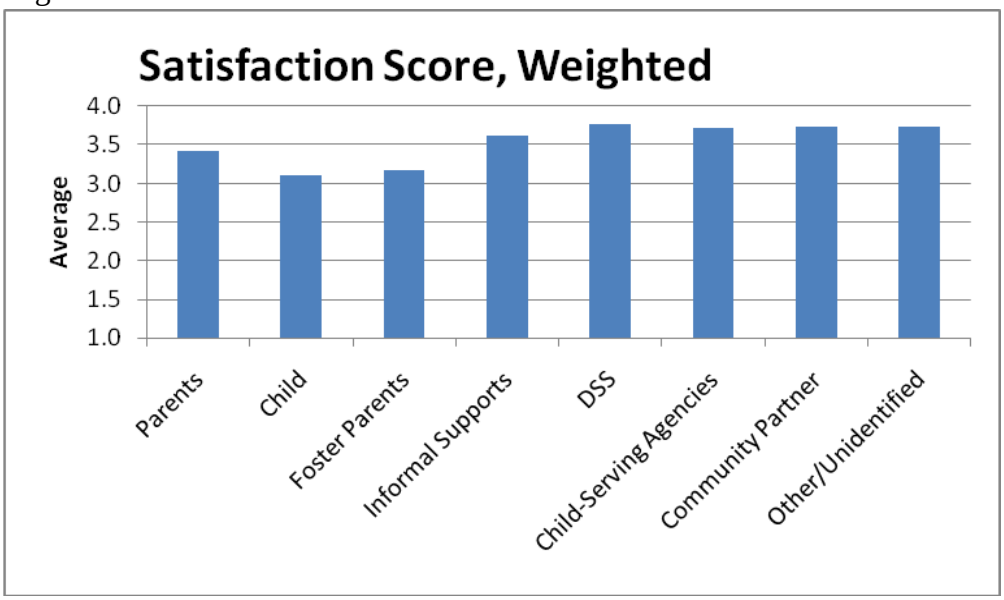
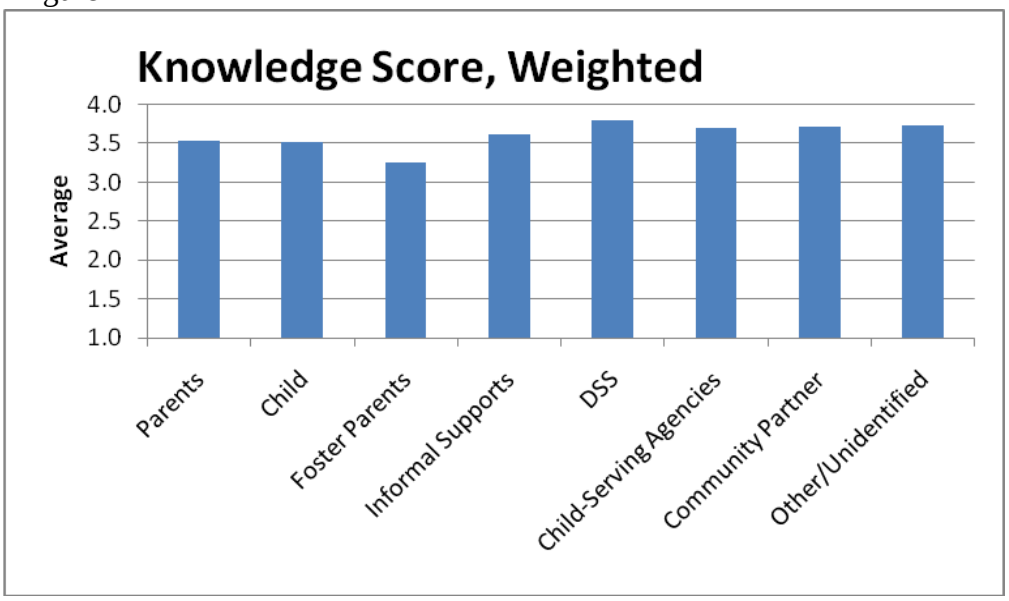


Figure 22



CFT Survey Summary

Overall, surveyed respondents at CFT meetings agreed or strongly agreed that the integrity of the Child and Family Team model had been adhered to; felt engaged in the meeting process; felt the meeting was run to achieve the desired goals; and understood

their respective roles in the meeting. While these data are encouraging, it is important to note some of the limitations of these findings. First, the surveys were administered by DSS staff and/or meeting facilitators; therefore, it is possible that more contentious meetings or those that did not produce optimal results were not surveyed. Further, given that the facilitator handed out the surveys and subsequently collected them, survey participants may not have felt sure about the confidentiality of their responses and therefore may not have been as forthcoming with their true opinions.

Caregiver Phone Surveys

Phone interviews with families were another key component of the overall MRS evaluation. During the 2006-2007 fiscal year evaluation, 223 phone interviews were conducted in the 10 pilot counties to assess MRS implementation and family satisfaction with the process. An additional 188 surveys were completed in the 10 wave 2 counties during the 2007-2008 fiscal year, for a total of 411 surveys. Informed consent documents were collected from families by their social workers regardless of where the case was along the DSS continuum of services, from assessment through foster care services. However, more than three-quarters of families who participated in the survey were in the investigative/family assessment phase of their case. The survey tool focused on the following aspects of MRS practice: investigative and family assessments, case planning and management activities, Child and Family Team meetings, Shared Parenting, coordination with Work First, and overall interactions with child protective services. The survey tool is available for review in Appendix E.

Demographics

The table below presents the demographic characteristics of the sample.

Demographic Characteristics	Percentage of Respondents
Marital Status	
Married	36%
Single	34%
Divorced/Widowed	30%
Race/Ethnicity	
White	53%
African American	38%
Hispanic	5%
Other	4%
Education Levels	
Less than HS Diploma	30%
HS Diploma/GED	30%
Some College	26%
College Degree /Cert.	14%

As shown above approximately a third of the sample were married (36%) and half were white (53%). Thirty eight percent were African American, and only 5% were Hispanic. Pilot counties had a larger number of African American respondents at 46%

compared to wave 2 counties with only 28%. Two thirds of the sample (60%) had less than HS or a HS Diploma/GED. Almost half the respondents were unemployed and indicated that their annual income was less than $25,000. Those earning $35,000 or more per year made up only 14% of the total sample. Roughly half of all families surveyed said that they had had previous experience with CPS.

Investigative/Family Assessment

Families were asked numerous questions about their initial contact with CPS and the process of the assessment. The following are highlights from their responses:

- Forty three percent of families reported they were contacted by phone, 37% face to face, and 20% received a note, were contacted through a neighbor, etc.
- The most frequently reported feelings in response to contact from CPS were anger, stress, confusion, annoyance, and worry.
- Approximately two thirds (62%) of the respondents indicated they were told their cases were either investigative or family assessments, but 38% said they did not know what type of assessment they had.
- In a third of the cases (32%), families indicated that their social worker explained the difference between an investigative and a family assessment. Twenty-eight percent said that the differences were not explained, and 40% said they did not recall.
- Seventy-nine percent indicated that their social worker was interested or very interested in trying to understand their family's situation.
- Sixty-three percent stated that the social worker asked them if they had any needs. Of those who did, tangible needs (e.g., car seats, diapers, furniture), mental health services, food and childcare were the most frequently cited. Interestingly, none reported emergency money, housing, medical care, dental care or transportation needs. The table below presents these needs and the number of people reporting each one.

None	200
Other	76
Child Care	52
Mental Health	41
Food	39
Parenting Skills	13
Domestic Violence Services	11
Employment Training	10
Drug/Alcohol Treatment	8
Work First Services	6
Emergency Money	0
Housing	0
Medical Care	0
Dental Care	0
Transportation	0

- Almost 80% of the families felt they were respected by their social worker.
- More than half said that they were asked about what they thought would be best for their family.
- About half indicated that they did not develop a list of strengths and needs with their social worker.
- Sixty-three percent of respondents said they did not receive any services prior to case decision; 34% indicated they did and 3% could not recall.

Overall, it appears that the majority of families felt respected and reported their social worker was interested in trying to understand their family's situation and what would be best for them throughout the investigative/family assessment process. At the same time, some procedural challenges were reported that could easily be amenable to further training and/or enhanced supervisory oversight: explaining the difference between the investigative and family assessment tracks, developing a list of strengths and needs with the family's help, and providing services prior to case decision. It is also important to keep in mind that these survey responses may be affected by people's state of mind during the assessment process. The majority of families felt angry, stressed and confused during that time and thus may not remember circumstances with accuracy.

Case Planning/In-Home Services

A number of questions addressed the process of case planning and in-home services. Not all respondents were asked all these questions because either they had not yet participated in this process or were not sure if they had.

- Of those individuals who recalled developing a case plan, 87% said that they actively participated, 12% said that their child also participated, 23% said that their spouse participated and 15% said that an extended relative such as a grandmother participated. No one indicated that a Work First representative participated in developing their case plan.
- A majority (78%) of the respondents said that the plan included their ideas and 85% noted that the plan met their family's needs well or very well.
- Seventy-five percent of the people who were asked about the practice of utilizing one social worker for the life of a CPS case (i.e., blended caseloads) "liked the idea;" 5% reported they did not like it, 10% said they did not care either way and another 10% noted it depended on the social worker.

Overall, the majority of families who received case planning and in-home services reported active participation in the development of their case plan and a resulting plan that that was well suited to their needs. Furthermore, most families liked the idea of having one social worker for both the assessment and in-home services.

Child and Family Team Meetings

In an effort to explore how CFT meetings are being implemented from the perspective of the family, respondents were asked a series of questions on this topic. This section represented a challenge in the survey administration process because many families were not clear as to whether they had been involved in a CFT or other similar meeting. Interviewers provided an explanation as to what a CFT is and some examples of who might have attended such a meeting, but still many respondents could not confirm having participated.

- Approximately 30% of all respondents said that they had a CFT or similar meeting. Almost half (49%) of those indicated that they had participated in one CFT meeting, 23% said two, and 20% said they had gone to three such meetings.
- The most often noted participants were grandparents and other extended family, children, GAL representatives, social workers, social work supervisors, facilitators, and service providers. Work First was not cited by any respondent.
- More than half of the respondents said that they felt they had a say in who was invited to come to the CFT meeting and were encouraged to bring supports and other family members to the meeting.
- More than 85% indicated that the purpose of the meeting was explained to them clearly.
- Eighty-one percent noted that they were comfortable or somewhat comfortable sharing their ideas, but 54% also said that they did not feel their ideas were taken seriously and subsequently included in the plan.

In sum, half of those families who participated in a family-centered meeting received at least one Child and Family Team meeting and had numerous participants at the table. The majority of families said that the CFT process was explained to them and that they felt comfortable enough to share their ideas. However, approximately half of the families did not feel they were heard or that their ideas were included in the plan. It is important to note that families had difficulty ascertaining whether or not these meetings were CFTs or simply meetings that they had with their social worker.

Shared Parenting

In order to better understand how effectively Shared Parenting is being implemented, respondents who had children in foster care were asked a series of questions about their experiences. Only 17% of all respondents indicated that they had a child in foster care at the time the survey was administered. Of those:

- Half indicated that it was easy or very easy to have contact with their children;
- More than half said that their social workers had helped them to stay in contact with their children through arranging visits or assisting with transportation needs;

- Two-thirds said they believed they had input in decisions made about their children while in care; and
- Fifty-two percent of respondents indicated that they had participated in a Shared Parenting meeting.
- Of those who participated in Shared Parenting meetings, only half said they were encouraged to share information about their child's everyday routines, and many did not believe that their ideas and comments were taken seriously.

In sum, only half of parents who had children in foster care said that they had participated in Shared Parenting meetings, and only half of *those* were encouraged to share information about their children's everyday routines with foster parents. Many also indicated that they felt their ideas and comments were not taken seriously by foster parents or social workers. Given these findings, further training in the conduct and benefits of Shared Parenting may be helpful.

Work First and CPS Collaboration

Collaboration between CPS and Work First is one of the seven core strategies of MRS. As a result, a set of questions addressed the level of collaboration between the two programs within the Department of Social Services.

- Only 7% noted that they has simultaneous involvement with Work First and CPS;
- Half indicated that they had already been involved with Work First and then became involved with CPS, and half said that they began receiving Work First services during the time that their CPS case was open;
- Of those respondents who were involved with Work First prior to becoming involved with CPS, the majority noted that their social workers were aware of their Work First cases; and
- Seventy-five percent of families said they had not participated in joint case planning or meetings with both their CPS and Work First workers.

These findings indicate that even though there are few cases with simultaneous Work First and CPS involvement, more often than not the two programs are aware of each other's involvement. Some further training could address the benefits of joint case planning in cases of dual involvement.

CPS Experience

The concluding questions in the survey were related to the respondent's overall interaction with CPS, the effectiveness of services in helping them with various aspects of family functioning, and what they would change about the way that CPS works with families in the future.

- When families were asked how they felt about their overall experience with CPS, their most frequently reported feelings were satisfied, happy, relieved, and pleased, with a substantial number still reporting feeling annoyed and angry;
- Roughly 20% of families who received services reported that they definitely improved their parenting skills and helped them learn to better deal with conflict, know who to contact in the community should they need assistance in the future, better provide for their family's needs, and feel better about themselves and their family. However, a large proportion (37 to 52%) did not feel that the services helped them at all. The table below provides a breakdown of responses by question.

Question; Did the help you received from CPS …..	**Yes, definitely**	**Yes, a little**	**No, not much**	**No, not at all**	**No Response**
improve your parenting skills?	21%	11%	29%	37%	2%
help you to deal with family conflict?	20%	8%	33%	37%	3%
help you to know who to contact in the community when you need assistance?	17%	9%	20%	52%	2%
help you to better provide for your family's needs?	20%	12%	20%	45%	3%
help you to feel better about yourself and your family?	20%	7%	19%	51%	3%

- When respondents were asked what they would change, if anything, about the way that CPS works with families, 35% of families noted that they would not change anything. Sixty-five percent had suggestions for improvements. The following quotations highlight the changes families suggested, which centered around improving communication and respect, reserving judgment, and retaining the same social worker for the duration of the CPS case.

  "I don't think that they should leave a note on someone's door. I could not figure out what was going on and ended up going to DSS to find out."

  "Social workers don't need to make judgments about clients instead they need to make an effort to try to understand how and why the client got into the circumstances they are in."

"I think that they should be more considerate of families and not be so judgmental."

"They need to keep families more informed about how the case is going. My situation has been going on too long and I can't reach my caseworker to find out what is happening."

"It would have been nice to keep working with the same social worker instead of having to switch in the middle of the case."

"I think social workers need better training. They need to have a more caring attitude and make people believe that they are here to help."

Perspectives on overall interaction and experience with CPS were mixed. Generally, families expressed many more positive feelings about their interactions and experiences with CPS later in the process as compared to initially, which could be an early indicator of changing perceptions about the agency within communities. Additionally, 35% noted that they would not change anything about the way that CPS works with families.

Amid these positive findings, it should also be noted that of those that received services through CPS, only about 29% felt it definitely helped them or helped them a little. The remainder indicated that the services were not as helpful. This finding may suggest that there are not enough appropriate, high quality services available within surveyed counties; that families do not value the services they received; or they do not believe that they needed them. In any case, this has implications for improving service array and enhancing family-centered practice within case planning and management.

Caregiver Phone Survey Summary

The information obtained through this survey is useful in continuous improvement efforts yet it is important to note the limitations of these data. Self selection bias was likely a factor because families were asked by their social workers to voluntarily sign the consent if they had an interest in participating. Families in crises or those with the most severe CPS cases or familial challenges may not be fully represented within the sample. Further, because social workers collected the consents it is possible that they did not ask families to participate with whom they had contentious relationships fearing that families would provide negative feedback.

From the family perspective it appears that while DSS is implementing MRS effectively in many areas, there is room for improvement in others. The following points summarize the implications of the findings and indicate a need to:

- Enhance family understanding of the Investigative or Family Assessment phase of the CPS process including types of assessments, case decisions and what implications each has. Increase the levels of supervisory oversight to ensure

that social workers are consistently developing a list of strengths and needs with families;
- Better educate and prepare families involved with in-home services so that they know what a CFT is and whether or not they had one. Increased use of a blended case load structure because families prefer one social worker for the life of a CPS case;
- Improve the levels of family engagement within Shared Parenting meetings so that families feel that their input is valued;
- Explore service array and quality to better understand why the majority of families do not find the services they received through CPS helpful and identify ways to remedy this.

Conclusions

It is valuable to consider the findings of each of these sources of data as individual evidence of the efficiency and effectiveness of the Multiple Response System, but it is equally important to understand the story the data tell collectively. To that end, this section will summarize the quantitative and qualitative findings by topic area and/or key MRS strategy.

Dual Track Distribution of Assessments and Case Decisions

The pilot and wave 2 counties both showed significant increases in their use of the family assessment track in the first twelve months of implementation with a leveling off occurring over time as counties became more adept at utilizing an alternative track.

The use of findings Services Needed and Services Provided (CPS no longer needed) remained constant over time with similar rates in both sets of counties. There were notable differences in the use of the Services Recommended and Services Not Recommended findings in pilot versus wave 2 counties. Pilot counties were more likely to utilize the Services Recommended finding (35% as compared to 22.5%) which is an ideal outcome suggesting that as workers master the tenets of family-centered practice they may increase the numbers of families who participate in voluntary services.

Child Safety

Child safety as measured by the overall rates of assessment and rates of substantiated maltreatment have not been adversely affected by the implementation of MRS, and indeed may have been enhanced. Repeat assessments decreased following MRS implementation in both pilot and wave 2 counties suggesting that MRS is improving child safety by sufficiently meeting the needs of families and keeping them from returning to the attention of CPS.

Timeliness of Response and Case Decision

MRS does appear to have temporarily disrupted timeliness of response in pilot counties after implementation. In contrast, no such effect was detected for wave two or control counties. The likelihood that case decisions will be made on time has decreased for all counties regardless of when MRS was implemented. A number of factors may be influencing this trend including increased case loads and social worker turnover rates.

Frontloading of Services

Administrative data show that the rate at which counties are frontloading services increased significantly at MRS implementation in both pilot and second wave counties. Additionally, the average number of frontloaded minutes has increased annually suggesting that social workers continue to spend more time working with families earlier in the process. Consistent with 2006 findings, analyses showed that increased levels of frontloaded services reduced the likelihood of a re-assessment within six months.

These findings are further supported by qualitative data collected in focus groups with staff from 18 out of the 20 participating counties indicating that they were frontloading services more since MRS began. While focus group participants felt they were frontloading services more and administrative data suggests they are, this was not supported by the caregiver phone survey data. More than 60% of respondents said that they did not receive any services prior to case decision. Part of this discrepancy is inherent in how frontloading is defined for evaluation purposes but may also suggest that while social workers are clearly making efforts to link families with services, families may not be receiving actual services in a timely manner.

Contributory Factors

Administrative data indicate that across all categories (caregiver, child, and household), domestic violence and caregiver drug abuse are the most frequently noted contributory factors in child maltreatment cases. Cases with child contributory factors of physical disability, hearing impairment, or visual impairment were the most likely to be re-assessed within six months. These findings have important implications for enhancing case management strategies for maltreatment cases affected by these factors and the development of services and/or parental support mechanisms to reduce the risk of future maltreatment.

Child and Family Teams

Data related to the implementation of CFT meetings was acquired through three sources of information including focus groups, caregiver phone surveys and CFT surveys conducted in wave 2 counties (only). In focus groups, social workers, supervisors and community partners described the benefits of CFT meetings and generally expressed very positive attitudes about this key MRS strategy. Amid these positive comments a number of

barriers emerged that can impact implementation including logistics, scheduling, staffing, and participation by community partners.

A number of these findings are supported by the results compiled from the CFT surveys. Overall, those surveyed at CFT meetings agreed or strongly agreed that: the meetings adhered to model fidelity; they participated and were engaged in the process; they were satisfied with the meeting; and they understood the purpose of the meeting and their role therein.

These findings were echoed in data collected in the caregiver phone surveys. For example, the majority of families that recalled participating in a CFT noted that they had a say in who was included in the meeting and were encouraged to bring supports, both key elements in achieving fidelity to the CFT model. Additionally, more than 80% of these indicated that they understood the purpose of the meeting and felt comfortable sharing their ideas, factors associated with higher levels of participation. However, relatively few survey respondents recalled having a CFT and many were not clear as to whether or not they had participated in such a meeting. This suggests a need for greater education and improved preparation of families prior to engaging in this process.

Overall it appears that when CFT meetings are inclusive of various stakeholders; families are appropriately prepared; family ideas are incorporated into resulting plans; and barriers to implementation are strategically addressed, such meetings are productive and useful tools in engaging families, informal supports and community partners.

Shared Parenting

Information about the implementation of Shared Parenting was collected through focus groups and caregiver phone interviews. Social workers and supervisors provided numerous examples of the effectiveness of this tool in forging relationships between foster parents and birth parents and expressed positive attitudes about this MRS strategy. Five of the twenty participating counties indicated that they are not currently using Shared Parenting suggesting that additional support by NCDSS may be needed in helping some counties to reach compliance with this policy requirement. Resistance on the part of foster parents, engagement of birth parents and tight time frames for implementing Shared Parenting meetings were discussed as significant barriers.

The responses from the caregiver phone survey support these findings with only 52% of families with children in foster care indicating that they had participated in Shared Parenting. Of those, only half said that they were encouraged to share information about their children's routines, likes and dislikes during the meeting. Many felt their ideas and comments were not taken seriously which again suggests a need for additional support and training specific to this MRS strategy.

Child Welfare-Work First Collaboration

Data regarding the level of collaboration between Work First and CPS was collected through focus groups and caregiver phone interview. The data indicate that social workers are utilizing their Work First counterparts for collateral contacts and are engaged in joint case planning, or at a minimum case coordination, in situations where there are mutual clients. The system for determining dual involvement was generally well defined and incorporated into county information systems, however, it is important to note that the overall number of CPS cases where the family has simultaneous involvement with Work First may be relatively few based on discussions within focus groups.

