November 15, 2015

Patrick O' Donnell, Clerk of the Legislature
State Capitol, Room 2018
P.O. Box 94604
Lincoln, NE 68509

RE: Alternative Response Implementation Pursuant to Neb. Rev. Stat. 28-712 (3)

Dear Mr. O'Donnell,

In accordance with Nebraska Revised Statue 28-712 (3) please find the attached report on Alternative Response Implementation. According to the statute, DHHS shall provide a report of an evaluation on the status of alternative response implementation pursuant to subsection (2) of this section to the Children's Commission and electronically to the Legislature by November 15, 2015.

The Department shall contract with an independent entity to evaluate the alternative response demonstration projects. The evaluation shall include, but not limited to:

a) The screening process used to determine which cases shall be assigned to alternative response;
b) The number and proportion of repeat child abuse and neglect allegations within a specified period of time following initial intake;
c) The number and proportion of substantiated child abuse and neglect allegations with a specified period of time following initial intake;
d) The number and proportion of families with any child entering out of home care within a specified period of time following initial intake;
e) Changes in child and family well-being in the domains of behavioral and emotional functioning and physical health and development as measured by a standardized assessment instrument to be selected by the department;
f) The number and proportion of families assigned to the alternative response track who are reassigned to a traditional response; and
g) A cost analysis that will examine, at a minimum, the costs of key elements of services received.

If you have any questions, please contact me. Thank you.

Sincerely,

Douglas J. Weinberg, Director,
Division of Children and Family Services
Department of Health and Human Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILDREN AND FAMILY SERVICES
11-15-2015

Legislative Report:
Alternative Response Implementation
Pursuant to Neb. Rev. Stat. 28-712 (3)

Department of Health & Human Services
DHHS
NEBRASKA

1. The Department shall provide a report of an evaluation on the status of alternative response implementation pursuant to subsection (2) of this section to the commission and electronically to the Legislature by November 15, 2015.
2. The Department shall contract with an independent entity to evaluate the alternative response demonstration projects. The evaluation shall include, but not limited to:
   a) The screening process used to determine which cases shall be assigned to alternative response;
   b) The number and proportion of repeat child abuse and neglect allegations within a specified period of time following initial intake;
   c) The number and proportion of substantiated child abuse and neglect allegations with a specified period of time following initial intake;
   d) The number and proportion of families with any child entering out of home care within a specified period of time following initial intake;
   e) Changes in child and family well-being in the domains of behavioral and emotional functioning and physical health and development as measured by a standardized assessment instrument to be selected by the department;
   f) The number and proportion of families assigned to the alternative response track who are reassigned to a traditional response; and
   g) A cost analysis that will examine, at a minimum, the costs of key elements of services received.

The Department of Health and Human Services (DHHS), Division of Children and Family Services (DCFS) implemented an Alternative Response pilot project on October 1, 2014 in five counties across Nebraska (Scotts Bluff, Hall, Lancaster, Dodge and Sarpy). Alternative Response is one intervention DCFS has implemented as part of the Title IV-E Wavier Demonstration Project awarded by the U.S. Department of Health and Human Services, Administration on Children Youth and Families (ACF) in 2013. As part of the terms and conditions of the demonstration project, the state was required to secure a third party, independent evaluator to assess the process, outcomes and costs of the project. The University of Nebraska at Lincoln, Center on Children, Families, and the Law (CCFL) was awarded the contract for the program evaluation.

The development of the Alternative Response program was a collaborative project with internal and external stakeholders. To obtain feedback from the numerous entities, various Alternative Response Committees were created:

- The Alternative Response Internal Workgroup is comprised of DCFS field staff and administrators who researched Alternative Response and drafted the program and practice model; recommendations from this workgroup were shared with the Director's Steering Committee and the Alternative Response Statewide Advisory Committee.
- The Alternative Response Director's Steering Committee representatives include the Foster Care Review Office, Office of Inspector General, Region V Behavioral Health, Lancaster County Attorney's Office, Court Improvement Project, Nebraska Children and Families Foundation, a Child Advocacy Center, Voices for Children and internal DCFS Administrators.
- The Alternative Response Statewide Advisory Committee is comprised of the Director's Steering Committee along with community and family partnering organizations.

DCFS utilized the expertise of the members within each workgroup to obtain feedback and generate ideas on how best to develop an Alternative Response model for Nebraska. Their participation was vital to the development and implementation of Alternative Response. DCFS continues to meet regularly with each of these committees to share implementation and program progress.

I. Screening Criteria and Response Reassignment

The Alternative Response eligibility criteria, known as the exclusionary criteria, were developed in collaboration with internal and external statewide stakeholders. Currently there are 21 exclusionary criteria applied to intakes accepted at the hotline to determine eligibility for Alternative Response.

Exclusionary Criteria: Any Intake Accepted for Assessment that meets one or more of the criteria listed below will automatically be assigned to a local office for a Traditional Response.