These findings were supported through feedback solicited in the caregiver phone survey. Only 7% of phone respondents indicated that they were concurrently involved with Work First and CPS. Almost half of them indicated that they became involved with Work First during the CPS assessment phase or while receiving in-home services. Additionally, families affirmed that in the majority of these cases, their CPS social workers were aware of their involvement with Work First.

Re-design of In-Home Services

Practice and logistical aspects of the re-design of in-home services were discussed in focus groups with social workers and supervisors providing important feedback specific to case contact requirements and the implications they have on case load management. Social workers noted a need for increased flexibility in case contact requirements, a more appropriate risk assessment tool, and changes to county processes for case assignment.

Families were asked a series of questions as part of the caregiver phone survey in an effort to gauge perceptions about experiences at this point along the CPS service continuum. The majority of families noted that they actively participated in the development of their case plans; felt their ideas were included in the plan; and believed that the resulting plan met the needs of the family. As noted above, it was not clear that all of these families had developed their case plans within a CFT meeting indicating an area for further growth in MRS implementation. The statewide adoption of standardized documentation for CFT meetings will surely be helpful for supervisors in their efforts to ensure that moving forward, case plans are developed utilizing this important MRS strategy.

Collaboration with Community Partners

The level of collaboration occurring between DSS and other community organizations was discussed in focus groups with various representatives from other county agencies and community-based organizations. Based on these discussions, it appears that DSS is doing a good job of collaborating with community partners in meeting the needs of families. One area identified for continued improvement was communication and feedback so that strong collaborative relationships endure. A key factor affecting communication is social worker turnover. This was mentioned in half of participating

counties as an issue that greatly impacts collaboration and subsequently services to families.

Other comments made in these groups suggesting that DSS is not holding families accountable or not doing enough to protect children suggesting a need for counties to conduct outreach and educational activities on MRS to address and/or alleviate these concerns. Outreach activities were widely conducted in the pilot 10 counties in early MRS implementation but should be part of an ongoing effort to educate stakeholders about this evolving systems change.

Blended Case Loads

Based on focus group data it appears that there is little support among social workers and supervisors for a blended case load structure due to logistical, staffing and administrative challenges. Many participants acknowledged that this structure likely represents best practice for working with families but also believe that given the high case load levels in many counties, the barriers associated were too great. Families surveyed in the caregiver phone survey overwhelming supported the idea of having one social worker for the life of a CPS case. These findings suggest that counties and NCDSS need to continue to work on the development of strategies to overcome the barriers associated with blended case loads in the interest of better serving families.

Family Satisfaction/Experience

Family satisfaction with their CPS experience was gauged through the caregiver phone surveys yielding mixed results. Overall, families expressed more positive feelings about their interaction with CPS later in the process as compared to initially. This finding indicates that negative perceptions about the role of CPS in the community may be effectively changing based on recent interactions with social workers. Further supporting this idea, 35% of respondents said they would not change anything about the way that CPS works with families. It should also be noted that of those that received services through CPS, only 29% felt they were helpful. It is not clear as to why the majority found the services to be less valuable but it may be an indicator of poor service array/quality or it could also be true that families did not agree that they needed the services in the first place.

Recommendations

Based on quantitative and qualitative findings within this report, the following recommendations address ways to foster continuous improvement in the implementation of a number of Multiple Response System strategies.

Practice/Policy Recommendations

The practice recommendations focus on four key areas; Shared Parenting, blended case loads, Child and Family Team meetings, and the re-design of in-home services. The data indicate that Shared Parenting meetings can be effective in forging relationships

between foster parents and birth parents with the end goal of providing a smoother transition for children in foster care. Even so, five out the of twenty participating counties indicated that they are not currently utilizing Shared Parenting meetings suggesting a need for increased accountability and documentation of these meetings to ensure that they are being held with consistency and the objectives of Shared Parenting are met. Given that the success of Shared Parenting is largely dependent on foster parents' willingness to engage with birth parents, it may be prudent to strengthen the curriculum and training efforts currently in place within required MAP training. It may also be useful for NCDSS to engage in discussions with counties about the seven day timeframe for holding Shared Parenting meetings, strategize how to overcome associated barriers and/or consider policy changes.

Similarly, NCDSS should continue to consult with counties specific to the benefits and challenges associated with a blended case load structure. This would be particularly important should changes to current policy come under consideration. It is clear from the data that many social workers and supervisors believe that blended case loads represent best practice in working with families but there is not broad support for this structure due to a number of valid logistical, staffing and case management issues. It is also important to note that the majority of respondents (families) in the caregiver phone survey supported the idea of one social worker for the life a CPS case. This has important implications for improving family centered practice and warrants further exploration and the development of strategies for addressing the challenges inherent in blended case loads so that more counties could adopt this structure.

The benefits of Child and Family Team meetings are broadly acknowledged across stakeholder groups as an effective MRS strategy however, they do present significant barriers in actual implementation. In an effort to better document and measure the success of these meeting, NCDSS has already put into place a statewide documentation tool which will greatly support continuous improvement efforts around CFT implementation. In addition, it may be useful for counties to develop more formalized local agreements with community partners to increase the level of participation among direct service providers which by extension will increase fidelity to the CFT model and ultimately better serve the needs of families. Additional training and/or coaching for social workers in preparing and engaging families in this process would also likely improve outcomes. Lastly, as funding permits, the addition of dedicated, trained CFT facilitators would go a long way in helping to address some of the staffing and logistical issues associated with this MRS strategy.

Findings related to the re-design of in-home services suggest a need for continued dialogue regarding policy on case contact requirements and case assignment strategies. NCDSS is already in the process of developing an updated risk assessment tool that will no doubt address many of the concerns related to case contact requirements because one is dependent upon the other.

Supervision

Enhanced supervision of social workers was a recommendation in the 2006 evaluation report but merits repeating because it is essential to the ongoing success of MRS. Supervisors must reinforce and monitor implementation to ensure that MRS strategies are being consistently and appropriately applied on a day-to-day basis. The development of training curriculum specifically for supervisors that focuses on the mentoring and coaching of social work staff could yield tremendous benefits for MRS implementation as well as for child welfare as a whole.

Collaboration with Community Partners

The findings of the evaluation suggest that participating counties are effectively collaborating with other agencies and community-based organizations in serving families however, there is a need for increased outreach and education with stakeholders specific to MRS policy and practices. In many instances, community-based organizations also experience high levels of staff turnover so outreach and education should be a continuous process.

Evaluation

Ongoing evaluation remains important for several reasons: to ensure that MRS standards and policies are being adhered to in day-to-day practice; to continually monitor the success of the strategies in improving child safety, permanence, and well-being; and to foster continuous improvements in practice. NCDSS is currently sponsoring evaluation specific to CFT meetings in an effort to better understand variations in practice and implementation and improve the process.

In addition, NCDSS should continue to work with counties to ensure more consistent data entry particularly related to the MRS tracking form (5106 form). This would substantially improve the availability of data on blended case loads or the practice of transferring of cases from one social worker to another. Additionally, more complete data entry of contributory factors associated with cases that are substantiated or found in need of services would provide a more complete picture of the kind of caregiver, child and household factors most prevalent in maltreatment cases. Such information would be extremely useful in service array development and expansion within counties.

Ongoing training and support for counties in the use of existing queries within the Client Services Data Warehouse would also be beneficial in helping counties to begin to track their own progress on key measures.

Appendix A

Data Sources and Data Processing

Child Protective Services (CPS) Assessments

Source

Data provided in the Central Registry records of the Client Services Data Warehouse are from the DSS-5104 form. These data include records for all CPS assessments. For this evaluation, data were extracted with the following parameters:

Dates of Downloads – February 17, 2009.

Time Period – July 1996- December 2008. Records from 7/1/1996 through 12/31/2008 (inclusive) were selected based on the Investigation Completed Date.

County – County Name was used to select data for the 10 pilot counties, 10 wave 2 sample counties and the 9 comparison counties identified for administrative data analyses.

View – All fields were selected from the Central Registry with an Individual Type of "Victim."

Fields – The following fields were included:

Initial Report Date	Investigation Initiated Date	Investigation Completed Date
County Case Number	Form Number	County Name
First Name	Middle Initial	Last Name
Birth Date	Race	Race Code
Sex	SIS Client ID	Social Security Number
Type Reported	Type Reported Code	Type Found
Type Found Code	Primary Maltreatment Type Found	Perpetrator Relationship
Caretaker Contributory Factor	Child Contributory Factor	Household Contributory Factor
Social Worker First Initial	Social Worker Middle Initial	Social Worker Last Name

Processing

Initial Processing

The three data files (one per wave) were downloaded from the Data Warehouse, and converted into a SAS® dataset[5]. This process included re-naming variables,

[5] All data processing was done with the SAS® statistical package, version 9.1.3.

converting dates, converting "#EMPTY" values to blanks, and other non-substantive changes. Records with a Perpetrator Relation of "Female Employee of Institution/Group Home," "Female Employee of a Day Care Facility/Plan," "Male Employee of Institution/Group Home," or "Male Employee of a Day Care Facility/Plan" were deleted, as were records with any variation of "Delete," "Do Not Use," "Invalid," or "Duplicate" for the First Name or Last Name. Also, 24 records were deleted because they were complete duplicates (based on the downloaded fields). Following this, a unique ID was assigned to all records for each child according to the following rules:

1. Records in the same County with the same SIS # were assigned the same ID, AND
2. Records in the same County with the same Last Name, First Name, Birth Date, and Sex (where all values for these fields are non-missing) were assigned the same ID.

There were a total of 732,920 records (all 29 counties, 7/1996-12/2008).

"Fuzzy" Matching

The data were further processed to assign the same unique ID to records with slight variations in the First Name, Last Name, Birth Date, or Sex fields. In all cases, the records were required to be within the same county, and the identifying fields were required to be non-missing. In some cases, SSN, SIS Number, Case Number, or Form Number were used to verify whether variations in the identifying variables indicated the records were for different children.

Children with Duplicate Records Except Form Number

For these, only one record was kept since all other information is the same, and the Form Number was not used in analyses.

Records with Missing Finding

These records were deleted.

Multiple Overlapping Assessments

Records showing multiple overlapping assessments for the same child exist in the CPS data. These records were combined if they had the same Investigation Completed Date. When combining, each field was looked at separately and the worst case for the field was kept in the combined record.

Final Data File

The final data file contains 707,622 (all 29 counties, 7/1996-12/2008) records. The final SAS® programs to process these data are as follows:

ReadCPS_S08	02/25/2009	3:37:21 PM
ID1_Init_S08	02/25/2009	4:03:32 PM
ID2_FName_S08	03/02/2009	10:15:35 AM
ID3_LName_S08	03/02/2009	10:52:35 AM
ID4_BDate_S08	03/02/2009	11:19:11 AM
ID5_Sex_S08	03/02/2009	11:34:52 AM
CrMastCPS_S_9608	03/25/2009	4:00:36 PM
CleanCPS_S_9608	03/26/2009	11:56:38 AM

Services Information System (SIS) Daysheet Data

Source

Data provided in the SIS Daysheet records of the Client Services Data Warehouse are from the DSS-4263 form. These data include a record for every time a person receives a service. For this evaluation, data were extracted with the following parameters:

Dates of Downloads – April 14, 2007 (Records for 4/2000 to 12/2006, delivered via FTP), April 16, 2008 (Records for 1/2007 to 12/2007), and February 18, 2009 (Records for 1/2008 to 1/2009)

Time Period – April 2000 - January 2009. These data contain selected records from 4/1/2000 through 1/31/2009 (inclusive) based on the Service Date.

Service Code – Only records for Service Code 210 (CPS-Investigative Assessment) were selected.

Fields – The following fields were included:

Service Date	Service Code	Program Code
County Name	Form Number	SIS Client ID
Minutes Amount	Worker Name (2007 to 2009)	Worker ID (2007 to 2009)
Service Description (2000 to 2006)		

Processing

Initial Processing

Four data files (two each per year) for 2007 and 2008 were downloaded from the Data Warehouse, while the 2000 - 2006 file was delivered via FTP. All files were then converted into a SAS® dataset. This process included re-naming variables, converting dates, converting "#EMPTY" values to blanks, and other non-substantive changes. Records with invalid SIS numbers (less than '20000000001' or greater than '20099999999') were deleted. A total number of Service Minutes per child and day was calculated with a maximum allowable value of 1440 minutes (24 hours) per day. There were a total of 3,722,821 records (all 29 counties, 4/2000 to 1/2009).

Summarizing Number of Minutes for CPS Assessments

The data were further processed and combined with the Central Registry data to determine the number of 210 service minutes associated with each CPS assessment. Only CPS assessments with Investigation Completed Date from July 1, 2000 through December 31, 2008 were used when working with the Daysheet data.

First, results from work done with the CPS assessments to assign a unique ID to all records for the same child were used to assign the same unique ID to all Daysheet records. Within each county, SIS numbers found in the CPS records were matched to the SIS numbers in the Daysheet data. Where a match was found, the associated unique ID was attached to the Daysheet records. Daysheet records with no matching SIS number in the CPS records were excluded.

Using the unique ID assigned to both the CPS assessment and Daysheet records, along with the report/investigation dates and service dates, these data were combined to identify all 210 service records associated with a CPS assessment. The 210 services were noted as happening during the assessment time period, within 7 days before the CPS report/investigation initiated date, or 30 days after the investigation completed date. The 210 services were then summarized by CPS assessment to yield the total number of minutes of 210 services provided before, during, or after the assessment time period for each CPS record.

It is possible to have CPS assessments for the same child with overlapping time periods. In this case, both assessments may match to the same 210 service records. When this happened, the 210 service record was associated with the CPS assessment that was closest in time.

Relationship between CPS assessments and Daysheet 210 Services

It is important to note that, while every CPS assessment should have corresponding 210 service minutes, and vice versa, this relationship is not consistent in the data provided through the Data Warehouse. For example, 8.42% of the CPS assessments had no corresponding 210 service minutes before, during, or after the assessment time period. Table A1 shows the breakdown of the relationship between all CPS assessment and Daysheet records processed for the time period of 7/1/2000 through 12/31/2008.

Table A1

	CPS Records		Daysheet Records	
	#	%	#	%
CPS Assessments with 210 Services	**433,612**	**85.4**	**2,977,927**	**80.0**
210 Services within 7 days BEFORE	8,790	1.7	11,252	0.3
210 Services DURING	421,383	82.9	2,652,792	71.3
210 Services within 30 days AFTER	168,520	33.2	313,883	8.4
CPS Assessments with no 210 Services	**74,451**	**14.6**		
210 Services with no CPS Assessment			**744,894**	**20.0**
No SIS Number match			313,367	8.4
Service Date not within Assesment dates (or 7 days before/30 days after)			431,527	11.6
Total	**508,063**		**3,722,821**	

Notes: The"CPS Records" component numbers and percentages for 210 services BEFORE, DURING, and AFTER will not sum up to the totals for CPS assessments with 210 services because a CPS assessment may have 210 service records for more than one of the BEFORE, DURING, or AFTER time periods.

In all analyses performed for this report, only the assessments with some 210 service minutes were included. In addition, only 210 service minutes that were received during the assessment, or within 7 days before the assessment were included. According to state DSS personnel, 210 service minutes received before the assessment start date involved a pre-assessment of the family. Those received within 30 days after the case decision date are primarily for completing paperwork, and do not usually include services provided directly to the child or family.

Final Data File

The final data file includes one record per CPS assessment, with the total number of 210 service minutes before, during and after the assessment for all assessments with Investigation Completed Dates from July 1, 2000 through December 31, 2008 for all 29 counties. The final file contains 508,063 records.

The final SAS® programs to process these data are as follows:

Read100_Day210_2006	04/13/2007	10:45:38 AM
Read100_Day210_2007	05/05/2008	2:29:58 PM
Read100_Day210_2008	03/03/2009	10:07:35 AM
Cr29_Day210_2008	03/26/2009	2:58:23 PM
Sum210_Cnty29_08	03/30/2009	2:41:28 PM

MRS Multiple Response and MRS Services Data

Source

Data provided in the MRS records of the Client Services Data Warehouse are from the DSS-5106 form. For this evaluation, data were extracted with the following parameters:

Dates of Downloads – March 18, 2009

Time Period – July 2007 – December 2008. Records from 7/1/2007 through 12/31/2008 (inclusive) were selected based on the Date of Case Decision.

Fields – The following fields were included:

MRS Multiple Response Database

Initial Report Date	Date of Case Decision	
County Name	Form Number	SIS Client
First Name	Last Name	Birth Date
Type Found Code	Social Worker Name	Service Code
Transfer Case Description	Transfer Reason Description	

MRS Services Database

County Name	Form Number	SIS Client ID
MRS Service Type Code	MRS Service Type Desc	Service Code
MRS Service Needs Indicator	MRS Service Needs Other Description	
MRS Service Provided Indicator	MRS Service Provided Other Description	
MRS Service Referred Indicator	MRS Service Referral Other Description	

Processing

The two data files were downloaded from the Data Warehouse, and converted into SAS® datasets. This process included re-naming variables, converting dates,

converting "#EMPTY" values to blanks, and other non-substantive changes. There were a total of 84,573 records (all 29 counties, 7/2007-12/2008) in the Multiple Response data and 131,316 records (all 29 counties, 7/2007-12/2008) in the Services data.

The final SAS® program to process these data was:

ReadMRD_2008 03/25/2009 2:43:02 PM

Population Estimates

Source

All county level source data files for child population were downloaded from the NC Office of State Budget and Management (OSBM) web site (http://www.osbm.nc.us/). While both the Census Bureau and the NC OSBM web site release intercensal population estimates for July 1 every year, the NC OSBM data use a methodology that is more precise than that used by the Census Bureau. For this evaluation, population estimates were downloaded as follows:

Dates of Downloads – September 25 and 29, 2008.

Time Period – 1990 - 2007. 1990 is the 1990 Census (posted on the NC OSBM web site). The 1991-2007 data are July 1 estimates.

Counties – All North Carolina counties.

Processing

For the years 1990 and 1999-2007, the NC OSBM data files provide estimates for individual ages 0-17. For the remaining years 1991-1998, OSBM supplies population estimates for select child age groups 0-2, 3-4, 5, 6-9, 10-13, 14, 15, and 16-17. In each case, the child population was calculated as the sum of the population for the individual ages, or the age groups, for ages 0-17. As of the time of this evaluation, population estimates for 2008 were not available. Therefore, the 2008 population counts are estimated using incremental differences from 2007.

Appendix B

Data Analyses and Statistical Findings

Data Setup

To investigate case distribution, child safety, timeliness of response, and frontloading in MRS counties, Child Protective Services reports and Services Information System Daysheet data were used. For all analyses, individual counties were clustered into county groups. One group consisted of the 10 pilot counties. Additional analyses grouped the 9 paired pilot counties together (all pilot counties except Mecklenberg) for comparison with their 9 matched control counties. Finally, 10 selected counties from wave 2 of MRS implementation were grouped to examine dissemination effectiveness. Within each county grouping, data were weighted so that each county contributed equally to the analysis. Data were analyzed by fiscal year. All data analyses were performed using the SAS® Version 9.1 statistical software.

Unit of Analysis

In general, analyses were based upon "unduplicated assessments." This means that the dataset consists of one assessment per child within a fiscal year. For children with more than one assessment during the year, the assessment with the most severe finding was used[6]. For example, if a child had two assessments in 2006, one with a finding of Substantiated Neglect, and the other with a finding of Services Recommended, only the record for Substantiated Neglect was kept for use in the analysis.

Some analyses, such as those examining timeliness of response, utilized all assessments regardless of duplication. These datasets included all assessments for all children.

Weighting Methods

Child population and the number of children and cases assessed annually varied by county. To ensure that each county contributed equally within each analysis, a weighting method was employed. Some analyses required individual records for the unit of analysis, and some required that the individual records be summarized to the county level. Two weighting methods were used, dependent upon which of these two levels of data were appropriate for the analysis.

[6] The order of severity of findings was defined, from most severe to least severe, as: Abuse, Neglect, Dependency, Services Needed, Services Recommended, Unsubstantiated, and Services Not Recommended.

"Individual Record Level Weighting" – The individual records for the unit of analysis were weighted equally by county for each year. A sampling weight was calculated as N/n, where N = the average number of records per county across all counties in the dataset for the year, and n = the actual number of records in the dataset for the county during the year. For example, for analyses of rates of assessment in pilot counties in 2003 the number of assessments in Mecklenburg County was n=10368 while the number of assessments analyzed in Nash County was n=1295. The average number of assessments analyzed across the 10 pilot counties was N=2823. Therefore the weight for Mecklenburg was calculated as N/n=2823/10368 or 0.272, while the weight for Nash County was 2823/1295 or 2.180.

"County Level Weighting" – Whether the analysis was based on percentages, rates, or means within a county and year, each county was weighted equally within a county group. This was done by first calculating statistics (percentages, rates, or means) within each county and year. These data were included in a county-level dataset with one record per county and year. Analyses then considered each of these statistics as a separate, equally weighted data point.

Matrix of Dummy Variables

Due to the high correlation of cases within counties and the fixed, non-random selection of the counties analyzed, generalized linear and logistic regression models incorporated the deviation from the means methodology. The deviation from means method requires setting up a matrix of dummy variables for the group of counties analyzed. When pilot counties were analyzed as a group, Transylvania County was set as the reference county, with a value of -1. For the non-reference counties, the dummy variable for each county was set to 1, with the value of the remaining 8 counties' dummy variables set to 0. Separate matrices of dummy variables were setup for the 9 paired pilot counties, 9 control counties, and 10 wave 2 counties respectively, with separate reference counties established for each county grouping.

Case Distribution

Use of Dual Tracks and Case Distribution

Data Preparation

To investigate use of the dual track strategy and the case finding distribution for Family Assessments, all assessments from July 1, 2002 (pilot counties) or July 1, 2003 (wave 2 counties) through June 30, 2008 were examined. To look at dual track usage, we

examined the percentage of cases handled in the family assessment track in each fiscal year, weighted evenly across counties. For the 2002-2003 fiscal year (pilot counties) and 2003-2004 fiscal year (wave 2 counties), proportions were particularly low because MRS was not implemented for the full year (i.e., MRS started at some point during the fiscal year in each county). To examine changes in Family Assessment case findings over time, we examined the proportion of cases in each county and fiscal year with findings in each of the four categories: Services Needed, Services Recommended, Services Provided (CPS no longer needed), and Services Not Recommended.

To investigate changes in case findings for Investigative Assessments, all assessments from July 1, 1996 to June 30, 2008 were examined. Case findings over time were calculated as the proportion of cases in each county and fiscal year with findings in each of the four categories: Substantiated Abuse, Substantiated Neglect, Substantiated Dependency, and Unsubstantiated.

Statistical Methods and Findings

Logistic regressions were used to test for associations between the year of MRS implementation and the distribution of assessments by track and by decision. Analyses were run separately for pilot and wave 2 counties, and included the matrix of dummy variables to control for intra-county correlations. Each analysis was conducted on data weighted at the individual record level so that each county contributed equally to the analyses.

For pilot counties, the proportion of assessments in the Family Track increased significantly over time (X^2=6843.89, p<0.0001). The proportion in the Family Track with a finding of Services Needed decreased slightly, but significantly, over time (X^2=7.71, p<0.01). The proportion with a finding of Services Recommended increased over time (X^2=272.14, p<0.0001). The proportion with a finding of Services Provided increased over time (X^2=1511.45, p<0.0001). Finally, the proportion with a finding of Services Not Recommended decreased over time (X^2=752.53, p<0.0001). In the Investigative track, the proportion with a finding of Substantiated Abuse increased over time (X^2=73.31, p<0.0001). The proportion with a finding of Substantiated Neglect decreased over time (X^2=74.25, p<0.0001). The proportion with a finding of Substantiated Dependency increased slightly over time (X^2=58.26, p<0.0001). The proportion with a finding of Unsubstantiated did not change significantly over time in a linear fashion, despite a brief drop after MRS initiation (X^2=3.44, ns).

For wave 2 counties, the proportion of assessments in the Family Track increased significantly over time (X^2=3284.93, p<0.0001). The proportion in the Family Track with a finding of Services Needed decreased slightly, but significantly, over time (X^2=4.37, p<0.05). The proportion with a finding of Services Recommended increased over time (X^2=229.02, p<0.0001). The proportion with a finding of Services Provided increased over time (X^2=983.63, p<0.0001). Finally, the proportion with a finding of Services Not Recommended decreased over time (X^2=649.77, p<0.0001). In the Investigative track, the

proportion with a finding of Substantiated Abuse remained stable over time (X^2=2.81, ns). The proportion with a finding of Substantiated Neglect increased slightly, but significantly, over time (X^2=27.16, p<0.0001). The proportion with a finding of Substantiated Dependency also increased slightly over time (X^2=12.98, p<0.001). The proportion with a finding of Unsubstantiated decreased significantly over time (X^2=42.04, p<0.0001).

To compare track and case decision rates over time by county group (pilot vs. wave 2), logistic regressions were run using the following predictors: year (operationalized as number of years since implementation), county group, and the interaction of year by county group. For proportions of assessments in each track, all three predictors were significant. This demonstrates that, as mentioned above, the proportion of assessments placed into the Family Track increased over time (X^2=7971.74, p<0.0001). Additionally, pilot counties maintained a higher level of Family Assessments across time (X^2=166.51, p<0.001), though wave 2 counties showed a larger increase in Family Assessments (X^2=46.54, p<0.001; due mostly to the low rate in year one, when MRS implementation started mid-way through the fiscal year).

For Family Assessment case findings, wave 2 counties had a slightly higher rate of Services Needed findings across the years as compared with pilot counties (X^2=8.45, p<0.01), but a much lower rate of Services Recommended (X^2=696.49, p<0.0001). Wave 2 counties had higher rates of Services Provided (CPS no longer needed) and Services Not Recommended findings (X^2=511.52, p<0.0001 and X^2=284.44, p<0.0001, respectively). For Investigative Assessment case findings, wave 2 counties had slightly higher rates of Substantiated Abuse across time (X^2=16.43, p<0.001), but equivalent rates of all other case findings (X^2=3.54, ns for Substantiated Neglect; X^2=2.91, ns for Substantiated Dependency; and X^2=0.50, ns for Unsubstantiated).

Child Safety

Changes in Rates of Assessments and Substantiations

Data Preparation

In order to examine changes in rates of assessments and substantiations over time, unduplicated assessments were used as the unit of analysis. Estimated population counts of children under the age of 18 in each county for each fiscal year 1996-1997 through 2007-2008 were obtained and merged with the data (see Appendix A). Three summarized datasets were created: one for the 10 pilot county group, one for the 9 paired pilot and control counties, and one for the 10 selected wave 2 counties. Unduplicated assessments and child population were used to calculate the rates of assessment, and unduplicated substantiations and child population were used to calculate the rates of substantiation. Each summarized dataset included one record per year and county. This ensured that each county contributed equally to the analysis.

Statistical Methods

To analyze the changes in rates of assessment and substantiation, we employed a regression-based interrupted time series (ITS) procedure amenable to time series with fewer than 50 observations (Lewis-Beck, 1986). To test for serial dependency and autocorrelation in the time series data, this procedure uses the Durbin-Watson statistic (ideally approximately = 2), and subsequently tests the rho (ρ: population correlation between error terms; ideally < .30) if the DW test suggests autocorrelation. If significant autocorrelation is found, a further step is taken to adjust for the autocorrelation in order to render the error terms independent.

ITS models test for intercept or level change immediately after an interruption (here, MRS implementation) as well as the overall slope change following an interruption. For comparisons between pilot and control counties, we also include a parameter for main effect of county group and interaction effects for: slope differences by county group pre-MRS; post-MRS changes in levels by county group; and post-MRS changes in slope by county group. Because MRS is an on-going child welfare model (vs. a single time point interruption as is often tested in these models), our focus was on the county by slope change interaction parameter as a test of the effects of MRS. This interaction term models changes in pilot county trajectories after the initiation of MRS as compared with trajectories in control counties. The time-series regression equation is:

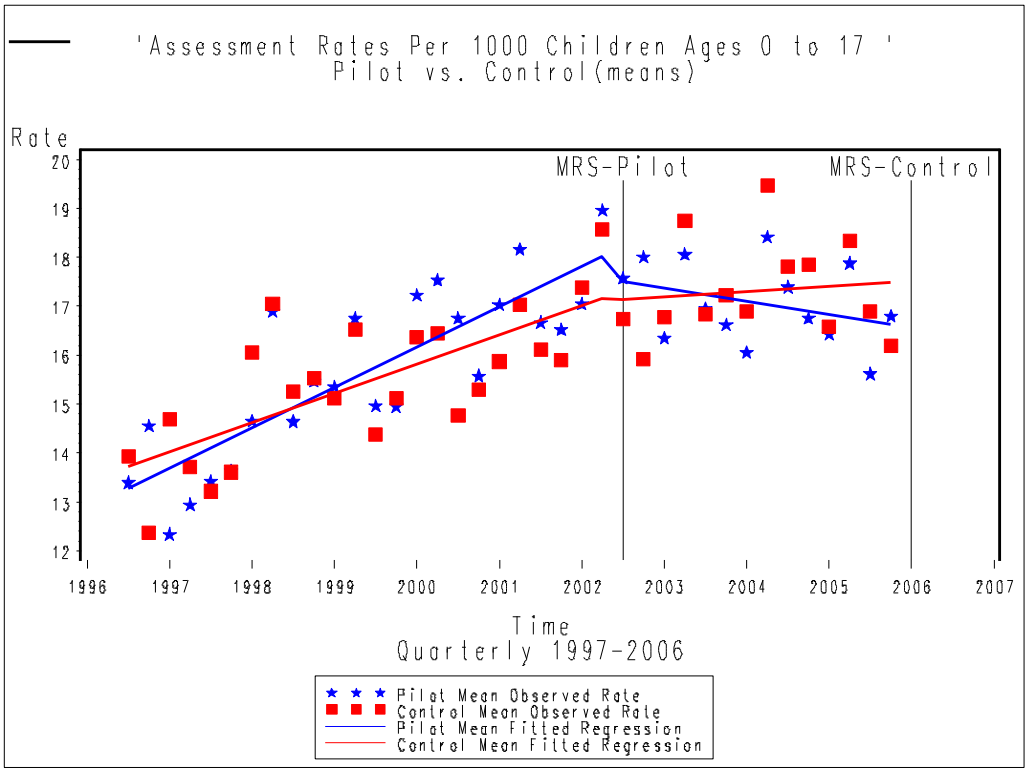
$$Y_1 = b_0 + b_1X_{1t} + b_2X_{2t} + b_3X_{3t} + b_4X_{4t} + b_5X_{1t}X_{4t} + b_6X_{2t}X_{4t} + b_7X_{3t}X_{4t} + e_t.$$ [7]

Findings

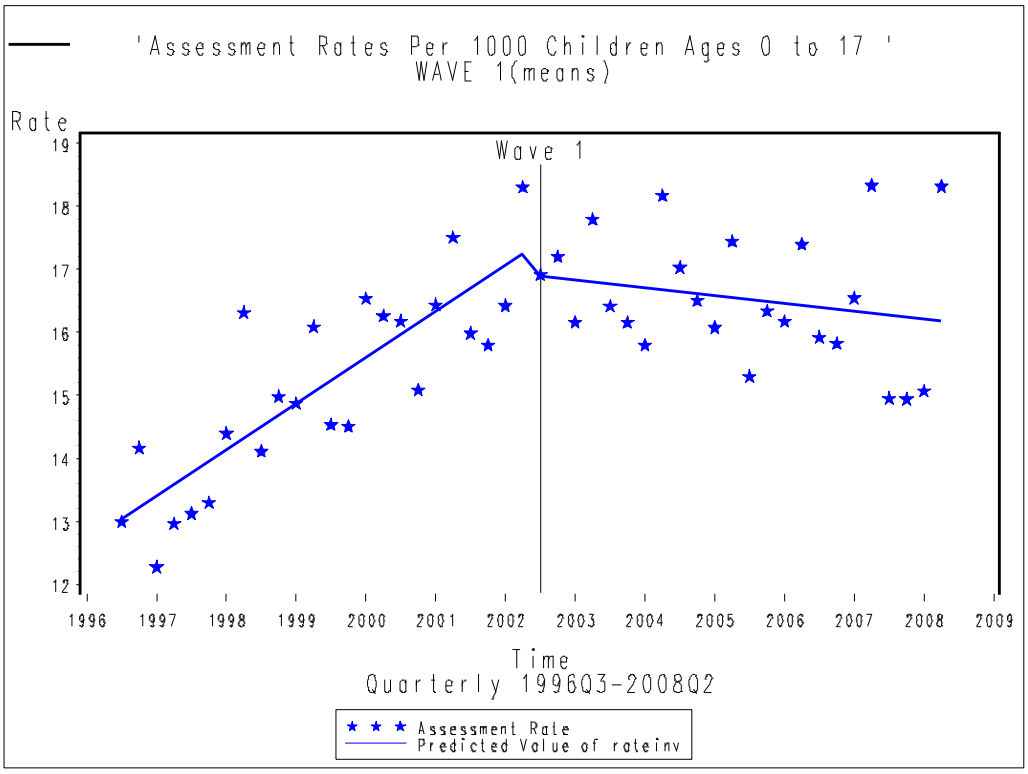
Findings for the ITS models showing rates of assessment and substantiation are presented below, first as a comparison of pilot and matched control counties, then separately for all 10 pilot counties and 10 wave 2 counties. Figures depict the trend lines before and after MRS implementation, and text describes the statistical results.

[7] Terms in the model are: Y_1 = outcome variable, b_0 = intercept, b_1 = pre-MRS slope, b_2 = pre-post intercept change, b_3 = pre-post slope change, b_4 = main effects of county group, b_5 = county group difference (interaction effects) in pre-intervention slope, b_6 = county group difference (interaction effects) in pre-post intervention intercept change, b_7 = county group difference (interaction effects) in pre-post intervention slope change, X_{1t} = ordinal variable for time, 1 to N time points, X_{2t} = dummy variable: 0 before MRS and 1 after, X_{3t} = dummy variable: 0 before MRS and ordinal after (1, 2, 3…), X_{4t} = county group, $X_{1t}X_{4t}$ = interaction county group*time, $X_{2t}X_{4t}$ = interaction county group*postMRS, $X_{3t}X_{4t}$ = interaction county group*timeMRS, e_t = error.

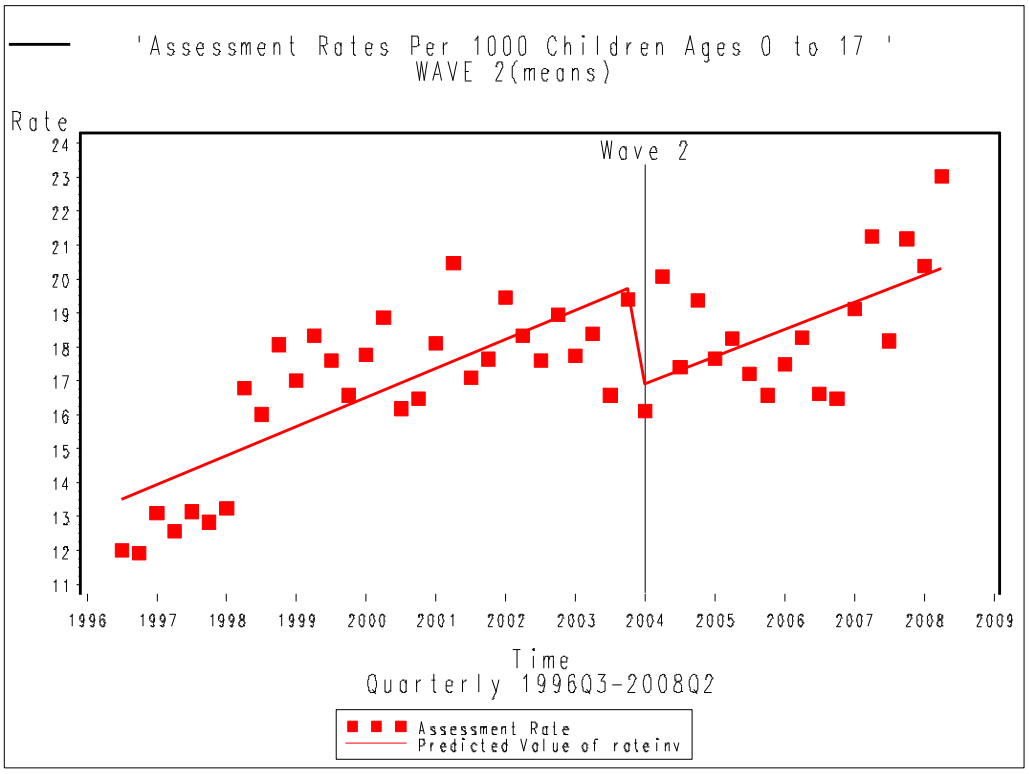
Assessment Rates



The overall model for all children (children ages 0-17 years old) was significant with acceptable autocorrelation ($F(7, 68) = 18.7$, $p < 0.0001$, $R^2 = 0.66$, Adj $R^2 = 0.62$, DW = 2.0, $\rho = -0.01$). There was no significant change in the slope or intercept of assessment rates pre- to post-MRS in pilot counties relative to in control counties.

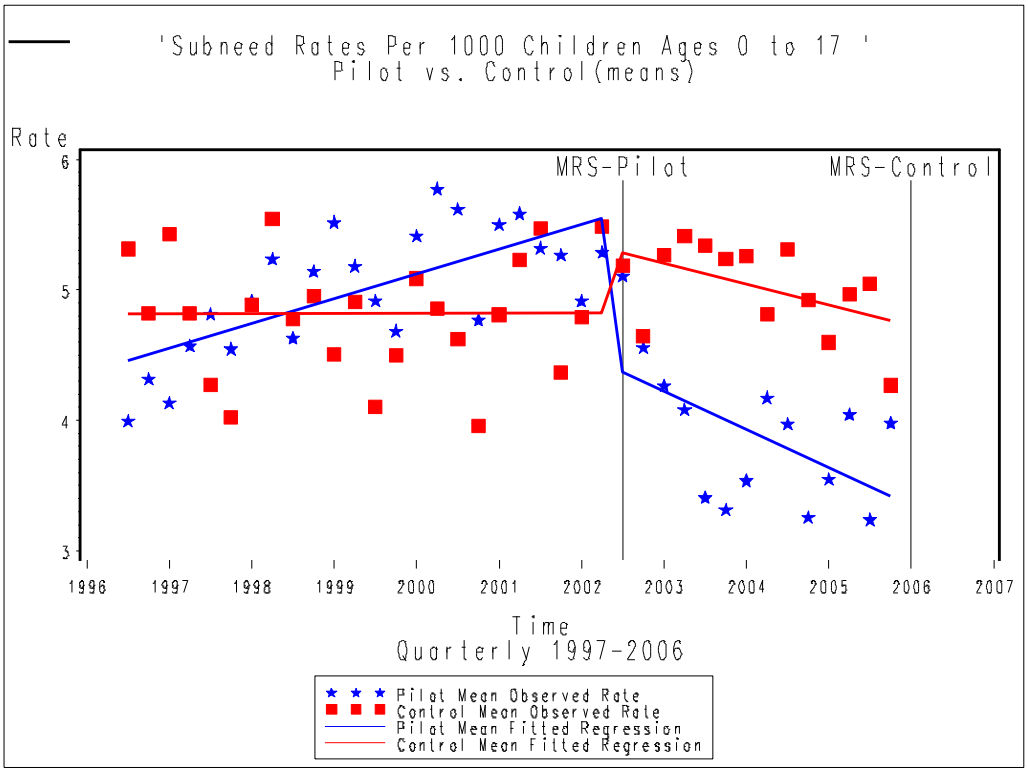


In wave 1 (pilot) counties, the overall model for all children (ages 0-17) was significant with acceptable autocorrelation ($F(3, 44) = 23.5$, $p < 0.0001$, $R^2 = 0.62$, Adj $R^2 = 0.59$, DW = 2.2, $\rho = -0.14$). The intercept (level) of assessment rates did not change pre- to post-MRS in wave 1 counties; however, with a longer follow-up time, there was a significant decrease in the slope of assessment rates for all children pre- versus post-MRS implementation ($t=-5.4$, $p<0.0001$).

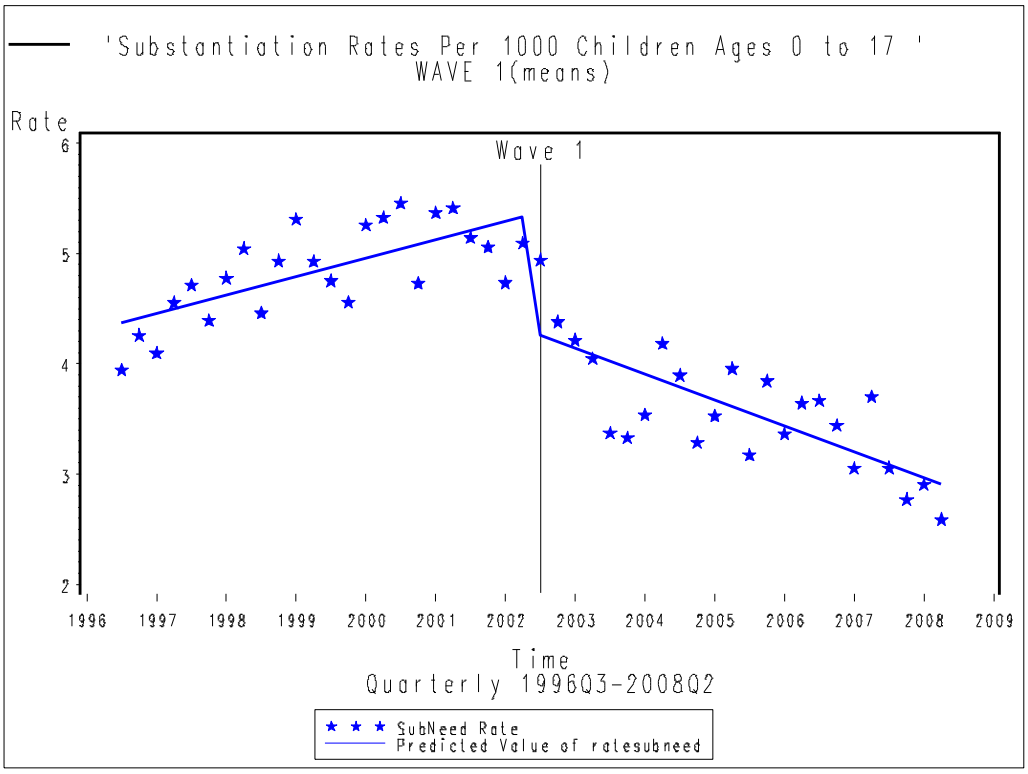


In wave 2 counties, the overall model for children (ages 0-17) was significant with unacceptable autocorrelation ($F(3, 44) = 21.9$, $p < 0.0001$, $R^2 = 0.60$, Adj $R^2 = 0.57$, DW = 1.3, $\rho = 0.32$). After adjusting for autocorrelation, results show that the intercept (level) of assessment rates dropped significantly at the pre- to post- MRS time point (t=-3.1, p=0.003); however there was no pre- to post-MRS change in the slope of the rate of assessments (the assessment rates for children in wave 2 counties continued to rise with the same trajectory after MRS began).