1. Report alleges physical abuse that:
    i. has resulted in serious bodily injury to a child (Neb Rev Stat 28.109 (20))
    ii. involves a child under the age of 6 years AND has an injury to the head or torso
    iii. involves a child that is limited by disability
    iv. is likely to cause death or severe injury to a child (i.e. shaken baby, rough handling of an infant)
2. Reported domestic violence.
3. Report alleges sexual assault and/or sex trafficking of a child/minor. (Neb Rev Stat 28-319.01 and 28-320.01; 28-830 (13) and 28-831).
4. Report alleges a child in imminent danger due to sexual exploitation.
5. Report alleges neglect that has resulted in serious bodily injury to a child. (Neb Rev Stat 28-109).
6. Any report that requires Child Advocacy Centers, Law Enforcement and DHHS coordination. (Neb Rev Stat 28-728, Section 3, Sub-section D, Sub-section iii).
7. Report alleges maltreatment resulting in a child death and other children reside in the home of the alleged perpetrator.
8. Report alleges newborn with a positive urine or meconium drug screen for alcohol or drugs AND
    i. parent has as an addiction
    ii. prior delivery of drug exposed infant without successful drug treatment
    iii. no preparation for infant's arrival
    iv. current use and expressed intent to breastfeed or is breastfeeding
    v. no in home support system or alternative primary care arrangements
9. Report alleges the manufacturing and/or use of methamphetamine (Neb Rev Stat 28-401 (14)) or other controlled substance (Neb Rev Stat 28-401 (4)).
10. Report of a positive methamphetamine or other controlled substance screen or test during the term of a pregnancy.
11. Report alleges a child had contact with methamphetamine or other controlled substance including a positive meconium or hair follicle screen or test.
12. A report of an adult or caretaker residing in the home with a child where such adult or caretaker has previously had their parental rights terminated or relinquished their parental rights during a court involved case. Caretaker definition: Neb Rev Stat 71-6721(3) which means a parent, foster parent, family member, friend, or legal guardian who provides care for an individual.
13. A report alleging abuse or neglect in a household where an active DCFS traditional investigation is occurring on one or more individuals residing in the home.

14. A report alleges abuse or neglect in a household where an individual or family is currently receiving services through the Protection and Safety section of the Division of Children and Family Services.
15. Report alleges abuse or neglect that is occurring in an out of home setting (i.e. foster care, kinship care).
16. Previous court substantiated reports of abuse/neglect.
17. Previous agency substantiated and currently on Central Registry.
18. Past maltreatment concerns not resolved at case closure and there are two or more children under the age of 5 or 1 child under the age of 2.
19. Parent name, whereabouts or address unknown at the time of the report.
20. Law Enforcement citation for child abuse issued to the parent/caretaker which is directly related to the intake.
21. DHHS is aware of a pending or current law enforcement investigation.

As required by Neb. Rev. Stat 28-710 (4), the department shall adopt and promulgate rules and regulations to carry out sections 2 to 4 of this act. The public hearing for said rules and regulations occurred on August 21st, 2015. The exclusionary criteria listed below are embodied into the rules and regulation submitted to the Attorney General's Office which incorporated the testimony from the public hearing. The criteria have been modified for clarity.

Exclusionary Criteria means criteria which, if alleged or otherwise learned by the Department, automatically excludes an Intake Accepted for Assessment from eligibility for Alternative Response. Exclusionary Criteria include

1. physical abuse of a child (i) under the age of six involving an injury to the head or torso; or (ii) with a disability; or (iii) which resulted in serious bodily injury to a child as defined in Neb. Rev. Stat. § 28-109(20); or (iv) is likely to cause death or severe injury to a child;
2. domestic violence involving a caretaker AND the alleged perpetrator has access to the child or Caretaker;
3. sexual assault of a child as defined in Neb. Rev. Stat. §§ 28-319.01, 28-320.01 ;
4. sex trafficking of a minor as defined in Neb. Rev. Stat. §§ 28-830(14), 28-831(3);
5. sexual exploitation of a child as defined in Neb. Rev. Stat. § 28-707(d);
6. neglect of a child resulting in serious bodily injury as defined in Neb. Rev. Stat. § 28-109(20);
7. allegations require Child Advocacy Center, Law Enforcement, and Department coordination (Neb. Rev. Stat. § 28-728(3)(d)(iii));
8. a Household Member allegedly caused the death of a child;
9. a newborn whose urine or meconium has tested positive for alcohol AND whose Caretaker (i) has an alcohol addiction; or (ii) previously delivered a drug-exposed infant and did not

successfully complete drug treatment; or (iii) did not prepare for the newborn's birth; or (iv) currently uses controlled substances as defined by Neb. Rev. Stat. § 28-401 or alcohol and breastfeeds or expresses intent to breastfeed; or (v) has no in-home support system or alternative primary care arrangements;