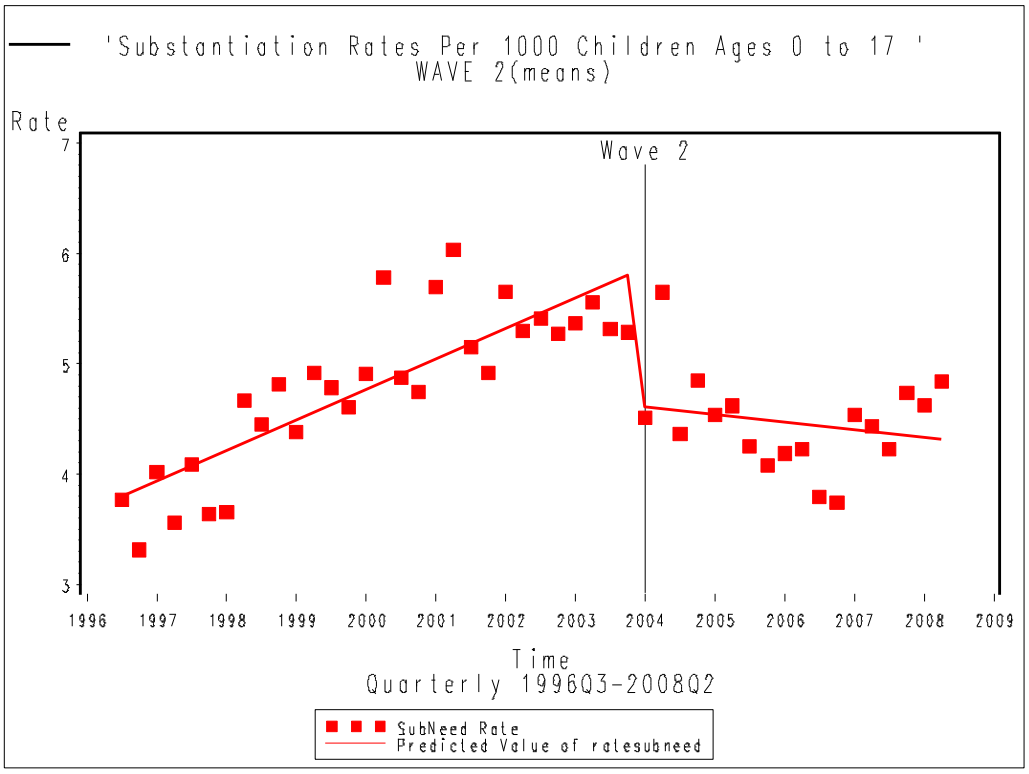
Substantiation Rates



The overall ITS model for substantiation rates was significant with acceptable autocorrelation for all children (ages 0-17 years old), ($F(7, 68) = 14.5$, $p<0.0001$, $R^2 = 0.60$, Adj $R^2 = 0.56$, DW = 1.7, $\rho = 0.15$). The intercept (level of substantiation rates) decreased significantly pre- to post- MRS in pilot counties relative to in control counties (t=-4.0, p<0.001). This is likely because of the added case decision option for "services recommended". Services recommended cases are not included in the substantiated/services needed category, but it is likely that some of these cases would have be substantiations under the previous system. There was also a trend effect for the pre- to post-MRS change in the slope of substantiation/services needed rates in pilot counties (decreased more) versus in control counties (t=-1.9, p=0.06).



In wave 1 (pilot) counties, the overall model for all children was significant with acceptable autocorrelation ($F(3, 44) = 73.4$, $p < 0.0001$, $R^2 = 0.83$, Adj $R^2 = 0.82$, DW = 1.7, $\rho = 0.12$). The intercept (level) of substantiation rates dropped significantly at the pre- to post- MRS time point (t=-5.2, p<0.0001), and the slope of the substantiation rates for all children dropped significantly after MRS began in wave 1 counties (t=-7.1, p<0.0001).



In wave 2 counties, the overall model for all children was significant with acceptable autocorrelation ($F(3, 44) = 23.4$, $p < 0.0001$, $R^2 = 0.61$, Adj $R^2 = 0.59$, DW = 1.6, $\rho = 0.18$). The intercept (level) of substantiation rates dropped significantly (t=-4.7, p<0.0001); furthermore the pre- to post-MRS change in the slope of substantiation rates was significant for children in wave 2 counties (t=-4.1, p=0.0002).

Repeat Assessment

Data Preparation

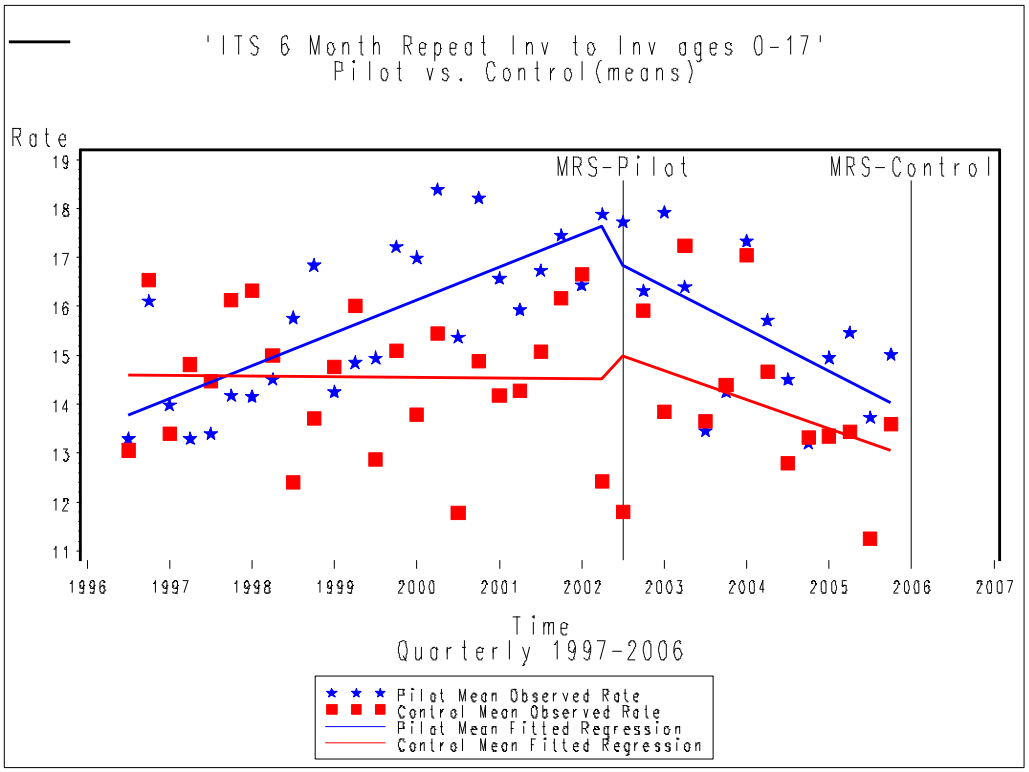
In order to assess trends in repeat assessments within six months, three summarized datasets were created: one for the 10 pilot county group, one for the 9 paired pilot and control counties, and one for the 10 selected wave 2 counties. The count of within six month re-assessments and the count of unduplicated assessments were used to calculate the rates of repeat assessment. Each summarized dataset included one record per year and county. This ensured that each county contributed equally to the analysis.

Statistical Methods

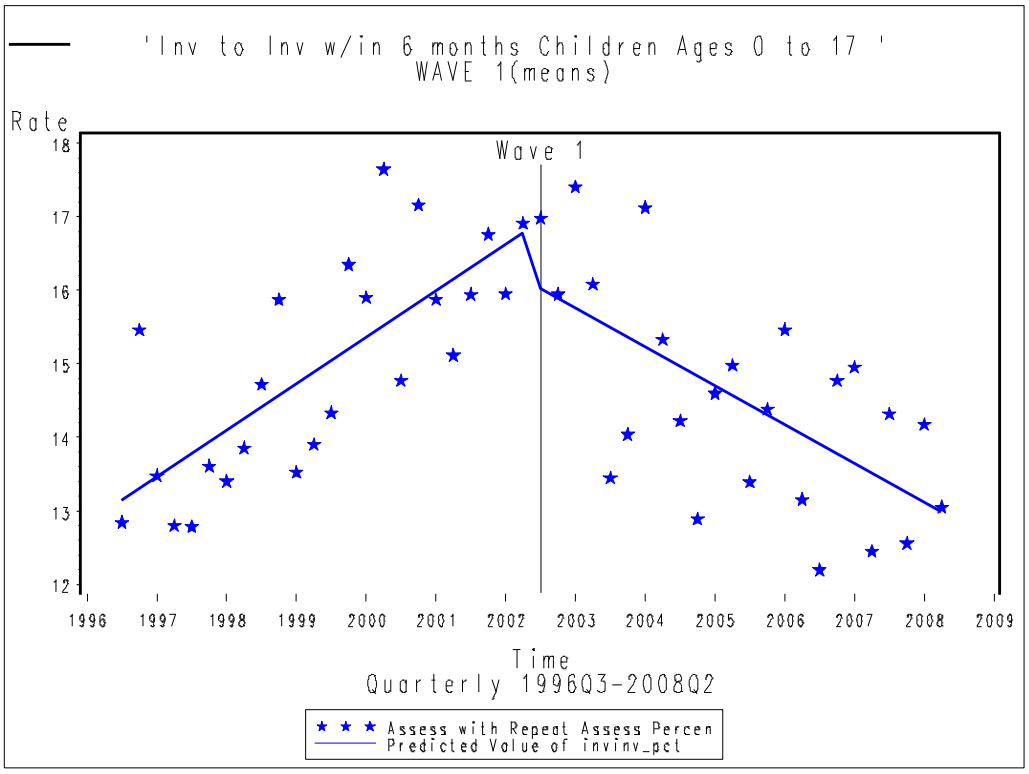
Interrupted Time Series (ITS) analyses were utilized to assess changes in rates of repeat assessment at the point of MRS implementation. ITS analytic procedures are described above.

Findings

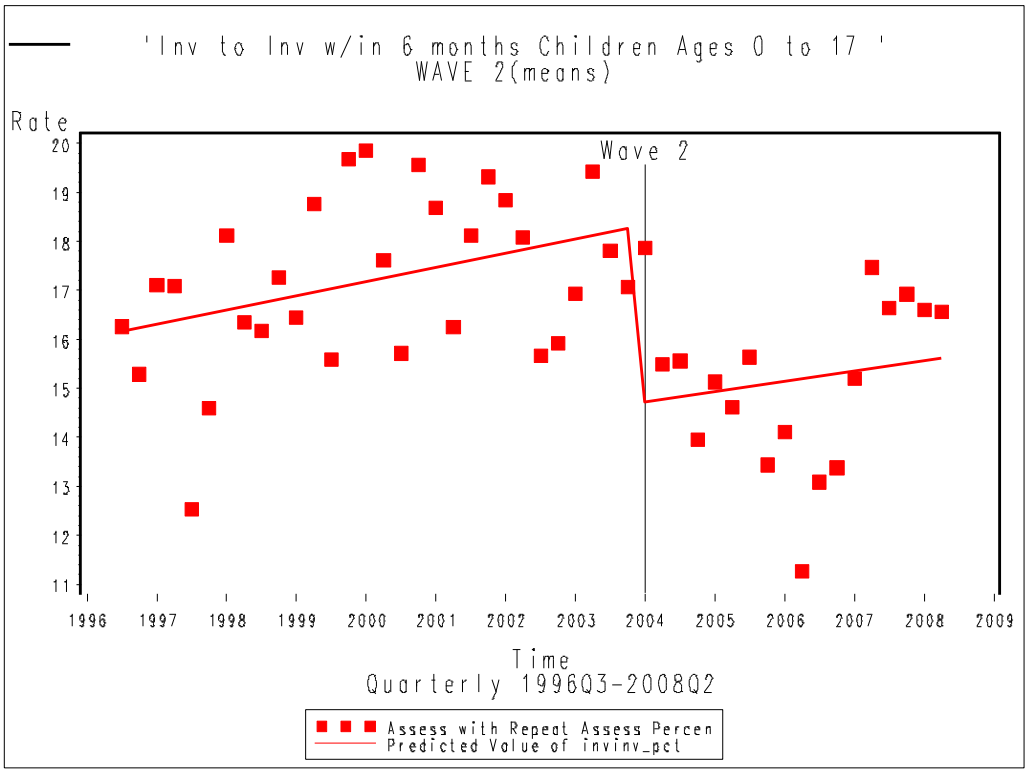
Findings for the ITS models are presented below, first as a comparison of pilot and matched control counties, then separately for all 10 pilot counties and 10 wave 2 counties. Figures depict the trend lines before and after MRS implementation, and text describes the statistical results.



The overall model for all children (ages 0-17 years old) was significant with acceptable autocorrelation ($F(7, 68) = 4.5$, $p<0.0001$, $R^2 = 0.39$, Adj $R^2 = 0.33$, DW = 2.2, $\rho = -0.10$). The intercept of repeated assessment rates (within 6 months) for all children did not change at the MRS implementation time point for pilot counties versus control counties. A trend effect was evident for the pre- to post- MRS change in slope in pilot counties versus in control counties, the trajectory for repeated assessment rates decreased more in pilot counties than in control counties (t=-1.7, p=0.09).



In wave 1 (pilot) counties, the overall model for all children (ages 0-17) was significant with acceptable autocorrelation ($F(3, 44) = 14.2$, $p<0.0001$, $R^2 = 0.49$, Adj $R^2 = 0.46$, DW = 2.1, $\rho = -0.05$). The intercept (level) of repeated assessment rates (inv to inv w/in 6 months) did not change pre- to post- MRS in wave 1 counties; however there was a significant change in slope (reverse in trajectory) of repeated assessment rates for children pre- versus post-MRS implementation (t=-6.3, p<0.0001).



In wave 2 counties, the overall model for all children (ages 0-17) was significant with acceptable autocorrelation ($F(3, 44) = 7.3$, $p<0.001$, $R^2 = 0.33$, Adj $R^2 = 0.29$, DW = 1.5, $\rho = 0.23$). The intercept (level) of assessment rates decreased significantly pre- to post- MRS in wave 2 counties (t=-3.6, p<0.001); however the slope of repeated assessment rates for children did not change pre- versus post-MRS implementation.

Timeliness of Response: Initial Response and Time to Case Decision

Initial Response

Data Preparation

Using all cases as the unit of analysis, data were compiled to include the length of time to initial response and an "on-time" flag. The length of time to initial response was calculated as the number of days from report date to case start date. The on-time flag was then set to 1 if DSS responded to the case within the required time period (depending on the type of report), and 0 if not. Summarized data sets were then created by county and year, including one for the 10 pilot counties, one for the 9 paired pilot and control counties, and one for the 10 selected wave 2 counties. On-time response and case counts were used to calculate the rates of on-time initial response. Each summarized dataset included one

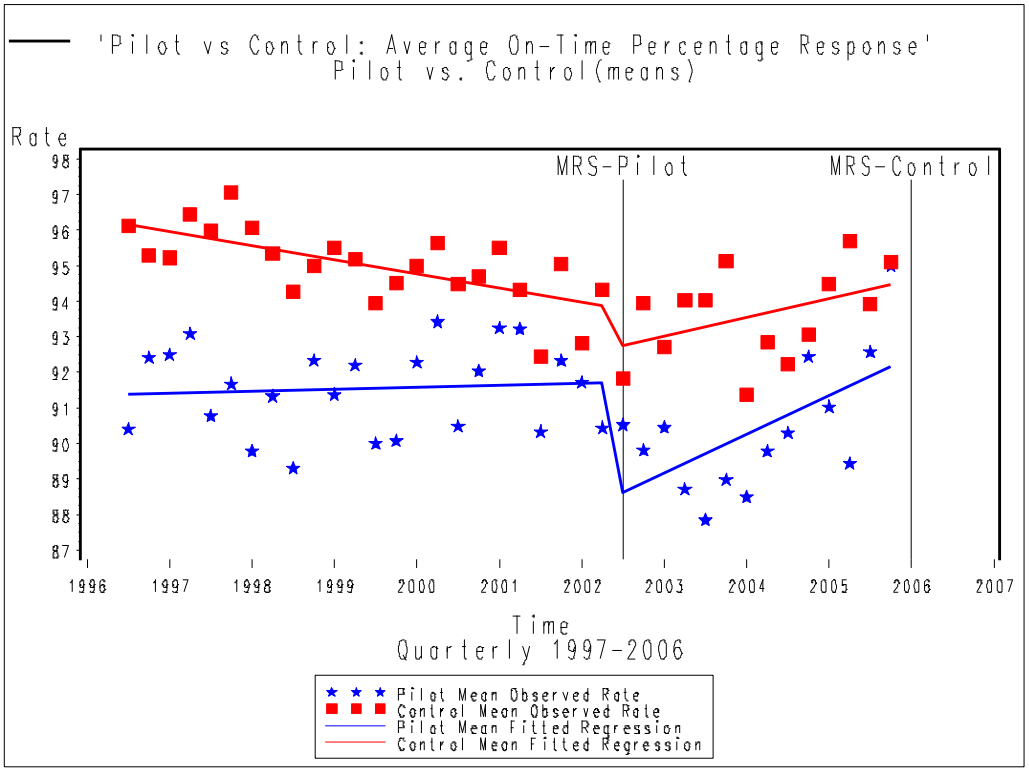
record for each year for each county. This ensured that each county contributed equally to the analysis.

Statistical Methods

Interrupted Time Series (ITS) analyses were utilized to assess changes in timeliness of initial response at the point of MRS implementation. ITS analytic procedures are described above.

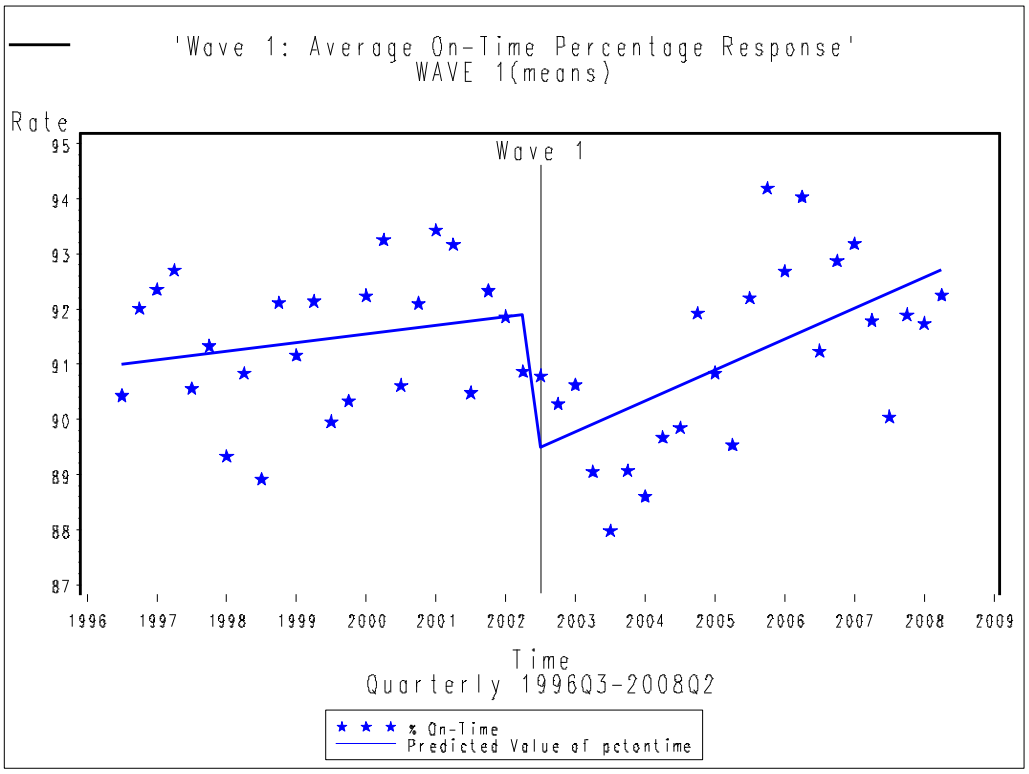
Findings

Findings for the ITS models are presented below, first as a comparison of pilot and matched control counties, then separately for all 10 pilot counties and 10 wave 2 counties. Figures depict the trend lines before and after MRS implementation, and text describes the statistical results.

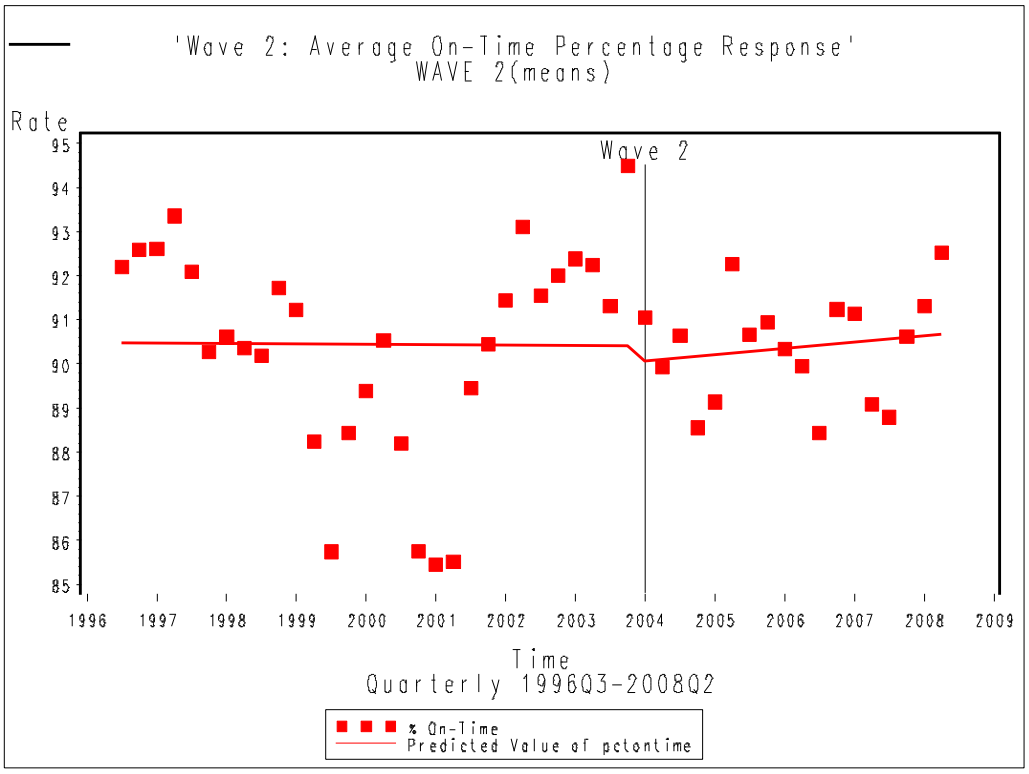


The overall model for average percent of on-time case response was significant with acceptable autocorrelation ($F(7, 68) = 28.1$, $p < 0.0001$, $R^2 = 0.74$, Adj $R^2 = 0.72$, DW = 1.9, $\rho = 0.03$). The intercept (level) of on-time responses decreased in pilot counties relative to in control counties (a trend effect) at the MRS implementation time point (t=-1.8, p=0.08). The slope of on-time responses did not change in pilot counties relative to control counties

pre- to post-MRS implementation. In sum, it appears that MRS temporarily disrupted time to response in pilot counties, but it has returned to previous levels.



In wave 1 (pilot) counties, the overall model for on-time case response was significant with acceptable autocorrelation ($F(3, 44) = 5.0$, $p = 0.004$, $R^2 = 0.26$, Adj $R^2 = 0.20$, DW = 1.5, $\rho = 0.22$). The model indicated the intercept (level) of percentage on-time case response dropped significantly at the MRS implementation time point in wave 1 counties (t=-3.4, p=0.002); the slope of percentage on-time case response increased (a trend effect) post-MRS implementation (t=1.9, p=0.07). Similar to above, timeliness of response fell just after MRS, but has rebounded to previous levels.



In wave 2 counties, the overall model for on-time case response was not significant and had unacceptable autocorrelation ($F(3, 44) = 0.05$, $p = 0.98$, $R^2 = 0.003$, Adj $R^2 = -0.06$, DW = 0.65, $\rho = 0.66$). After adjusting for autocorrelation, MRS does not appear to have affected timeliness of response in wave 2 counties.

Time to Case Decision

Data Preparation

Using all cases as the unit of analysis, data were compiled to include the length of time to case decision and an "on-time" flag. The length of time to case decision was calculated as the number of days from case start date to case decision date. The on-time flag was set to 1 if case decision was made within 30 days for all cases in control counties and for Investigative track cases in MRS pilot counties, or within 45 day for pilot county Family Assessment Track cases. The on-time flag was set to 0 for cases in which the number of days until case decision exceeded those guidelines.

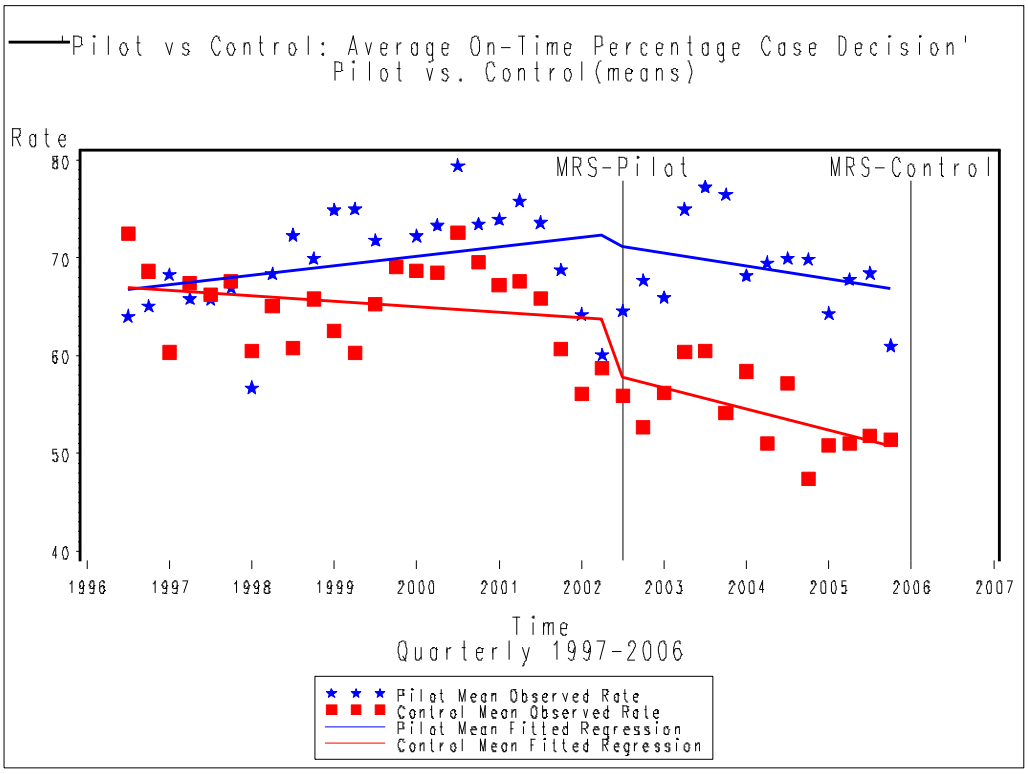
Summarized data sets were then created by county and year, including one for the 10 pilot counties, one for the 9 paired pilot and control counties, and one for the 10 selected wave 2 counties. On-time case decision and case counts were used to calculate the rates of on-time case decision. Each summarized dataset included one record for each year for each county. This ensured that each county contributed equally to the analysis.

Statistical Methods

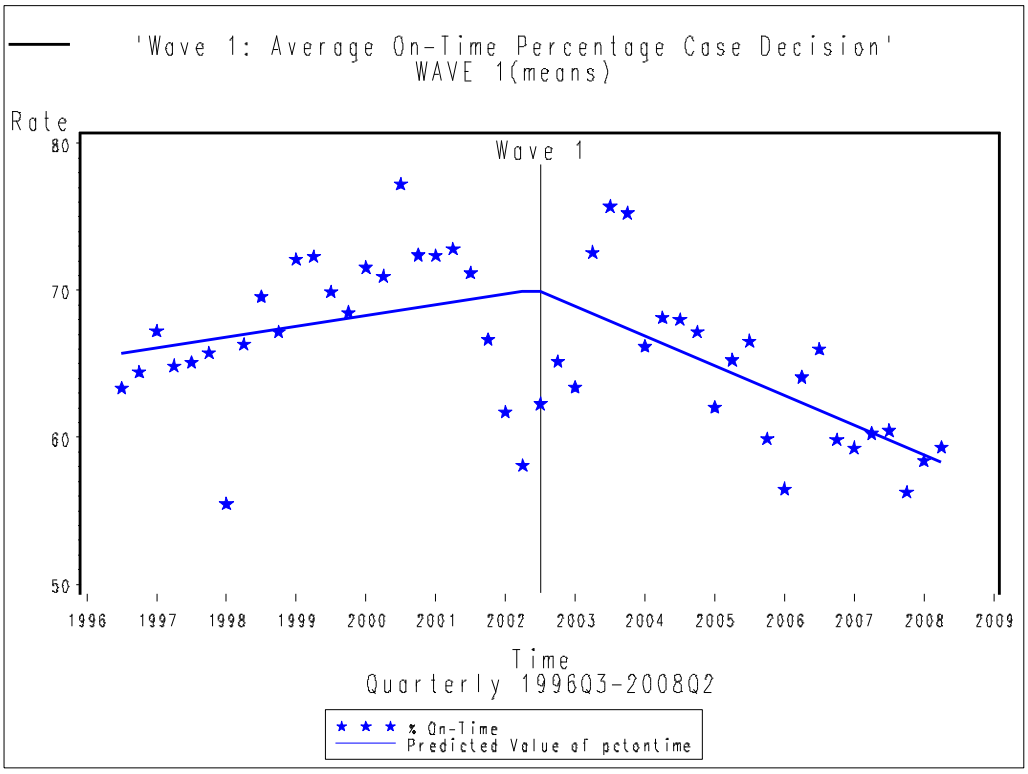
Interrupted Time Series (ITS) analyses were utilized to assess changes in timeliness of case decision at the point of MRS implementation. ITS analytic procedures are described above.

Findings

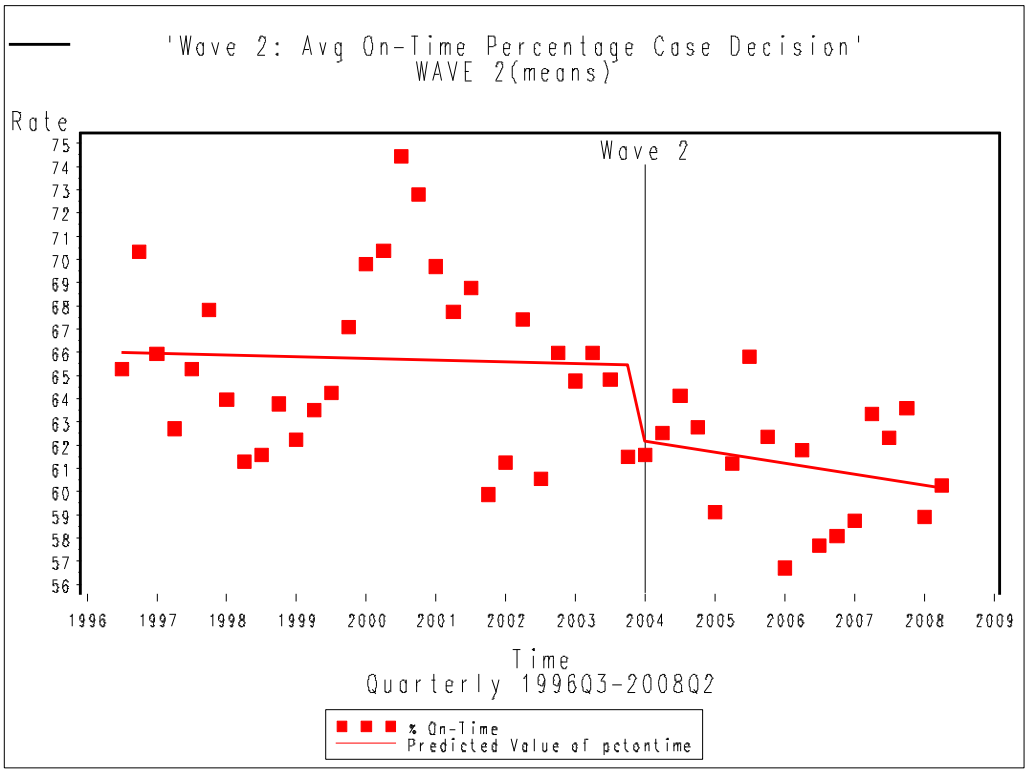
Findings for the ITS models are presented below, first as a comparison of pilot and matched control counties, then separately for all 10 pilot counties and 10 wave 2 counties. Figures depict the trend lines before and after MRS implementation, and text describes the statistical results.



The overall model for average % on time case decision was significant with unacceptable autocorrelation ($F(7, 68) = 17.6$, $p < 0.0001$, $R^2 = 0.64$, Adj $R^2 = 0.61$, DW = 1.2, $\rho = 0.42$). The results of the autoregressive model indicated that neither the intercept (level) nor the slope of percentage on time case decisions changed in pilot counties relative to control counties pre- to post-MRS implementation.



In wave 1 (pilot) counties, the overall model for on-time case decisions was significant with unacceptable autocorrelation ($F(3, 44) = 8.1$, $p < 0.001$, $R^2 = 0.36$, Adj $R^2 = 0.31$, DW = 0.95, $\rho = 0.52$). The auto-regressive model indicated the intercept (level) of percentage on-time case decisions did not change pre- to post- MRS in wave 1 counties; however there was a significant slope decrease in percentage on-time case decisions pre- versus post-MRS implementation ($t=-3.7$, $p<0.001$).



In wave 2 counties, the overall model for on-time case decisions was significant with unacceptable autocorrelation ($F(3, 44) = 7.1$, $p < 0.001$, $R^2 = 0.33$, Adj $R^2 = 0.28$, DW = 1.1, $\rho = 0.45$). The auto-regressive model indicated that neither the intercept (level) nor the slope of percentage on-time case decisions changed in wave 2 counties post-MRS implementation. In general, though, timeliness of case decision looks like it has been dropping since about 2000 for all 3 waves.

Frontloading of Services

Data Preparation

"Frontloading services" were defined as 210 services received during an assessment or within 7 days before an assessment; 210 services received after the assessment end date were not included in these analyses. For each assessment the total number of minutes of 210 services was determined, and this number of minutes was averaged to create a mean number of frontloaded minutes per county per year. In order to assess trends in frontloading, three summarized datasets were created: one for the 10 pilot county group, one for the 9 paired pilot and control counties, and one for the 10 selected wave 2 counties. Each summarized dataset included one record per year and county. Within each county group and year, county level weighting was used to calculate the weighted mean number of frontloading minutes. The mean number of assessments across

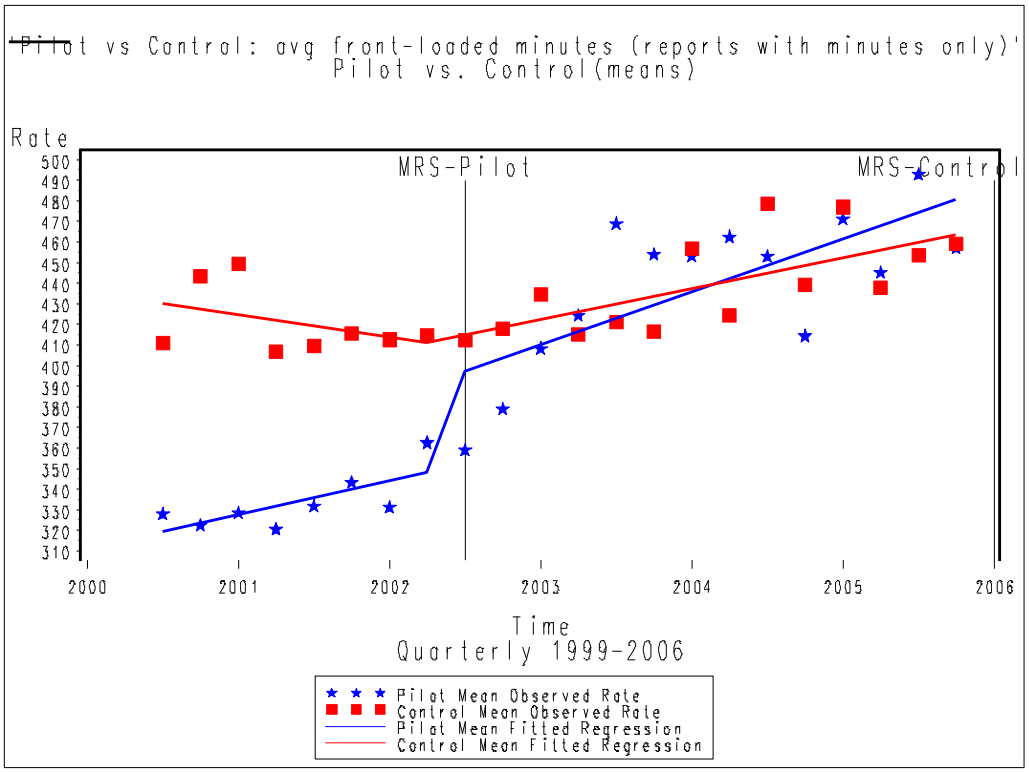
the county group, with the individual county mean number of minutes, was used for this weighting.

Statistical Methods

Interrupted Time Series (ITS) analyses were utilized to assess changes in frontloading at the point of MRS implementation. ITS analytic procedures are described above.

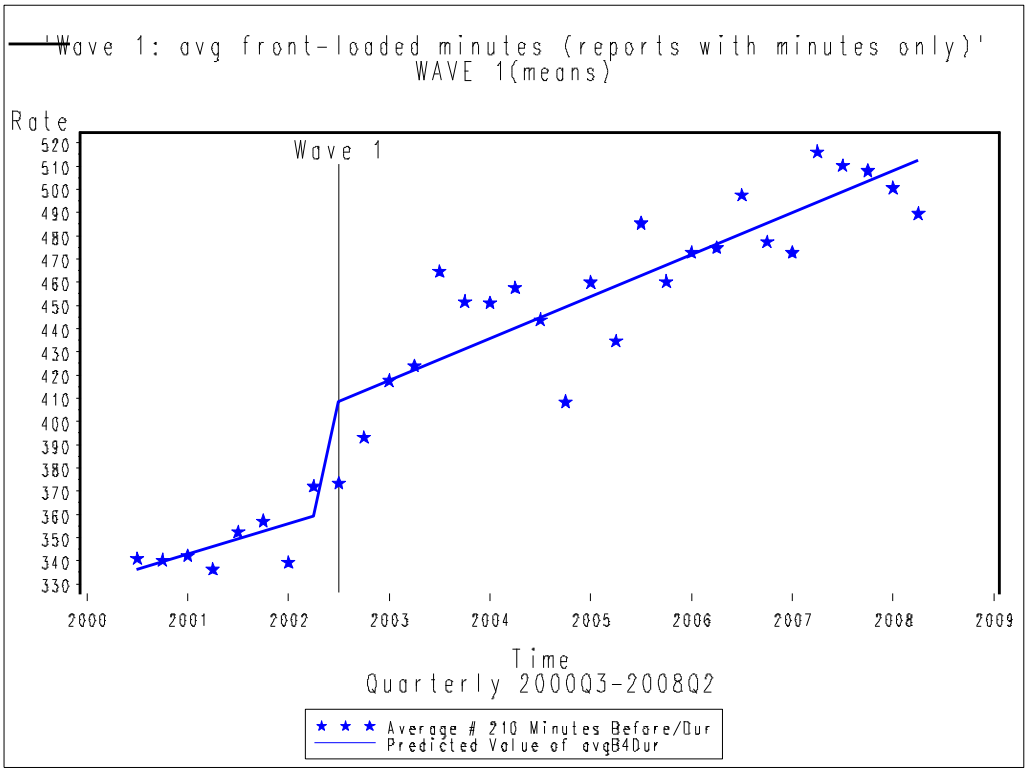
Findings

Findings for the ITS models are presented below, first as a comparison of pilot and matched control counties, then separately for all 10 pilot counties and 10 wave 2 counties. Figures depict the trend lines before and after MRS implementation, and text describes the statistical results.

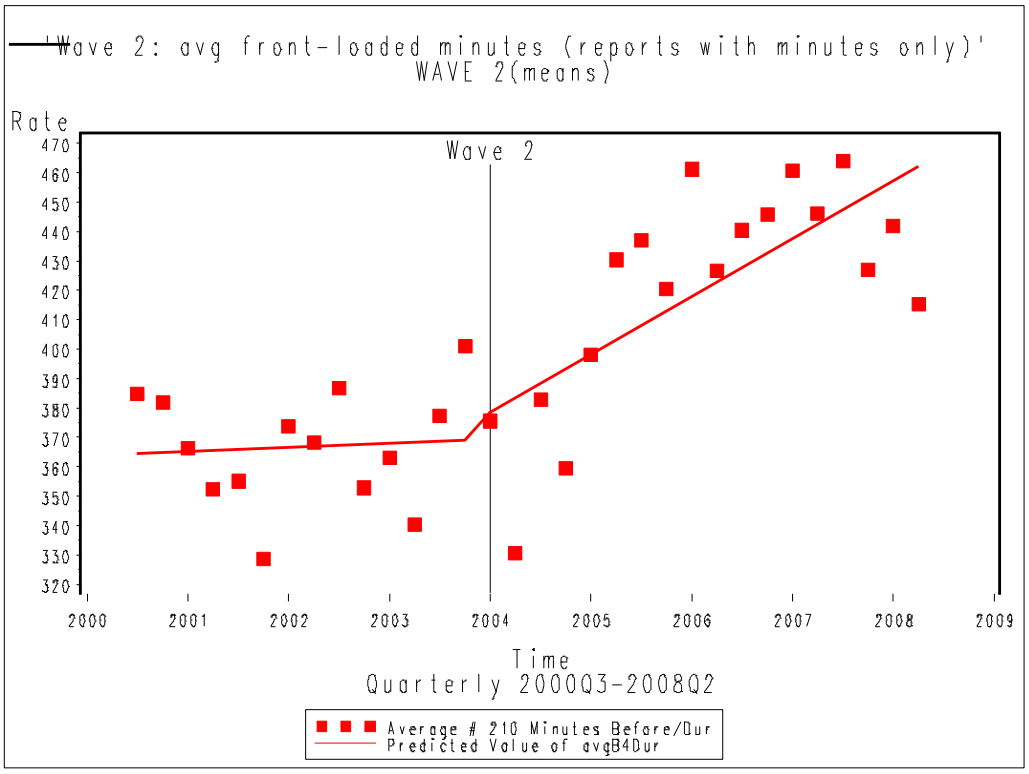


The overall model for average frontloaded minutes (reports with minutes only) was significant with acceptable autocorrelation ($F(7, 36) = 29.4$, $p < 0.0001$, $R^2 = 0.85$, Adj $R^2 = 0.82$, DW = 2.1, $\rho = -0.05$). The intercept (level) of front loaded minutes increased in pilot

counties relative to in control counties (a trend effect) at the MRS implementation time point (t=1.8, p=0.085). The slope of average frontloaded minutes did not change in pilot counties relative to control counties pre- to post-MRS implementation. Basically, MRS brought the pilot counties up to the level of frontloading being used already in control counties. It is unclear why the frontloading was so discrepant in these counties to begin with.



In wave 1 (pilot) counties, the overall model for average frontloaded minutes (reports with minutes only) was significant with acceptable autocorrelation ($F(3, 28) = 100.8$, $p < 0.0001$, $R^2 = 0.92$, Adj $R^2 = 0.91$, DW = 1.9, $\rho = 0.04$). The intercept (level) of average case frontloaded minutes increased at the MRS implementation time point (t=3.2, p<0.01); however the slope did not change pre- to post- MRS in wave 1 counties.



In wave 2 counties, the overall model for average frontloaded minutes (reports with minutes only) was significant with acceptable autocorrelation ($F(3, 28) = 19.3$, $p < 0.0001$, $R^2 = 0.67$, Adj $R^2 = 0.64$, DW = 1.4, $\rho = 0.24$). The slope of average case frontloaded minutes increased following MRS implementation ($t = 2.3$, $p < 0.05$); however the intercept did not change pre- to post- MRS in wave 2 counties. So – for wave 2 counties there is a more obvious and ongoing effect of MRS on frontloading activities.