10. a Household Member uses or manufactures methamphetamine or other controlled substances as defined in Neb. Rev. Stat. §§ 28-401, 28-405;
11. a pregnant woman tested positive for methamphetamine or other controlled substance as defined in Neb. Rev. Stat. §§ 28-401, 28-405;
12. a child has had contact with methamphetamine or other controlled substance as defined in Neb. Rev. Stat. §§ 28-401, 28-405, including a positive meconium or hair follicle screen or test;
13. a child resides with a Household Member whose parental rights have been terminated or relinquished during a court-involved case;
14. abuse or neglect of a child who resides with (i) the subject of an active Traditional Response or (ii) an individual or family that is receiving services through the DCFS Protection and Safety section or (iii) an individual or family who is involved in juvenile court petition pursuant to Neb. Rev. Stat. § 43-247(3)(a);
15. child abuse or neglect has occurred in an out-of-home setting;
16. a Household Member has a prior court substantiated report of child abuse or neglect or is a sex offender;
17. a Household Member appears on the central registry of child protection cases under Neb. Rev. Stat. § 28-720;
18. a child under the age of two or at least two children under the age of five reside(s) with a Household member where the current maltreatment concerns are the same as prior maltreatment concerns included in an Intake Accepted for Assessment;
19. a child whose Caretaker's identity or whereabouts are unknown;
20. law enforcement has cited a Caretaker for the child abuse or neglect alleged in the Intake Accepted for Assessment;
21. the Department is made aware by law enforcement of an ongoing law enforcement investigation involving a Household Member; and
22. a safety concern is otherwise identified which requires Department intervention within 24 hours.

In addition to the exclusionary criteria, the intake screening process includes a supplementary set of criteria that if alleged in the intake accepted for assessment, requires a Review, Evaluate and Decide (RED) Team review. These criteria are not an automatic exclusion from Alternative Response, the RED Team conducts a critical analysis of the familial dynamics including but not limited to the severity of the allegation, vulnerability of child(ren) involved, and family history to

determine appropriate track assignment. The original RED Team criteria applied to intakes accepted at the hotline to determine eligibility for Alternative Response are outlined below.

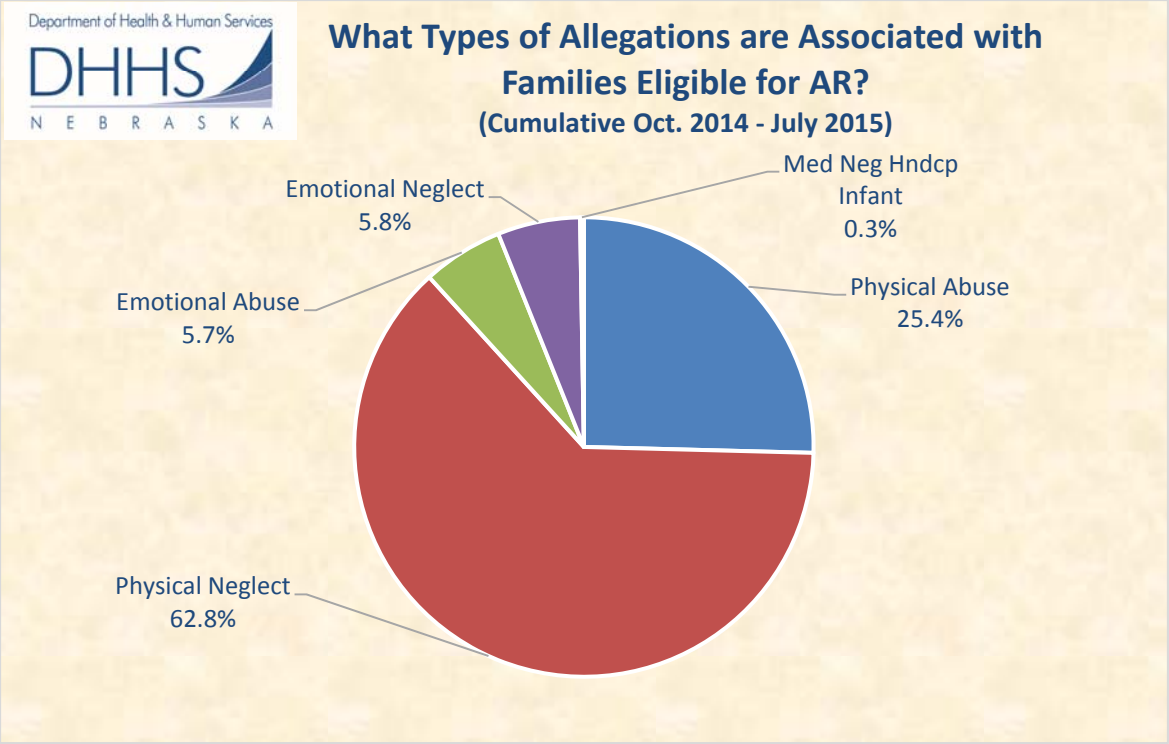
Review, Evaluate and Decide (RED) Team Criteria: Any Intake Accepted for Assessment that does not meet the exclusionary criteria described above, require further review and analysis. The original 6 RED Team criteria applied to intakes accepted at the hotline to determine eligibility for Alternative Response includes intakes that have the following circumstances:

1. Report by a physician, mental health or other health care provider alleging significant parental mental health diagnosis.
2. Report alleges symptoms related to a parental significant mental illness including but not limited to: psychotic behaviors, delusional behaviors and/or danger to self of others.
3. Biological parent(s) of alleged victim is a current or former state ward.
4. Family has had a prior accepted report within the past 6 months and there are two or more children under the age of 5 or 1 child under the age of 2.
5. Current open Alternative Response Case.
6. Report alleges abuse or neglect AND alcohol/or other substance abusing issues AND there are two or more children under 5 or one child under 2.

After the initial implementation of Alternative Response, a larger proportion than expected of intakes eligible for Alternative Response had allegations of physical abuse (Refer to Diagram 1). Therefore, in October 2014, a 7th RED Team Criteria was added to assess for appropriate track assignment.

7. Intake Accepted for Assessment includes an allegation of physical abuse that does not rise to the level of physical abuse identified in the Exclusionary Criteria.

Diagram 1



*Data Source, **Alternative Response IV-E Pilot Project Statistics 8.5.2015**

In response to the testimony provided at the Alternative Response public hearing held on August 21st, 2015 and for purposes of clarity to both the exclusionary and RED Team criteria, an additional RED Team criteria was included into the Alternative Response regulations.

8. A Household Member or alternate caregiver noted on the Intake Accepted for Assessment has a history of using or manufacturing methamphetamine or other controlled substances as defined in Neb. Rev. Stat 28-401, 28-405.

Table 1 on the following page is a depiction of accepted reports of child abuse and neglect taken by the statewide hotline and the number and percent of intakes/families eligible for Alternative Response. From October 1, 2014 through July 31, 2015, 7.3% of all intakes accepted at the hotline were eligible for Alternative Response. This data suggests that NE is taking a conservative approach with AR implementation.

What Percent of Statewide Intakes are Eligible for Alternative Response?

(October 1, 2014 through July 31, 2015)

Table 1

Total Number of Accepted Child Abuse and Neglect Intakes/families	9,977
Of the Total Number of Accepted Child Abuse and Neglect Intakes, How Many Intakes/families are Eligible for AR?	732
% AR Families Eligible for AR	7.3%

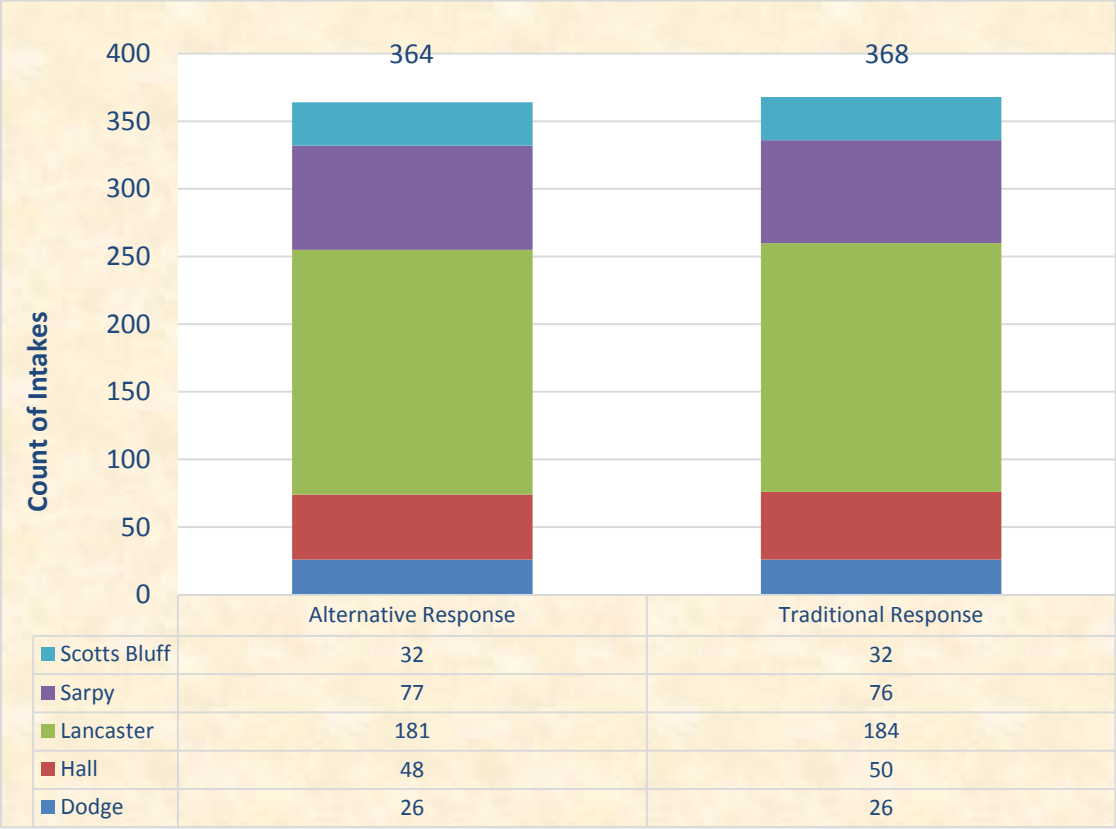
* Data Source, **Alternative Response IV-E Pilot Project Statistics 8.5.2015**