Appendix C

Focus Group Guiding Questions

Social Workers

Work First / CPS Interface:
1. Let's start by talking a bit about how information about families is shared between WF and CPS case workers.

- Tell me about how WF and CPS case workers interact with one another in your county.
- Do you have a system for knowing which families are in one another's caseloads?
- Are you initiating communication concerning mutually served families?
- Is their any cross training of staff going on between the program areas?

2. Now let's explore the level of collaboration between WF and CPS in terms of helping families create case plans and reach goals.

- Has anyone been involved in creating joint or complimentary plans? If so, how did this come about?
- Are you making joint home visits? How often? In what percentage of your cases?
- Do you attend one another's meetings such as SUCCESS and Child and Family Team meetings? How frequently? In what percentage of your cases?
- Has anyone combined such meetings as a convenience for families?
- Are you using one another as collateral contacts?

.

Implementation of new finding – "services provided and no longer needed":

1. This finding was instituted in part, so that the state could keep track of how many cases would have had to be opened for 215 services were it not for the front loaded services and to reflect the amount of work that goes into providing frontloading of services.

- How much are you using this finding? How often/ in what percentage of your cases?
- Describe the ways in which you use this finding/the cases for which you use this finding.
- How often would you say that you see repeat maltreatment allegations in these particular cases?

Frontloading:

- Are you frontloading services more often since MRS began? How much more?
- What are the top three services you are frontloading?
- Which seem to be most helpful to families?
- Which are most difficult to get into place in time to close before sending to 215?

Child and Family Teams - Quality and Impact:
1. I want to spend a little time now talking about CFT meetings. Specifically I want to get a sense of how they are going, what issues or concerns you have about CFT meetings and your perception of their effectiveness as a tool for working with families.

- At what point do you typically start the conversation with parents about CFTs and begin soliciting input regarding who they would like to be a part of their CFT?
- Who are you typically inviting to CFTs? Who shows up? Who doesn't and why?
- What kind of lead time do you usually give invitees?

- Who would you like to see there the most?
- Can anyone share their experiences in either facilitating or participating in these meetings? Do others have similar or different experiences to share?
- How receptive to this idea are your families? Examples?
- Can someone describe a successful CFT meeting?
- What challenges do CFT meetings bring? How are they overcome?
- How often do family members bring support persons with them? (e.g. family members, clergy, etc.?)
- How often are you conducing CFT meetings? More than quarterly for intensive/high risk?
- How are you typically structuring these meetings? Do you feel that you are able to reach decisions, gain some degree of consensus and establish a plan for moving forward? Why or why not?
- Are you using CFT meetings to meet the requirements for permanency planning action team meetings?
- Is anyone using facilitators or do you have plans to begin using them for this purpose?
- Do you feel that families are engaged in the process? Can you provide an example of this? Are they offering input, ideas and exhibiting a commitment to the safety and well being of the child? Examples?
- What strategies do you employ to engage the families and ensure that the meetings are WITH the family and not ABOUT the family? Examples?
- From your perspective do you feel that this approach has changed the perception that families may have about CPS and your role in protecting children? How has it changed?
- Do you think that using CFT meetings as a tool has helped families to see CPS/social workers more as advocates and less like adversaries? How so?
- How have CFT meetings affected the level of cooperation from families?
- How do you think CFTs effect family progress toward their plan goals given their involvement in creating them?

Redesign of In-Home Services:

1. As Child and Family Team meetings are a key component of in-home services, let's spend some time talking about how the redesign of in-home services is working for the families on your caseloads.

- In terms of case distribution, how many high risk, moderate and voluntary do you have?
- Given the required number of contacts with families, what would you say are some of the challenges and benefits associated with these contacts? How productive would you say these meetings are?
- Can someone give me some perspective on how the redesign is working for your caseload overall? Do others have similar or different perspectives?
- What about the availability of services defined as needs? Where are the gaps in services for your county?
- How have bi-weekly/monthly contacts and the ongoing re-assessment activities affected risk level?
- Do you think they aid families toward making progress toward the goals outlined in their in home services agreement? Why or why not?
- Can anyone share your experiences around "stuck cases"? How often do you see this situation? How are these handled in your county?
- What about voluntary services (family support services)? Are families utilizing these?
- Are you using CFTs in working with these families? Why or why not?

Shared Parenting:
1. Next we will spend some time talking about Shared Parenting meetings. Specifically, we want to know how these are going, what issues or concerns you have about Shared Parenting meetings and your perception of their effectiveness as a tool for working with families that have children placed in foster care.

- Do these meetings seem to build relationships between foster parents and birth parents? Specific Examples?
- Are foster parents resistant to participating? Why or why not?
- Can anyone share their experiences related to Shared Parenting and the effectiveness or ineffectiveness of these meetings? Do others have similar or different experiences?
- How engaged in this process are birth parents? Are they offering suggestions and fully participating in this process? Can you give us a specific example?
- Do you set initial ground rules for these meetings to ensure they are productive? If so, what are they?
- Overall, are these meetings beneficial in providing information to both sides as is intended? Why or why not?

Social Worker Assignment - Keep or Transfer Cases after Case Decision:
1. The last area I want to cover today is related to social worker assignment. We want to better understand practice variations in social worker assignment.

- Do you generally keep a case or transfer it after a case decision is made?
- Can you describe the process/policy for this county related to transfer or cases?
- What are some of the most typical reasons for case transfers?
- What are the pros and cons of either approach?
- Which do you believe produces better outcomes for families? Why?

Is there anything else you would like to add that I didn't ask about during the course of this focus group?

Community Partners

As you know, we have invited you here today to learn more about how the Multiple Response System is working in this county from the perspective of community partners that regularly work with DSS and families. Specifically, we want to talk about two main areas that may impact your agencies directly; overall level of collaboration with DSS and in-home services/CFT meetings.

I want to start by getting some idea about how you view your overall working relationship and level of coordination with DSS as an agency as well as with individual staff?

I would like to get a sense of what your opinions are about how using a multiple track system in responding to child maltreatment allegations is working in this county.

- What are your perceptions about how this is working for families in this county?
- Do you think that this is translating into practice on the part of DSS that is more family centered? Why or why not?
- How has the implementation of MRS affected your working relationship with DSS?
- From your perspective, do you feel that this approach has improved the perception that families may have about CPS and their role in protecting children?

Redesign of in-home services/CFT meetings

Now I want to spend some time talking specifically about your impressions regarding how DSS is implementing the redesign of in-home services.

- What are some of the challenges and benefits associated with working with DSS in serving families? Are you being contacted by social workers on a monthly basis to provide an update about specific cases? (DSS calls these collateral contracts)
- Do DSS workers share case plan information and/or goals with you?
- Have you ever been asked to participate in Child and Family Team meetings by a family or by a social worker?
- If yes, what is your perception of their effectiveness as a tool for working with families? What issues or concerns, if any, do you have about CFT meetings?
- How receptive are families to this process? Examples?
- Do you feel that families are engaged in the process? Do families offer input, ideas and exhibit a commitment to the safety and well being of the child? Examples?
- What strategies did you see employed to engage the families and ensure that the meetings are WITH the family and not ABOUT the family? Examples?
- How are CFT meetings structured?
- What was your role in the meeting?
- Do you think that using CFT meetings as a tool has helped families to see CPS/social workers more as advocates and less like adversaries? How so?
- Have CFT meetings increased the level of cooperation from families?
- Do you think that they progress in their plans more readily as a result of their involvement in creating them?
- What suggestions, if any, do you have for improvements in the process that DSS is implementing around in-home services?

Does anyone have anything else that you would like to add or share?

Supervisors

Work First / CPS Interface:

1. Let's start by talking a bit about how information about families is shared between WF and CPS case workers.

- Tell me about how your WF and CPS case workers interact with one another in your county.
- Is there a formalized system in place for determining which families are in one another's caseloads? How about informal processes?
- Are cases reviewed periodically to determine which social worker would be the most appropriate in terms of ongoing case management?
- Is their any cross training of staff going on between the program areas? Examples? Benefits? Outcomes?

2. Now let's explore the level of collaboration between WF and CPS in terms of helping families create case plans and reach goals.

- Are you aware of times when your staff have been involved in creating joint or complimentary plans? If so, how did this come about?
- Do they make joint home visits? How often?
- Are they attending one another's meetings such as SUCCESS and Child and Family Team meetings? How frequently?
- Do they ever combine such meetings as a convenience for families?
- Do they use each other as collateral contacts when applicable?

.

Implementation of new finding – "services provided and no longer needed":

1. This finding was instituted in part, so that the state could keep track of how many cases would have had to be opened for 215 services were it not for the front loaded services. As well as to better reflect the amount of time/work social workers were putting in to address the needs of these families initially. .

- How often are you using this finding? Can someone give me a rough idea of what percentage of cases?
- Describe the ways in which this finding is being used/the cases for which you use this finding.
- How often would you say that you see repeat maltreatment allegations in these particular cases?
- In a perfect world, and if caseloads or staff time were not an issue, would some degree of contact with these families be your recommendation as a measure of prevention?
- Do your community partners want/request ongoing involvement by DSS? Is this occurring? How have/do you respond?

Frontloading:

- Are your staff frontloading services more often since MRS began?
- Which services would you say you are frontloading the most?
- Which seem to be most helpful to families?
- Which are most difficult to get into place in time to close before sending to 215?

Child and Family Teams - Quality and Impact:

1. I want to spend a little time now talking about CFT meetings. Specifically I want to get a sense of how they are going, what issues or concerns there may be about CFT meetings and your perception of their effectiveness as a tool for working with families.

- Can someone give us some perspective on how CFTs are structured in your county?
- What about outcomes? Are these meetings resulting in decisions, the building of some degree of consensus and the establishment of a plan for moving forward? Why or why not?
- What challenges do your staff face related to CFT meetings? How are they overcome?
- How often are these meetings being conducted?
- Are you using CFT meetings to meet the requirements for permanency planning action team meetings?
- Does this county use facilitators for CFTs or do you have plans to begin using them for this purpose?
- How receptive to the idea of CFTs are your families? Examples?
- Do you think that your families are engaged in the process? What feedback are you getting from staff in this regard? i.e. Are families offering input, ideas and exhibiting a commitment to the safety and well being of the child?
- Can someone describe what you think a successful CFT meeting looks like?
- From your perspective do you feel that this approach has changed the perception that families may have about CPS and your role in protecting children? How has it changed?
- Do you think that using CFT meetings as a tool has helped families to see CPS/social workers more as advocates and less like adversaries? How so?
- How have CFT meetings affected the level of cooperation from families?
- How do you think CFTs effect family progress toward their plan goals given their involvement in creating them?
- Can anyone share their experiences in either facilitating or participating in these meetings? Do others have similar or different experiences to share?

Redesign of In-Home Services:

1. As Child and Family Team meetings are a key component of in-home services, let's spend some time talking about how the redesign of in-home services is working for the families in this county. .

- Can someone give me some perspective on how the redesign is working? Do others have similar or different perspectives?

Follow-up Questions……

- Given the required number of contacts with families, what would you say are some of the challenges and benefits associated with these contacts? How productive would you say these meetings are?
- What about the availability of services defined as needs? Where are the gaps in services for your county?
- Do you think the contacts aid families toward making progress toward the goals outlined in their in home services agreement? Why or why not?
- Are Intensive Family Preservation Services available in this county? If so, how effective has this been? Describe the level of communication between the DSS social worker and the IFPS social worker. Are CFTs being held at the conclusion of IFPS?
- Can anyone share your experiences around "stuck cases"? How often do you see this situation? How are these handled in your county?
- What about voluntary services (family support services)? Are families utilizing these?
- Are your staff using CFTs in working with these families? Why or why not?

Shared Parenting:

1. Next we will spend some time talking about Shared Parenting meetings. Specifically, we want to know how these are going, what issues or concerns you have about Shared Parenting meetings and your perception of their effectiveness as a tool for working with families that have children placed in foster care.

- Do these meetings seem to build relationships between foster parents and birth parents? Specific Examples?
- Can anyone share their experiences related to Shared Parenting and the effectiveness or ineffectiveness of these meetings?
- Do others have similar or different experiences?
- Are foster parents resistant to participating? Why or why not?
- How engaged in this process are birth parents? Are they offering suggestions and fully participating in this process? Can you give us a specific example?
- Do you know if your workers tend to set initial ground rules for these meetings to ensure they are productive? If so, what are they?
- Overall, are you finding that these meetings are beneficial in providing information to both sides as is intended? Why or why not?

Social Worker Assignment - Keep or Transfer Cases after Case Decision:

1. The last area I want to cover today is related to social worker assignment. We want to better understand practice variations in social worker assignment.

- Do you staff generally keep a case or transfer it after a case decision is made?
- Can you describe the process/policy for this county related to transfer or cases?
- What are some of the most typical reasons for case transfers?
- What are the pros and cons of either approach?
- Which do you believe produces better outcomes for families? Why?

Is there anything else you would like to add that I didn't ask about during the course of this focus group?

Additional Focus Group Comments

Child and Family Team Meetings

Barriers Expressed

"The barriers that I have seen are turf issues. DJJ, schools, mental health and DSS have all signed on to adhere to the CFT system of protocol which is a really nice, family centered strength based approach to facilitating Child and Family Teams. The two people that I have the hardest time getting to the table were therapists, mainly for issues of pay and billing (and if I were in their shoes, might have difficulty coming), and schools. If you can't hold the CFT at the school, it can be difficult to get school to the table. I have a lot of sympathy for teachers because there is so much that is required of them it is difficult for a teacher to get away from the classroom even within the school. You have better luck getting school counselors. It has helped a lot of our mental health providers have clinicians out posted in the schools and those people can gather information and bring it to the table." (CPS Supervisor)

"It's inherently hard because the model dictates that it is supposed to be family driven but it's really DSS saying this is where you have issues this is what we are going to do to help you. This can be hard because sometimes the family is not even recognizing the issues as a problem. In the end it still comes down to DSS imposing things on families so it's kind of contradictory." (CPS Supervisor)

"I think one barrier for us is giving the family the power and letting them develop the plan. I think we struggle with that sometimes because we're in a hurry and it takes longer when they make the decisions so I think that is an area we need to grow in." (CPS Supervisor)

"CFTs won't be fully implemented unless you have a person (facilitator) who is dedicated to doing it and you can hand it over to them." (Social Worker)

"Sometimes it is hard to get the family here. They don't want to come to the meeting or they don't have transportation. I have had situations that by the time I pick the parents up after work we don't get back to start the meeting until after 7pm." Also, if there is domestic violence then you need to have one CFT for the mother and one for the father." (Social Worker)

"For in-home services cases they are almost absurd. If you are implementing services right from the start, by the time you get the meeting organized and can get everybody together, you already have everything in place. The therapists and professionals don't come because they can't bill for it. For most in-home services cases, it becomes one of those things you just check off the list, but it does not accomplish much. It is a great tool for stuck cases or those that might be going to court. It is really good there, but as a mandatory thing it is really not needed." (Social Worker)

"I found that the clients are usually intimidated when we have CFT meetings because it is me and I have brought my SW supervisor or program manager or others like that. As much as I remind the family that we are here to help, it is still intimidating to them. They don't bring as many people." (Social Worker)

I think one of the biggest barriers is getting families to involve other people. It is their choice as to who they want to have at the team meeting. They may not want their probation officer or grandma to be there or to be privy to the information we have to share. Some families don't want anyone else to know these things." (Social Worker)

"Scheduling is the hardest thing, getting everybody's time right. Nothing is going to prevent that because it will always be difficult to try to mange the logistics and make sure that everybody can be at one place at one time." (Community Partner)

"When we ask our families if they have had a CFT I think that sometimes they don't understand what they're being drawn into. I'm not sure the families understand that we (community partners) could be there with them. Sometimes they don't understand the process." (Community Partner)

"One of the challenges I see is that often I've been told about the meetings that day or day before, so a lot of times I am not able to go on such short notice. Why not let folks know and give us enough time to schedule it." (Community Partner)

"A lot of times families just see CFTs as another meeting DSS is calling and they don't understand this is a positive thing for them and an opportunity to speak up and have other supports with them. I don't think they understand or are made aware that they can invite people." (Community Partner)

<u>Staff Experiences and Attitudes</u>

"I think that if you can get to a place where the parent sees a crisis coming and understands that she/he really needs help, that is good participation. When they call to say that they want to have a CFT you know that the parent understands why they need that team. It is difficult to get to that point." (Social Worker)

"I had this one particular mom on my case load that was not following through on her case plan. My concern was that one of her children was not receiving the MH services he needed. We found out at the CFT meeting that she had explored options for her son on her own and brought support to the table. With her resource and some others, we were able to meet the needs of the family. That is an example of a very productive meeting." (Social Worker)

"I have five CFTs this week I like them because it lets me see everyone in one day and it helps me meet some of my guidelines in one sitting." (Social Worker)

"I'll say I love CFTs. I think CFTs are a good tool but the success depends largely on how engaged the family is in the meeting and how you prepare the family for them." (Social Worker)

"I participated in a meeting with over 20 people at the table. The family had lived in New York, Virginia, and North Carolina and they felt this was the first community that cared about their son. They saw it as a support. It felt good to sit at the table and be the helper instead of the accuser." (CPS Supervisor)

"I think any time you can get everyone to the table, you can stop that triangulation of communication that can occur. Parents trying to say - this person said this, and this one said

that. When you have everyone together, it produces the best outcomes. In my unit, there are some low risk cases that don't have a CFT every month. Anything that is high risk or where there are lots of providers involved, I believe that they should have one every month because they are invaluable in terms of getting positive outcomes." (CPS Supervisor)

"Our county supports the use of CFTs, but they can be hard to get in place. We are thinking about hiring a facilitator because it takes so much staff time to implement correctly." (CPS Supervisor)

"One that sticks out in my mind centered around two grandparents working diligently on visitation issues. Everybody else around the table just sat back and let these two grandmothers work it out. One had primary custody, the other had visitation. These two women had not historically communicated well so it was great. It felt safe enough to them; at least that is what I felt." (Community Partner)

"I have been to several CFT meetings. I can think of situations where the family started out somewhat defensive, but by the end of the meeting their viewpoints had been heard and considered. I think that is what helps to break down trust barriers partly because of the full disclosure piece and people knowing that the decisions are made based on the information shared there and everybody has equal time to share. I do feel that the families that I was involved with were onboard with what the team had agreed upon. It (CFTs) can really take away that animosity and in some cases denial. It also takes away the finger pointing." (Community Partner)

"To me CFTs are the way we should work with families." (Community Partner)

"From a very broad perspective, the language I use is that CFTs make the system more userfriendly. In my opinion with the family being the user. It is almost a shift in mindset with the realization that placing kids does not help. Fixing families, if you can, by helping them with resources, helping them with coping skills, that is what helps children." (Community Partner)

<u>Strategies in Implementation</u>

"You have to think outside the box. Can that teacher or doctor write something up if they can't attend? Also, can they join the meeting by speaker phone"? (CPS Supervisor)

"We might start with the purpose of the meeting and why CPS is involved. Then we move to the strengths. We get them to say something positive about themselves. (Social Worker)

"I like to ask the family to tell me about a time when they felt like things were going well with their family and they communicated and solved their own problems? I think people are responsive to that." (Social Worker)

"One thing that helps is to allow the parents and children to bring forth their concerns first. I like this as opposed to having everyone else on the team go first and the parents last." (Social Worker)

"I have to be careful and make sure have a balance of professionals and family supports there or it can be overwhelming for the family." (Social Worker)

"I have noticed that some of the families come in angry and we need to allow a little venting time during the first part of the meeting." (Community Partner)

"In order to get them done at least quarterly, I ask my staff to do them monthly and that way we have some leeway if we don't get them done monthly." (CPS Supervisor)

Blended Case Loads

"The problem is in the need to know different programs. You need to know the standards for both investigative and family assessments as well as in home services so it can get a little crazy." (CPS Supervisor)

"We put ourselves in a position to potentially have a lot of things out of compliance in terms of visits and paperwork because of the flow of family assessments come in weekly and paperwork has to be done on them and you have these high risk intensive cases that you are trying to balance, I don't think it's a good practice." (CPS Supervisor)

"I know that I am set in my ways. I did in-home for three years. Personally I don't like long term intervention with clients, I like investigations. There is a reason why people have specialties and many good reasons for having specialties. That does not mean that you can't be holistic and know about other program areas. I am going to be blunt in saying that we already have struggles with people not being able to do what they are expected to do, and when you put another program on them, it increases liability and increases turnover. Some people are not investigators. They cannot go out and get the information. Some are not nurturing enough to be an in-home worker. So I think that it is a horrible idea. I understand the philosophy but I think we are setting ourselves and our families up for failure." (CPS Supervisor)

"My fear is that because investigations take priority, you will see an increase in cases where in-home services must take a back seat. Suddenly we are going to be in custody situation because in-homes services had to take a back seat." (CPS Supervisor)

"With some families it can be good but I can think of many cases where it would be bad. To be honest with you we are supposed to be family centered/family friendly, and we really do try to do that but sometimes they can't get over that resentment and it is not just taxing on you but it limits their success because they keep blaming you. Sometimes it is better for them to start over with new person. I kept some cases when I went from being an investigator to a case manager and I think for some it was good for some not so much." (Social Worker)

"I have found with blended case loads that the in-home cases take up every bit of my time, I could not keep up with my investigations. I could not keep up with paperwork. I was ready to lose my mind. I just decided that I would not do it." (Social Worker)

"The quality of services will fall down. You are trying to wear all these hats simultaneously instead of concentrating on something you are skilled at - the quality of services might fall down." (Social Worker)

"I found that I was often calling my in-home cases and telling them that I was sorry but I wouldn't be able to make our scheduled meeting. I found it challenging to do that. I am not saying it is impossible, but it felt impossible unless you were absolutely working yourself to death. We get new cases constantly." (Social Worker)

"We have always had a lot of social worker turnover and that impacts everything we do with families. Theoretically the idea of working with a family for an extended period of time makes sense, but realistically when you don't have enough workers or you keep losing workers you aren't serving anyone's interests." (Social Worker)

"Yes, it would be great for a family to have same social worker through whole process because it would create better rapport between the social worker and the family. I've done case management and investigation, and trying to stick with family through whole thing can be very stressful. I think that could lead to higher social worker turnover rates. Sometimes you are glad to be finished working with a particular family and excited to push it along to case management." (Social Worker)

"I am not saying that it always works best, but I am saying that it does work. To have one worker on a case is possible - it is possible for a worker to follow that case all the way through. A social worker goes from bad to good with a client anyways. We don't come into an in-home services case being the "good guy" just because we did not do the investigation. The fact is, you are with DSS and the family doesn't really see the difference. You can still stick it out. I am not saying that we could do with the case load numbers in this agency but I am saying that it is possible." (Social Worker)

"I guess it is good in theory if the goal is one family, one SW. The family knows him and he knows the family, so the relationship has already been developed." (Social Worker)

Shared Parenting

<u>Barriers</u>

"It is not a waste of time if it is sold to the foster parents effectively and they buy in. The trouble is that most of our foster parents want to be adoptive parents so they don't want anything to do with the birth parents." (Social Worker)

"Some birth parents do not want a relationship with the foster parents. They just feel like the foster parents want their kid(s)." (Social Worker)

"Some foster parents can't get beyond the circumstances that caused the child to come into care in the first place and as a result they don't trust the birth parents with unsupervised visits." (Social Worker)

"A lot of our foster parents are old school. Some are just not open to the Shared Parenting process." (Social Worker)

"Sometimes there are just too many safety issues. Other times it is hard for the foster parent to set boundaries without affecting that relationship that they are trying to build with the birth parents. It is difficult and they feel that it puts them in a bad position. They want to assist in

parenting the child while the birth parents get their stuff together but at the same time they can't let them run their house. For foster parents it brings in extra issues that they did not have before Shared Parenting began." (Social Worker)

"Sometimes it is difficult to do within 7 days of placement with some of our families because of safety issues or they are just not ready." (Social Worker)

"I don't think that foster parents are receptive. It is a very scary thing for them. If you start at the beginning when they enter the agency and make it clear that this is the expectation in MAP training then that becomes the way they operate. If they do it once and have a fairly successful meeting it takes away some of the fear. It is a scary thing." (Supervisor)

"Our social workers are not equipped to facilitate developing a relationship between foster parents and birth parents. They have time constraints and are juggling a zillion different things." (Supervisor)

"I've not had much success with implementing this especially in the seven day time frame. It seems to me that I seen better interaction between birth parents and foster parents in passing at visitation rather than in formal meetings." (Supervisor)

Effectiveness of the Process

"Shared Parenting is the best thing that I've seen with MRS. Some of our foster parents are still active with the children that were in their care. These children and their parents still use the foster parents as a resource or for respite care." (Social Worker)

"If the foster parent has bought into the process, it is extremely helpful. The parent knows who has their child. The foster parent puts the parent at ease so that they can focus on what they need to do. The foster parent can focus on the child while the parents can focus on their issues. In the cases that worked well, they maintain contact when the kids go home. In essence, foster parents have turned that into an ongoing support system." (Social Worker)

"I think it is helpful even for the children because when see that their parents and the foster parents are working together it helps the kids understand that they are here to help mommy and help them get back home. I think it is helpful." (Social Worker)

"I think it is very beneficial because it allows the parents to know where child is going and it makes the child feel safer and not as upset that they are going to a strange place because mom just gave her blessing that it is okay for the child to go with this person." (Social Worker)

"When foster parents buy into it and are really active at helping the mom and the children I have noticed in those cases the kids are more likely to go home. When the foster parents are more accommodating with visits and include birth parents in holidays and church we have seen higher success rates." (Supervisor)

Success Stories

"My best example of Shared Parenting was when we took custody of an infant who was in a homeless shelter with the mom who had a substance abuse problem. The baby had been addicted and was a fussy baby. I continued to see this mother when she would show up to meet

with the foster parents. She was amazed that the foster parents would talk with her about the strategies they used to help calm the baby down. She told me that she couldn't believe that the foster parents were willing to help her learn how to care for her child. She had lost custody of other kids in the past but being able to see her looking better and empowered was wonderful. She had hope, something that she did not have before. It gives them the reassurance that their child is not just disappearing into a vacuum." (Supervisor)

"I can give a great example. I had a young couple with a four year old who came into foster care in April. By October they had developed a bond with the foster parents and the birth parents voluntarily relinquished custody to the foster parents freeing the child up for adoption. They still keep in contact with the child and the foster parents." (Supervisor)

"We had a foster family who would allow the teen parent to come over to her house and she spent time mentoring the teen and showing her how to take care of the baby. Another let the birth parent come over on Christmas day. Another foster parent took the child to the in-home substance abuse program to let parent and child visit there. It depends on the trust between the birth parents and the foster parents. If the birth parents realize that adoption is imminent and they like the foster parents, they are more likely to relinquish earlier in the process." (Supervisor)

"I had case involving a Hispanic family and there were two different sets of foster parents involved. The kids all ended up going home. The foster parents didn't speak Spanish but they found resources in the community to help them communicate with the birth parents and are still involved. One of the foster parents was actually a nurse and the baby has a lot of special needs including a feeding tube, so that foster parent has remained very actively involved in helping mom get other resources in the community." (Social Worker)

Collaborative Relationships with Community Partners

<u>Concerns</u>

"Social workers are confused between family centeredness and family friendly. That is an issue that needs to be addressed. Your primary focus should be the safety of children and family. You can't just keep pacifying them (families) for the sake of family friendliness - there are certain levels of accountability that you have to hold them to."

"It has been a difficult transition for the community to understand. For so long the community was so aware of the CPS investigation process. You call in a concern and the next thing you know a social worker is at the school initiating an investigation and that has changed now. It is harder for them, especially the school folks to feel like DSS is "doing" something about the situation.

"It makes more sense to respond differently because not every case warrants an investigation that includes meeting with the kids at school in the absence of their parents but some still do. We have almost swung too far because children do not always speak truthfully in front of their parents. I think DSS is taking some of those reports as a family assessment in an attempt to be family friendly and they are missing the boat on what is going on with the family."

"I have found 90% of the time, I get the letter and that is the extent of the partnership. I don't get called in for meetings or feedback or follow-up or anything else."

"At times when I have sat down with a few of these parents and when I finally help them sort out how many meetings they had or what they had to do, I have thought that if DSS were giving me that, I don't think that I could do it either. Keeping in mind some of these people don't have a car. We have to be sensitive when we start throwing out these sort of requirements, get all three kids to therapy, go to this meeting and go to that meeting, parenting classes, etc. There needs to be limits. How many hours can you spend going to different meetings"?

"I am putting my neck way out there by saying this, but sometimes, there are cases that have been taken as a family assessment that should have been investigations. I think sometimes serious cases are being dealt with less seriously."

"From a school perspective, communication about the status of our reports is never what it should be."

"I think it goes back to caseloads. Social workers have no time to fix the problem they just put a band-aid on it."

"I am from the health department and I think have very good working relationship with DSS we share a lot of the same families the only problem that we find is we don't get phone calls back in timely manner. We will call them not necessarily to make a report but to talk about mutual clients because we want to find out information about a family and what's going on but we don't get calls back"

"New employees need to know what can be shared with whom. Some work well but we get frustrated when a case transfers from one social worker to another."

"I don't think they're as forthright with the GAL in terms of sharing information. They kind of hesitate to give information up front and in general they're a bit more guarded with information."

"Getting information back about what's going on, the status of someone referred to them, that's where the frustration is."

"Information sharing is an issue. We give them everything we have but it's harder to get information from them a lot of times."

"It is difficult for our school counselors to understand what their role is because sometimes they are included and sometimes not. They feel that they need better communication with DSS and their argument is that they work at that school site day in and day out where kid is and what's going on at home is impacting that kid at school. They feel like they can't be effective in helping the child if they don't know what's going on."

"I think it is habit and they (DSS) have become not bad about calling people back in general. I think they can't be bothered."

"I will tell you what is frustrating, when you talk to the brand new intake or on-call person, who has never done it before. You are trying to make a report to someone who does not know how to take it. That happens frequently. You are better off to call at night or on the weekend because you tend to get someone more experienced."

"They are never going to be able to fully implement this kind of system reform (MRS) with the current case loads and high social worker turnover rates."

"This is a problem for kids especially. A child having three social workers in two years is a problem. The kid develops a relationship with one and then gets a new one and has to start all over again."

"DSS has so much turnover it's really hard to build those relationships with workers. I've worked in my job for a long time and it is a little harder now to make personal contacts because of the turnover."

"Some workers are so inexperienced that they have to call about something that an experienced person will not have to call about."

Inter-agency Collaboration

"In spite of some of our cases, our relationship is very good. I think it is exceptionally good with Work First. We get a lot of referrals from them and our communication with social work staff is good and they are receptive when we have issue with clients."

"They are very collaborative in the CFT process. We have agencies talking with each other separate of DSS."

"At some level we do a good job on communication, but it does not always filter down to the line worker level in terms of communication and team work. We have cross representation on boards and committees, but I am not sure that it is always is the same if you are a line DSS social worker."

"There are a lot of things that could be improved, but we have good social workers in our county and we have a good overall relationship with them. I am not crazy about MRS, but that is what we have been talking about."

"We work with a lot of the same families because we have many children under court supervision or protective supervision or probation. We make a lot of reports to DSS about neglect or abuse situations and they send a lot of business our way in terms of undisciplined children. We attend the same meetings and work as closely as we can to help child and family."

"The Guardian ad Litem program work very closely with DSS. Even though we might have different recommendations about what the family needs - especially related to the child, we could not do our job without DSS."

"Compared to a while back, if you made a report, it was either neglect or not, or abuse or it wasn't. Now you are given a letter that says the case was taken as a family assessment and

found in need of services. It goes a little further than just stopping. There are services provided that in the old days might not have been provided."

"From our perspective, it (MRS) is certainly a kinder, gentler thing. It is easier for me when I have to tell a family that I am going to make a report because I explain MRS and help them understand that they have the same goal as us. There will not be a permanent record that will follow them around until they die. That is the good part of it."

"I want to say that there is a good relationship between the DSS and our schools. We can depend on them to follow up on our concerns when we call them in."

"At the Head Start program we have quite a bit of interaction with DSS when we have child abuse concerns. DSS goes to our Head Start Centers and trains staff on how to report cases."

"They key word to describe this agency is professionalism. I think that no one would disagree, but I think that there is room to explore whether or not this agency as well as agencies across the state can do more to make sure that when the day is done and when we take a child away and terminate parental rights that there is no room for debate about whether or not the parent had every reasonable chance."

"Before I became involved as a GAL, I just saw social services as a police agency. Now, I have actually been with these social workers and their clients and I see that they take on the role of coach and are not there to punish. They promote positive ideas. They are really doing social work."

"From law enforcement aspect, it is working well. We started out with one officer working with social services, working here and going out with them on some cases and staying with them during the interview and through the duration of the case. Since the inception of MRS, it is working better for us from the criminal aspect."

"Our district administrator was saying that since MRS was implemented, the numbers have gone down, which is good because, there were times that you would get cases that came in that you just thought, if only they done this or that they probably wouldn't have had to come in. Now we are getting cases that really need to be worked. They need a different approach from us because we only get involved once they get into the court system."

"I have to say that the social workers that I have worked with do have good follow through. They call regularly - not for any type of disclosure, but just to say they referred someone. Did they show up? Are they keeping their appointments? If not, they go out and talk with them and try to keep them on track and buy into being an active participant and improving whatever originated the report."

In-Home Services

"For high risk cases, you have to see somebody in the household once per week, everybody in the household twice per month. I know my workers kind of struggle. Most parents are working until 5:00pm and they cannot meet until evenings. Sometimes they are not available so we try to see parents at work. I don't know if I want for them to make this a habit, but if it gets to the point

that we cannot reach them any other way, they have to visit them at work or school. My workers would prefer not to go to a client's job, but they have to make the mandated contacts. That is the expectation of the department." (Supervisor)

"With regard to maintaining those contacts in your 215 cases, if you are carrying a blended case load you've got these expectations but you also have those requirements that are put on from your investigation or assessment cases doubling the challenge." (Supervisor)

"I think what is tough about it is trying to keep up with the monthly contacts that we are required to make because of our higher caseloads, and we are trying to get the services in place, coordinate them, do the paperwork, see the kids, see the parents, adjust your hours to the family hours because a lot of our families don't come home until after 5:00 after they pick up their children Yet, our workers have families too, and they have to pick up their own children. That balancing act can be difficult at times." (Supervisor)

"I think this is why a lot of people are leaving in-home. We were getting so many high risk cases. One time I had 7 high risk on my case load and 7 moderate that had more extensive issues so that I had to see them every week too. It is not just 14 cases. Some of the cases have 5 kids, so there are sometimes 40 kids on the caseload. Which is 80 visits a month. If you have two parents on those cases, you have 28 visits, two collaterals for each one of those, whole meetings, you just don't have time. There is no way that you can juggle all that. I keep saying that but nobody is listening." (Social Worker)

"I think it is too many home visits and then it's hard to get with them and they aren't court ordered to meet with you. I could go up there 5 times in one day and if they didn't open the door well you didn't get your contacts made. Parents will run you ragged." (Social Worker)

"We refer to them as drive bys especially if you have nonverbal or very small kids. You run by day care just to make sure they are okay but it doesn't allow you the time to spend in the places where you think you really need to spend the time. I wish we had more flexibility and ability to use our judgment about case contacts." (Social Worker)

"You are not catching those warning signs of crisis that are going to brew in families because you have to run out the door. You don't have time to sit with families that really need you because you're running all over. Also, there is too much paperwork, you could sit all day for a week and still not be caught up." (Social Worker)

"Sometimes it is a check in thing. Sometimes it is more productive. If it is substance abuse or inappropriate discipline, we are interviewing kids and tend to do more unannounced home visits. We want to see if momma and daddy look like they are high. Sometimes it is more of a surprise home visit or sometimes it is just that we need to lay eyes on them." (Supervisor)

"We try to be flexible and meet them at t-ball games or over the weekend to get contacts. Are they as effective? I don't know but sometimes you got to do what you've got to do." (Supervisor)

Appendix D

Child and Family Team Meeting Survey

Question #	Fidelity
1	The family meeting was fully explained to me before the meeting started.
2	I liked the time of the meeting.
3	I liked where the meeting was held.
7	I felt that everyone who needed to be at the family meeting was present.
11	The ground rules were followed during the meeting.
12	The meeting moved along at a reasonable pace.
14	My responsibility to the plan was clearly identified.
15	A plan was developed for what to do if a crisis occurs.
16	I was given a copy of the plan or was told it would be mailed.
	Participation
6	I felt included in the family meeting.
8	I felt comfortable sharing my thoughts and concerns in this meeting.
9	I felt the group listened when I spoke.
10	I felt that my thoughts and concerns were considered before a final decision was reached.
13	I felt I had a role in developing the plan.
	Satisfaction
17	I believe that family meetings are worthwhile.
18	I was satisfied with the way the meeting was run.
	Knowledge
4	I understood the purpose of the family meeting.
5	I understood my role in the family meeting.

Family Centered Meeting Summary Sheet

Case #	Date:	County:

Start time:	☐ Initial meeting	☐ On site	☐ Moderate risk
End Time:	☐ Follow-up meeting	☐ Off site	☐ High risk

Type of Family Meeting (Check ONE)

☐ Child and Family Team (CFT)	☐ Team Decision Making (TDM)
☐ Permanency Planning and Action Team (PPAT)	☐ Shared Parenting
☐ Success Meeting	☐ Other:

Facilitator

☐ I am the SW for this case.
☐ I am a neutral facilitator for this case. (Primary job responsibility)
☐ I am a supervisor.
☐ I am a SW not involved with this case asked to facilitate the meeting for another SW.
☐ I am not a DSS employee.

Present	Invited but unable to attend

☐ Family declined to fill out survey.

Family Centered Meeting Survey

Your answers will be used to help us evaluate how we run the meeting and help us organize better meetings in the future for other families. Your answers will only be read by a neutral meeting facilitator and university researchers. Complete the form and return it to the facilitator. Thank you for your assistance.

Date: _____

Your role on the Team: ☐ Mother ☐ Father ☐ Relative _____ ☐ Live-in Partner ☐ Child ☐ Friend ☐ Neighbor ☐ Foster Parent **DSS Staff:** ☐ Child Protection Investigation /Family Assessment worker ☐ Family Interventions/In home worker ☐ Intensive Family Preservation Services ☐ Foster Care Worker ☐ Work First ☐ Supervisor **Court Staff**: ☐ Attorney ☐ Juvenile Justice Staff ☐ GAL **Mental Health Staff**: ☐ Therapist ☐ Mental Health Provider **School Staff**: ☐ Regular Teacher ☐ Counselor ☐ Administrator ☐ Special Education Teacher **Community Member**: ☐ Community Partner _____ ☐ Service Provider _____ ☐ Other _____

Fidelity Participation Satisfaction Knowledge

For each question below, circle the number to the right that best fits your response.

QUESTIONS	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The family meeting was fully explained to me before the meeting started.	1	2	3	4
2. I liked the time of the meeting.	1	2	3	4
3. I liked where the meeting was held.	1	2	3	4
4. I understood the purpose of the family meeting.	1	2	3	4
5. I understood my role in the family meeting.	1	2	3	4
6. I felt included in the family meeting.	1	2	3	4
7. I felt that everyone who needed to be at the family meeting was present. Please note any missing members below.	1	2	3	4
8. I felt comfortable sharing my thoughts and concerns in this meeting.	1	2	3	4
9. I felt the group listened when I spoke.	1	2	3	4
10. I felt that my thoughts and concerns were considered before a final decision was reached.	1	2	3	4
11. The ground rules were followed during the family meeting.	1	2	3	4
12. The meeting moved along at a reasonable pace.	1	2	3	4
13. I felt I had a role in developing the plan	1	2	3	4
14. My responsibility to the plan was clearly identified.	1	2	3	4
15. A plan was developed for what to do if a crisis occurs.	1	2	3	4
16. I was given a copy of the plan or was told it would be mailed.	1	2	3	4
17. I believe that family meetings are worthwhile.	1	2	3	4
18. I was satisfied with the way the meeting was run.	1	2	3	4

What could have made the meeting better? _____

Thank you for taking the time to complete this survey!

Appendix E

Caregiver Phone Survey

DATE: ____/____/_____ **INTERVIEWER:**	
Client name: _____ **Social Security Or ID Number:_____** **County: _____**	Services: ☐ **210 Investigative/Family Assessment** ☐ **215 CPS In-Home Services** ☐ **109 Foster Care** **Client #: _____**

Call attempts:

Date:_____Time: _____Notes: _____

Date:_____Time:_____Notes:_____

Date:_____Time:_____Notes:_____

My name is . I work for the Center for Child and Family Policy at Duke University. The North Carolina Division of Social Services has asked us to study how effectively it provides services to families. In April, you signed a form called a consent that gave us permission to call you and talk to you about this survey we are doing. By calling and talking with you, we want to learn how families like yours are doing after you received services and whether you found the services to be helpful. We value your opinions and as a token of our appreciation, we will mail you a $10 gift card if you agree to participate in this survey.

During the survey, I will ask you about yourself and your family. I will ask you questions about how Child Protective Services worked with you and your family. Some of the questions are very personal. We hope that you will answer them, but you don't have to. You can skip any question that you would not like to answer.

No matter what, all of your answers are kept private. Information you give us will never be used in a way that would identify you. We do not put your name on any information that you give us. We use ID numbers only. We will not share your individual answers with your case worker or anyone else from Child Protective Services. The only time we would have to tell someone about your answers is if we had serious concerns about safety – yours or someone else's. If this comes up, we will talk with you about it first.

The whole interview will take about 30 minutes. Do you have any questions before we begin?

DEMOGRAPHIC INFORMATION **Now, let's begin the interview. First I have some basic questions about you:**		
1.	**What year were you born?**	☐ **Would not disclose** ☐ **Year: _____**
2.	**What is your marital status?** ***(check one)***	☐ Single and never married ☐ **Living with a partner** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**
3.	**How much school have you completed?** ***(check one)***	☐ **Less than 8th grade** ☐ **8th – 12th grade, but without a high school diploma** ☐ **High school diploma or GED** ☐ **Some college** ☐ **Certification (certificate or other specialized training)** ☐ **Associate's or vocational degree** ☐ **College degree** ☐ **Graduate degree**
4.	**Are you enrolled in any educational program now? For example a GED program, vocational program, or college classes?** ***(check one)*** **If other, what?_____**	☐ No ☐ **Yes, GED program/high school** ☐ **Yes, Associate's or vocational program** ☐ **Yes, Bachelor's program** ☐ **Yes, other**

	b. If '<u>yes</u>' are you enrolled full-time or part time?	☐ **Part-time** ☐ **Full-time**
5.	**Are you working at this time?** ***(check one)***	☐ **Not employed** ☐ **Full-time** ☐ **Part-time** ☐ **Multiple jobs** ☐ **Self-employed** ☐ **Seasonal / temporary** ☐ **On-the-job training**
6.	**If you are not working, are you….** **(*check one*)** **If other, what?_____**	☐ **Unemployed and looking for work** ☐ **A homemaker** ☐ **Unable to work due to a disability** ☐ **Retired** ☐ **Other**

7. Do you mind telling me how much money your family makes? You can tell me the amount by the week, month or year.

☐ **< 10,000 per year**	**< 833 / month**	**<192.31/week**	**<4.81/hour**
☐ **10,000 – 14,999**	**834/month – 1250/month)**	**192.31/week – 288.44/week**	**4.81/hour – 7.21/hour**
☐ **15,000 – 24,999**	**1251/month – 2083/month**	**288.46/week – 480.75/week**	**7.22/hour – 12.01/hour**
☐ **25,000 – 34,999**	**2084/month – 2916/month**	**480.77/week – 673.05/week**	**12.02/hour – 16.82/hour**
☐ **> 35,000**	**>2917/month)**	**>673.07/week**	**>16.82/hour**
☐ **Preferred not to disclose**			
☐ **Don't remember/Don't know**			

8.	How many adults contribute to this income?	**# of adults: _____**
9.	What is the total number of people that live in your home?	#_____
10.	**How many children, if any are living in your home now?**	# _____

	Age	**Gender**	**Is this your biological child?**	**Primary Caregiver**

	Child #1	#____	☐ Male ☐ Female	☐ No ☐ Yes	☐ myself ☐ relative ☐ other If other, who?
	Child #2	#____	☐ Male ☐ Female	☐ No ☐ Yes	☐ myself ☐ relative ☐ other If other, who?
	Child #3	#____	☐ Male ☐ Female	☐ No ☐ Yes	☐ myself ☐ relative ☐ other If other, who?
	Child #4	#____	☐ Male ☐ Female	☐ No ☐ Yes	☐ myself ☐ relative ☐ other If other, who?
	Child #5	#____	☐ Male ☐ Female	☐ No ☐ Yes	☐ myself ☐ relative ☐ other If other, who?
	Child #6	#____	☐ Male ☐ Female	☐ No ☐ Yes	☐ myself ☐ relative ☐ other If other, who?