Diagram 2 depicts the randomization of accepted intakes to AR and TR.

The Number of Families Eligible for AR by Initial Track Assignment

(October 1, 2014 through July 31, 2015)

Diagram 2



	Alternative Response	Traditional Response
Scotts Bluff	32	32
Sarpy	77	76
Lancaster	181	184
Hall	48	50
Dodge	26	26

* Data Source, **Alternative Response IV-E Pilot Project Statistics 8.5.2015**

Of the 364 intakes/families assigned to Alternative Response, 114 intakes/families were reassigned to Traditional Response. Response reassignments or track changes, are divided in two categories: programmatic and technical. The programmatic category includes intakes that are reassigned to Traditional Response when the following dynamics occur:

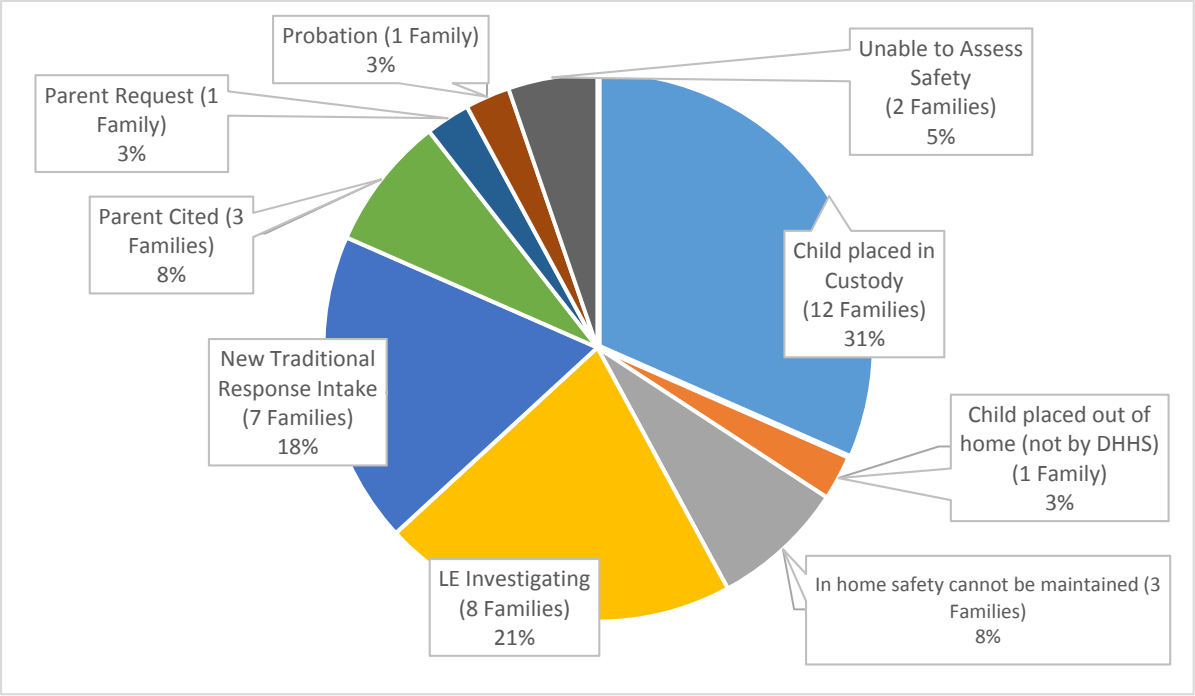
1. Mandatory Response Reassignment – The intake will automatically transfer from AR to TR if:
    a. A safety threat is present and cannot be managed in the home
    b. DCFS cannot assess for child safety
    c. Law enforcement will continue investigating the child abuse or neglect Intake Accepted for Assessment
    d. The caretaker requests a Traditional Response
    e. DCFS learns a household member allegedly caused the death of a child
2. RED Team Decision - A CFS Specialist will complete a 'Notice to RED Team' referral when an exclusionary criteria or red team criteria is learned about a family that is currently receiving Alternative Response. The RED Team will review the familial information to determine appropriate track assignment.

From October 1, 2014 through July 31, 2015 38 intakes or 34% of the 114 intakes reassigned to Traditional Response were programmatically driven (Refer to Diagram 3).

Programmatic Reasons for Track Changes from Alternative Response to Traditional Response

(October 1, 2014 through July 31, 2015)

Diagram 3



*Data prepared by RED Team Coordinator 8.5.2015

The technical category includes intakes that are were initially assigned to AR and then reassigned to Traditional Response (TR) due to how the Intake Specialists or Hotline staff applied the exclusionary criteria. Once the Intake Specialist has closed the intake as an AR case, the NFOCUS data system does not allow the Intake Specialist to make an assignment change to TR without creating a track change. In order to address this particular challenge, DCFS completed the following:

- Further definition was applied to the exclusionary criteria
- Integrated RED Team data with NFOCUS data
- Provided additional training to Hotline staff and implemented supervisory reviews all intakes that were preliminary determined to be AR eligible in order to have a second level of review.

II. Outcome Evaluation

The independent, third party evaluator contracted to conduct the Title IV-E Waiver Demonstration Project was awarded to the University of Nebraska at Lincoln, Center on Children, Families and the Law (CCFL) per Neb. Rev. Stat. 28-712 (3(2)). The evaluation consists of three components: 1. process evaluation, 2. outcome evaluation and, 3. A cost study as agreed upon between Administration for Children and Families (ACF)/DHHS and NE DHHS. DHHS will receive two formal evaluative reports from CCFL in March 2017 (Interim Report) and in February 2020 (Final Report). The three components are described below:

1. Process Evaluation: Description of how the program was implemented.
    - The planning process
    - Organization aspects: staff structure, funding committed, administrative structures, oversight
    - The number and type of staff involved including training, education and experience
    - The service delivery system
    - Role of courts
    - Contextual factors
    - The degree of implementation with fidelity
    - Barriers encountered
2. Outcome Evaluation: Differences between the experimental and control group in the following outcomes:
    - The number and proportion of repeat maltreatment allegations
    - The number and proportion of substantiated maltreatment allegations
    - The number and proportion of families with any child entering out of home care
    - Changes in child and family well-being

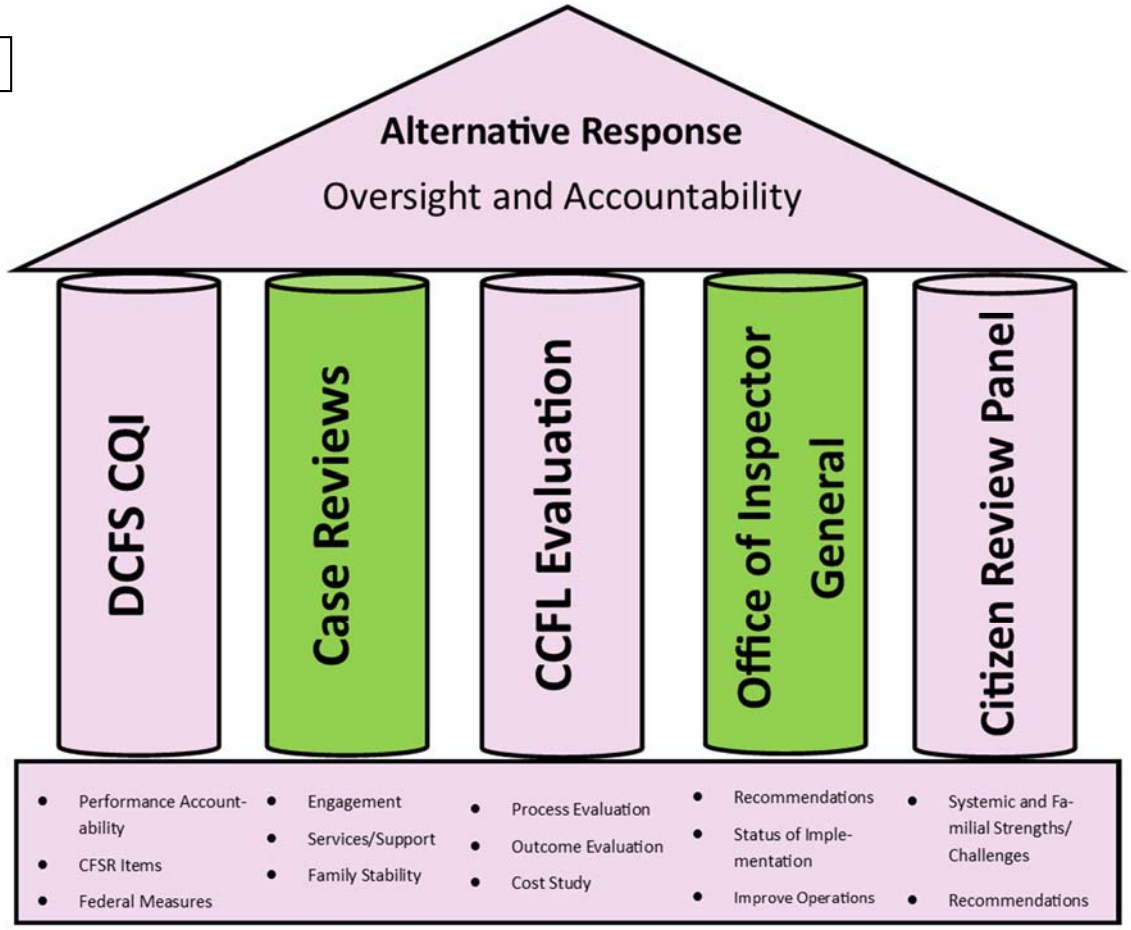
- The number and proportion of families assigned AR who are re-assigned to TR due to an allegation of maltreatment (For experimental group only).

3. Cost Study: Examine the costs of key elements of services designated for the intervention and compare these costs to services available prior to the start of the demonstration.

Given the limited amount of time the pilot has been implemented as well as the limited number of families who have received AR, CCFL has communicated with DCFS that at this time, it is premature to share outcome data analysis.

Knowing that the CCFL data analysis would not be available early on in the pilot implementation, due to the reasons previously cited, DCFS implemented an Oversight and Accountability structure to compliment the CCFL evaluation as well as to monitor the pilot implementation, AR model fidelity, demographic and outcome data and to provide opportunities to for formal feedback (Diagram 4).

Diagram 4



A. DCFS Continuous Quality Improvement:

The CQI data reported monthly directly relates to the core outcomes for AR. The data is used to continually analyze aspects of programmatic performance. Some examples included in the monthly data report: the number of children and families eligible for AR, the number of children and families served, child demographics (age, gender, and ethnicity), types of allegations associated with intakes eligible for AR, response reassignment data, the number of children removed from their family home, the number of children involved in a second accepted intake, the number of families who become court involved, the number of substantiated reports of abuse and neglect, and the average length of time a family receives AR.

The CQI monthly data is shared with and analyzed by the AR Director's Steering Committee, the AR Statewide Advisory Committee and the AR Internal Workgroup who played a significant role with identifying the data elements to be included in the monthly CQI report. This analysis of the data has yielded programmatic changes that have strengthened the quality of the AR model.

B. Case Reviews

Individual case reviews will assess the level of engagement, supports and services provided to the family. More specifically, the case reviews will pinpoint the familial or systemic issues impacting the reasons a subsequent intake is accepted at the hotline. It is anticipated a case review process will be operational within the first quarter of 2016.

C. CCFL Evaluation

In addition to the two formal evaluative reports conducted by CCFL, DCFS has requested and received the following process evaluation interim reports from CCFL:

i. The Nebraska Protective Factor and Wellbeing Questionnaire (PFWQ): a quarterly report assessing the implementation of the PFWQ tool and data analysis on wellbeing and protective factors (Attachment 1).
ii. AR Stakeholder Survey Results: a report analyzing stakeholder perceptions and experiences (Attachment 2).
iii. AR Family Experience Survey: a semi-annual report summarizing data collected from families who are eligible for AR (Attachment 3).
iv. Worker End of Case Survey: a semi-annual report summarizing data collected from case managers who were assigned a family eligible (Attachment 4).

D. Inspector General Report

Reports from the Inspector General will be incorporated into future DHHS AR reports.

E. Citizen Review Panel

An Alternative Response Citizen Review Panel has recently been established. The reports and recommendations generated from this panel will be utilized to identify areas of strength and areas challenges.

III. Service Array

A family's ability to access timely services within their community is vital component of AR. In an effort to expand service capacity, DCFS continues to collaborate with the Nebraska Children and Family's Foundation (Nebraska Children) who leads local efforts aimed at minimizing poverty, homelessness, and child abuse/neglect within communities. Developing and implementing Child Well Being Communities is one strategy designed to achieve this goal. Child Well Being Communities utilize the parental protective factor framework to link families to evidence based, evidence informed and promising practice services available in their community to enhance protective factors and promote family stability and sustainability. Integrating AR efforts with Child Well Being Community efforts enhances the likelihood of family success and reduces the likelihood a family will need future DCFS intervention.

Building service capacity is only one aspect of the overall service array component. The access to flexible funding is another critical component. Purchase cards are available in each pilot site to purchase the concrete supports that are often needed by families. As of July 2015, the most prevalent services utilized include Intensive Family Preservation, Family Support, housing related assistance (rent, cleaning, utilities, and deposits), transportation (motor vehicle repairs, gas, tires, and windshield), food and clothing. Expenditures for services and concrete supports through August 1, 2015 total ~$63,000. While the utilization of flexible funds for concrete services is less than expected, field staff report tremendous support from community agencies who have delivered supports and services at no cost.

Protective Factors Questionnaire: October 2014 – July 2015

Submitted to
The Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Submitted by
The University of Nebraska–Lincoln
Center on Children, Families, and the Law
206 S. 13th Street, Suite 1000
Lincoln, NE 68510

Draft August 27, 2015

University of Nebraska Lincoln | Center on Children, Families, and the Law

Executive Summary

At the request of the Nebraska Department of Children and Family Services (DCFS), the evaluators assisted the Alternative Response (AR) leadership with the development of an adapted version of the Protective Factors Survey, entitled the *Nebraska DCFS Protective Factors Questionnaire*. During this period of review, the Protective Factors Questionnaire (PFQ) was to be administered to AR families during the initial assessment process. Workers documented the family's rating of each item on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*) or frequency (*1 = Never, 5 = Always*). This was to be completed at the beginning and end of the case. Documentation of the family's responses was then to be scanned and uploaded into N-FOCUS. These data were then shared with the evaluators to examine changes in families' perceptions of their protective factors over the life of the AR case.

New AR guidelines were released in an AR program manual on July 1, 2015 along with an updated version of the PFQ, now titled the *Nebraska DCFS Protective Factors and Well-Being Questionnaire*. In partnership with DCFS, the PFQ was expanded to include the measurement of well-being. However, the data included in this report only reference the original PFQ. Future reports will examine the usage of this new form.

For this review, DCFS provided the evaluators with all PFQ data on closed AR cases from October 2014 through July 2015. The main conclusions of these analyses are as follows:

- About half (46%) of these cases have completed PFQ data, while the other half (46%) are missing PFQ data. In the remaining 8% of cases, families refused to complete the PFQ. Further analyses of PFQ completion rates are summarized in the full report, including comparisons over the last three quarters and between the pilot counties.
- Of the completed PFQs, the following issues were observed:
    - Families are continuing to refuse to complete the PFQ. Moreover, this appears to be on the rise when looking at these data over the last three quarters.
    - Only 8 cases (6%) have more than one PFQ attached.
    - There were 8 PFQs with incomplete information or blank headers.

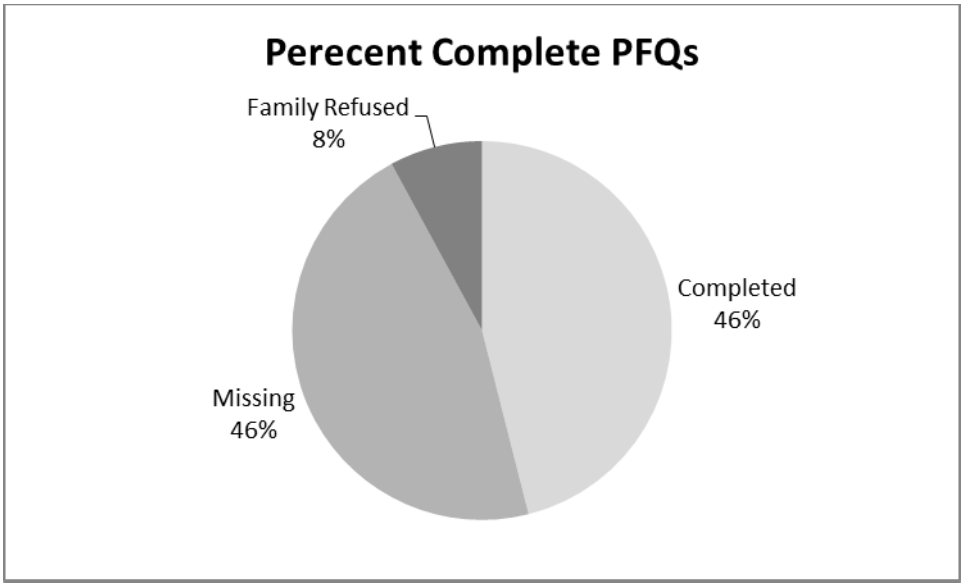
Summary of PFQ Completion

Statewide PFQ completion

The preliminary report of PFQ data included active and closed cases between October and December of 2014. In May 2015 the decision was made to only draw down data for closed cases. Therefore, this report will only include information from closed AR assigned cases. The overall data presented in this report includes PFQs completed between October 2014 and July 2015.

The original dataset provided by DCFS included 262 closed AR cases between October 2014 and July 2015. However, 11 of those cases were screened out, 8 cases changed track to a Traditional Response (TR) and were later screened out, and 70 cases changed tracks in less than 5 days. None of these cases would require the PFQ to be completed with the family; hence these cases were excluded from analyses. Additionally, 33 cases changed tracks from AR to TR after 5 or more days of the intake being accepted. Some of these cases were open long enough to require a PFQ be completed; however, because the ultimate measurement purpose of the PFQ is to examine changes in protective factors through repeated measures, this will only be possible in those cases that remain AR. Therefore, for clarity and the purposes of this report, these cases were also excluded from these analyses. Future reports could look at the completion rates and resultant data from these PFQs, if requested.