11.	**a.) Do you have any other biological children living outside your home?**	☐ **No** ☐ **Yes**
	b.) Why do they reside outside your home? ***Check all that apply.*** **If other, why?_____**	☐ **Joint custody** ☐ **Adult (18 or over)** ☐ **Foster care** ☐ **Kinship care** ☐ **Juvenile detention** ☐ **Other**

12.	**Besides you and your children, who else lives in your household?** ***Check all that apply*.** **If other(s), who?_____**	☐ **Spouse (parent/ step parent)** ☐ **Girlfriend / boyfriend** ☐ **Grandmother** ☐ **Grandfather** ☐ **Aunt / Uncle** ☐ **Cousins** ☐ **No one** ☐ **Other**

In this part of the interview I would like to ask you some questions about your contact with Child Protective Services. Again, I would like to remind you that your name will not be used and we will not share any of your individual answers with your social worker or Child Protective Services.

INVESTIGATIVE/FAMILY ASSESSMENT – ALL CLIENTS			
13.	**Do you remember when you started working with Child Protective Services (CPS) on this report?**	☐ **No** ☐ **Yes**	
	If "<u>yes</u>", enter month and year:	**Date: _____**	
14.	**Did you have any experience with Child Protective Services before this report? *IF YES, REMIND THEM THAT THIS INTERVIEW IS ONLY ABOUT THE MOST RECENT REPORT AND NOT OTHER EXPERIENCES.***	☐ **No** ☐ **Yes**	
15.	**How did the social worker first get in touch with you about this specific report?** **If other, how?_____**	☐ **Phone** ☐ **Face to face visit** ☐ **Other**	
16.	**When the social worker set up the first visit, was the time convenient for you?** **Comments: _____**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **N/A**	
17.	**How did you feel during this first visit with the social worker?** **C*heck all that apply.*** **If other, what?_____**	☐ **Happy** ☐ **Relieved** ☐ **Hopeful** ☐ **Pleased** ☐ **Comforted** ☐ **Thankful** ☐ **Encouraged** ☐ **Respected** ☐ **Satisfied** ☐ **Other:**	☐ **Sad** ☐ **Angry** ☐ **Afraid** ☐ **Stressed** ☐ **Annoyed** ☐ **Worried** ☐ **Discouraged** ☐ **Disrespected** ☐ **Confused**
18.	**a.) When you first met with the social worker about the concerns, did he/she call it an investigative assessment or a family assessment?**	☐ **Investigative Assessment** ☐ **Family Assessment** ☐ **Don't remember/ Don't know**	
	b.) Did the social worker explain how family assessment differs from investigative assessment?	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**	

19.	**When you first found out that your family was going through an investigative assessment or family assessment, how easy was it for you to get in touch with your social worker?**	☐ **Very Easy** ☐ **Easy** ☐ **Somewhat difficult** ☐ **Difficult** ☐ **Very Difficult** ☐ **N/A Did not attempt to contact**
20.	**a.) At that time, how interested was your social worker in trying to understand what your family was going through and your family's needs? (This refers to the first SW you had.)**	☐ **Very interested** ☐ **Somewhat interested** ☐ **Slightly interested** ☐ **Not at all interested** ☐ **Don't remember/ don't know**
	b.) What led you to think so?	
21.	**a.) Did the social worker ask you about your needs?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**
	b.) What needs did your family have at the time? ***Check all that apply.*** **If other, what kind of other services did your family need?** **_____**	☐ **Food** ☐ **Emergency money** ☐ **Housing** ☐ **Medical Care / Immunization** ☐ **Dental care** ☐ **Transportation** ☐ **Drug / Alcohol Abuse Treatment or Program** ☐ **Mental Health / Counseling** ☐ **Domestic Violence Support Services** ☐ **Employment training** ☐ **Work First** ☐ **Parenting skills / classes** ☐ **Day Care** ☐ **None** ☐ **Other**
22.	**Did the social worker ask for your ideas about what would be best for your child/family?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**
23.	**a.) Did you feel that the social worker respected you during this process?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **N/A**
	b.) Can you tell me more about that?	
24.	**a.) Did you feel that the social worker respected your culture and religious beliefs?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **N/A**
25.	**Did the social worker work with you to make a list of your family's strengths and needs?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**

26.	**Did you get a copy of a list of your family's strengths and needs?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**
27.	**a.) Did the social worker give you any help or services before you were told what your case decision was? This might include services provided by some other agencies outside of CPS.** **(*IF 'NO', GO TO QUESTION 28)***	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**
	b.) If yes, tell me what they were. (This might include things like emergency money or food, housing voucher, counseling, help getting services, etc…) **Note: case decision refers to the finding such as Substantiated/Unsubstantiated; In need of services, Services Recommended, etc.** ***Check all that apply.*** **If other, what?_____**	☐ **Food** ☐ **Emergency money** ☐ **Housing** ☐ **Transportation** ☐ **Medical Care / Immunization** ☐ **Dental care** ☐ **Drug / Alcohol abuse treatment or program** ☐ **Mental Health / Counseling** ☐ **Domestic Violence Support/Services** ☐ **Parenting skills classes** ☐ **Employment training** ☐ **Work First** ☐ **Day Care** ☐ **Help getting other services** ☐ **Other:**
	c.) About how long did it take to get help after the first visit from the Child Protective Services social worker?	☐ **1 – 2 days** ☐ **3 – 4 days** ☐ **5 – 7 days** ☐ **More than one week** ☐ **More than two weeks** ☐ **Don't remember/ Don't know**
28.	**What was the case decision made about your family?** ***Client may need examples of case decisions.***	☐ **Substantiated** ☐ **Unsubstantiated** ☐ **Services needed** ☐ **Services recommended** ☐ **Services Provided No Longer Needed** ☐ **Pending** ☐ **Don't remember/ don't know**
29.	**a.) Did your Child Protective Services social worker explain the decision to you in a way you could understand?**	☐ **No** ☐ **Yes** ☐ **N/A**

CASE PLANNING – 215 SERVICES *IF FINDING IS UNSUBSTATNIATED, OR SERVICES, PROVIDED AND NO LONGER NEEDED SKIP TO Q62*		
30.	**Once the decision was made, did you keep working with the same social worker or did you get another social worker?**	☐ **Same** ☐ **Different** ☐ **Don't Remember / Don't Know**
31.	**Overall, how many social workers from DSS worked with you from the time the report was made until now?** **(*If you are currently receiving Work First services, don't include that SW in your total.)***	**Enter # _____**
32.	**a.) What do you think about the idea of only having one SW for your whole case?** **<u>Clarification Comments</u>:** **"Whole case" refers to the entire time you had involvement with CPS. Sometimes CPS assigns one SW to work with the family during the assessment/investigation phase and that same worker continues to work with the family during the case planning/case management phase. Other times a new social worker is assigned to work with the family after the initial assessment is made.**	☐ **I like the idea** ☐ **I don't like the idea** ☐ **I don't care either way** ☐ **Depends on the relationship with the SW**
	b.) Why?	
33.	**After the case decision was made, did you get a plan that listed your family's needs, set some goals for your family, and explained what kind of help your family would receive ? (This question refers to the In-Home Services Agreement)**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ***If no, skip to Question 37.***
34.	**Who participated in making the plan?** ***Check all that apply.*** If other, who?_____	☐ **Me** ☐ **My child** ☐ **My spouse** ☐ **Other relatives (specify):** ☐ **Facilitator** ☐ **Social Worker** ☐ **Social Worker Supervisor** ☐ **Work First Caseworker** ☐ **Foster Parent(s)** ☐ **Guardian Ad Litem** ☐ **Service Provider(s) (specify):** ☐ **Don't remember/Don't Know** ☐ **Other**
35.	**Did the social worker include your ideas in the**	☐ **No**

	plan?	☐ **Yes** ☐ **Don't remember/ Don't know**
36.	**How well did the plan meet your family's needs at the time?**	☐ **Very well** ☐ **Somewhat well** ☐ **Not well** ☐ **Not at all**
37.	**a.) Besides the one we just talked about, did you have any other treatment or service plans with other social service agencies or your child's school?** ***For example:*** **Mental Health, Work First or domestic violence case plans?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ***If 'no' skip to Question 38.***
	b.) If <u>yes</u>, with whom?	
	c.) If <u>yes,</u> was your social worker aware of the other plan(s)?	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**

IN-HOME SERVICES – 215 SERVICES		
38.	**What services or help from other agencies did the social worker recommend (require) for you and your family? (Some examples: counseling, parenting classes, job training, medical care, etc.)** ****If no services were required/recommended, but services were in place prior to the report, please check "Other" and note that information below.** **If other, what?_____**	☐ **Food** ☐ **Emergency money** ☐ **Housing** ☐ **Transportation** ☐ **Medical Care / Immunization** ☐ **Dental care** ☐ **Drug / Alcohol abuse treatment or program** ☐ **Mental Health / Counseling** ☐ **Domestic Violence Support/Services** ☐ **Parenting skills classes** ☐ **Employment training** ☐ **Work First** ☐ **Day Care** ☐ **Help getting other services** ☐ **Other:**
39.	**Overall, how helpful were your social workers in getting you these services?**	☐ **Very helpful** ☐ **Somewhat helpful** ☐ **Not at all helpful** ☐ **N/A**
40.	**What did the social worker(s) do to help you get services?** ***Check all that apply.*** **If other, what? _____**	☐ **Called service provider** ☐ **Made appointment** ☐ **Took me to the appointment** ☐ **Other: _____** ☐ **Nothing** ☐ **N/A**
41.	**a.) Did you refuse or were you unable to take advantage of any help that was offered to your child and/or family?**	☐ **No** ☐ **Yes**

	If 'no' skip to Question 42.	
	b.) If yes, what was it? ***Check all that apply.*** **If other, what?_____**	☐ **Food** ☐ **Emergency money** ☐ **Housing** ☐ **Transportation** ☐ **Medical Care / Immunization** ☐ **Dental care** ☐ **Drug / Alcohol abuse treatment or program** ☐ **Mental Health / Counseling** ☐ **Domestic Violence Support/Services** ☐ **Parenting skills classes** ☐ **Employment training** ☐ **Work First** ☐ **Day Care** ☐ **Help getting other services** ☐ **Other:**
	c.) Why did you turn down services? **If 'other' reason** **Enter comments regarding why services were turned down or unavailable.** **_____**	☐ **Not culturally appropriate** ☐ **Not convenient (time)** ☐ **Too far /No transportation** ☐ **Not necessary** ☐ **Other**
42.	**Did you get enough services to help your family at the time?**	☐ **I received all the services I needed** ☐ **I received most of the services I needed** ☐ **I received some services but needed more help** ☐ **I did not receive enough services to help** ☐ **Not Applicable (note why)**
43.	**Of the services you received which service helped you and your child/family the most?** ***Check only <u>ONE</u>.*** ****If no services were received, but services were in place prior to the report, please check "Other" and note that information below.**	☐ **Food** ☐ **Emergency money** ☐ **Housing** ☐ **Transportation** ☐ **Medical Care / Immunization** ☐ **Dental care** ☐ **Drug / Alcohol abuse treatment or program** ☐ **Mental Health / Counseling** ☐ **Domestic Violence Support/Services** ☐ **Parenting skills classes** ☐ **Employment training** ☐ **Work First** ☐ **Day Care**

	If other, what?_____	☐ **Help getting other services** ☐ **Other:**

CHILD AND FAMILY TEAM – 215 SERVICES ***(IF THE FINAL ANSWER TO Q44 IS NO, SKIP TO Q54)***		
44.	**a.) Did you participate in a meeting with your social worker and other support people to talk about your family's needs and what would help you meet your goals?** **b.) Do you remember what the meeting was called?** ***If 'yes' enter the name(s) of the meetings that the client recalls.*** ***If 'no' or 'don't remember/don't know', interviewer may prompt client with: You may have heard this called a Child and Family Team (CFT) meeting or Family Group Conferencing, Family Centered Meeting or Team Decision Making (TDM) Meeting.***	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** **Name of meeting: _____**
45.	**How many meetings did you attend?**	**Enter # _____**
46.	**Who else participated in the meetings?** ***Check all that apply.***	
	Initial Meeting ☐ **Parent** ☐ **Spouse/Partner** ☐ **Child/Children** ☐ **Other family members (specify):** ☐ **Social Worker** ☐ **Social worker supervisor** ☐ **Facilitator** ☐ **Work First Worker** ☐ **Law enforcement representative** ☐ **Domestic violence agency representative** ☐ **School representative (i.e. counselor)** ☐ **Foster parent(s)** ☐ **Guardian ad Litem** ☐ **Other service provider(s) (i.e. mental health, substance abuse, specify):_____** ☐ **Other:_____**	**Follow-up Meetings** ☐ **NO FOLLOW UP MEETINGS** ☐ **Parent** ☐ **Spouse/Partner** ☐ **Child/Children** ☐ **Other family members (specify):** ☐ **Social Worker** ☐ **Social worker supervisor** ☐ **Facilitator** ☐ **Work First Worker** ☐ **Law enforcement representative** ☐ **Domestic violence agency representative** ☐ **School representative (i.e. counselor)** ☐ **Foster parent(s)** ☐ **Guardian ad Litem** ☐ **Other service provider(s) (i.e. mental health, substance abuse, specify):_____**

		☐ **Other:_____**
47.	**Did you have a say in choosing the people who attended the meeting(s)?**	☐ **No** ☐ **Yes**
48.	**Were you encouraged to bring other family members or support with you to the meetings?**	☐ **No** ☐ **Yes** ☐ **Don't remember / Don't know**
49.	**a.) Did someone explain the purpose of the meeting(s) to you?**	☐ **No** ☐ **Yes**
	b.) If yes, who?	
50.	**How clear was the purpose of the meeting(s)?**	☐ **Very clear** ☐ **Somewhat clear** ☐ **Not at all clear** ☐ **Don't remember / Don't know**
51.	**a.) Did someone lead the meeting(s)?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**
	b.) If yes, who?	
	c.) How good was the leader at making people feel comfortable? ***(On a scale of 1(best) to 4(worst).)***	☐ **Very effective** ☐ **Somewhat effective** ☐ **Somewhat ineffective** ☐ **Very ineffective**
52.	**How comfortable were you sharing your ideas at the meetings?**	☐ **Very comfortable** ☐ **Somewhat comfortable** ☐ **Slightly uncomfortable** ☐ **Very uncomfortable**
53.	**Were your ideas taken seriously and included in the plans for your family?**	☐ **A great deal** ☐ **Somewhat** ☐ **Very little** ☐ **Not at all**
SHARED PARENTING ***(If 54a is Yes and 54b is No then go toQ55. For all other combinations, proceed to Work First section Q62.)***		
54.	**a.) At the time of or as a result of the report that we are talking about, was/were your child(ren) in foster care?**	☐ **No** ☐ **Yes**
	b.) Was/Were your child(ren) placed with a relative?	☐ **No** ☐ **Yes**
55.	**a.) How would you describe your relationship with the foster parent?**	☐ **Very positive** ☐ **Positive** ☐ **Somewhat positive** ☐ **Not positive at all** ☐ **Would not comment**

	b.) How often did you have contact with the foster parent(s)?	☐ **1 to 2x per month** ☐ **3 to 4x per month** ☐ **5x or more per month** ☐ **No contacts were made** ☐ **Would not comment**
56.	**a.) How easy or difficult is/was it for you to have contact with or visit your child(ren)?**	☐ **Very Easy** ☐ **Easy** ☐ **Somewhat difficult** ☐ **Difficult** ☐ **Very Difficult** ☐ **N/A Did not attempt to contact**
	b.) If it is difficult, ask about the barriers.	
	c.) Did your CPS social worker help you stay in touch with your child(ren)?	☐ **No** ☐ **Yes**
	d.) If <u>yes</u>, describe some of the things the CPS social worker did to help you stay connected with your child. *Check all that apply.* **If other, what?_____**	☐ **Arranged visits** ☐ **Provided transportation** ☐ **Other**
57.	**Did you feel like you had much say when major decisions were made about your children? (i.e., what school they would attend, if siblings would be kept together, if cultural issues were taken into account for the placement of your children).**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**
58.	**Did you meet with the foster parent(s) and others to discuss your child's care and make plans for your child? (You may have heard these meetings called *Shared Parenting* meetings.)**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know**
59.	**Were you encouraged to share information about your child's everyday routines (what your child needs, his/her likes and dislikes) with the foster parent(s)?**	☐ **Strongly encouraged** ☐ **Somewhat encouraged** ☐ **Somewhat discouraged** ☐ **Strongly discouraged**
60.	**Did the social worker and the foster family take your ideas seriously?**	☐ **No** ☐ **Yes** ☐ **Don't Remember /Don't Know**
61.	**Did the social worker and the foster family respect your family's cultural and religious traditions?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **N/A**
WORK FIRST		

62.	**During your CPS involvement, are/were you or any of your family members receiving WF services?** **If "yes", who?** ***Check all that apply.*** **If "no" then enter "Not applicable" for questions 64 – 68.**	☐ **No** ☐ **Yes** ☐ **Client** ☐ **Spouse** ☐ **Other** **If other family member, who?** _____	
63.	**Did you or your family member(s) become involved with Work First *before* or *during* your involvement with CPS?**	☐ **Before the case was open** ☐ **During the time the case was open**	
64.	**If your Work First services started <u>before</u> your CPS involvement, did your Child Welfare social worker know that you were receiving Work First Assistance?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **Not Applicable**	
65.	**If your Work First services started during your CPS involvement, did your CPS social worker help you get Work First ?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **Not Applicable**	
66.	**Did you have to repeat the same information about you and your family to the CPS social worker and the Work First representative?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **Not Applicable**	
67.	**Did the Work First worker and CPS worker ever meet together with you?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **Not Applicable**	
68.	**a.) Did you have a different plan with each social worker?**	☐ **No** ☐ **Yes** ☐ **Don't remember/ Don't know** ☐ **Not Applicable**	
	b.) If yes, did the two plans ask you to do the same or different things?	☐ **Same** ☐ **Different** ☐ **Don't remember/ Don't know** ☐ **Not Applicable**	
CPS INTERACTION			
69.	**How do you feel <u>now</u> about your overall experience with Child Protective Services concerning this report?** ***Check all that apply.*** **If other, how?** _____	☐ **Happy** ☐ **Relieved** ☐ **Hopeful** ☐ **Pleased** ☐ **Comforted** ☐ **Thankful** ☐ **Encouraged** ☐ **Respected** ☐ **Satisfied** ☐ **Other:**	☐ **Sad** ☐ **Angry** ☐ **Afraid** ☐ **Stressed** ☐ **Annoyed** ☐ **Worried** ☐ **Discouraged** ☐ **Disrespected** ☐ **Confused**
70.	**Did the client receive any help or services from/through CPS?**	☐ **No** ☐ **Yes** ***If 'no' then skip to Question 71.***	

	If <u>yes</u>, did the help that you received from CPS…(repeat this phrase for each question)	
	a.) improve your parenting skills?	☐ **Yes, definitely.** ☐ **Yes, a little** ☐ **No, not much** ☐ **No, not at all**
	b.) help you to deal with family conflict?	☐ **Yes, definitely.** ☐ **Yes, a little** ☐ **No, not much** ☐ **No, not at all**
	c.) help you know who to contact in the community when you need assistance?	☐ **Yes, definitely.** ☐ **Yes, a little** ☐ **No, not much** ☐ **No, not at all**
	d.) help you better provide for your family's needs?	☐ **Yes, definitely.** ☐ **Yes, a little** ☐ **No, not much** ☐ **No, not at all**
	e.) help you feel better about yourself and your family?	☐ **Yes, definitely.** ☐ **Yes, a little** ☐ **No, not much** ☐ **No, not at all**
71.	**What, if anything, would you change about the way Child Protective Services works with families?**	
CONCLUDING THE INTERVIEW		
72.	**What is your race or ethnicity?** **If other, what?_____**	☐ **Black** ☐ **White – not Hispanic** ☐ **Hispanic / Latino** ☐ **Asian / Pacific Islander** ☐ **Native American / Alaska Native** ☐ **Other** ☐ **Would not disclose**
73.	For the purposes of our mailing you the gift card for completing this interview, I would like to ask for your mailing address.	**Street / PO Box** **City: _____** **State: NC** **Zip_____**
74.	Can I give you a call if I found that I left something out?	☐ No ☐ Yes

	Is there another number where I can reach you?	☐ No ☐ Yes
75.	Do you have any questions for me?	☐ No ☐ Yes

POST INTERVIEW ASSESSMENTS (FOR INTERVIEWER):

How well did the client appear to understand the interview questions?	☐ Not at all well ☐ Not well ☐ Moderately well ☐ Well ☐ Very well
How valid do you think this client's responses are? (reasons for invalid responses could include lack of understanding, lack of interest, responding in a socially desirable manner, etc.)	☐ No concerns about validity ☐ Some concerns about validity Please note reasons: ☐ Unable to determine

INTERVIEWER COMMENTS: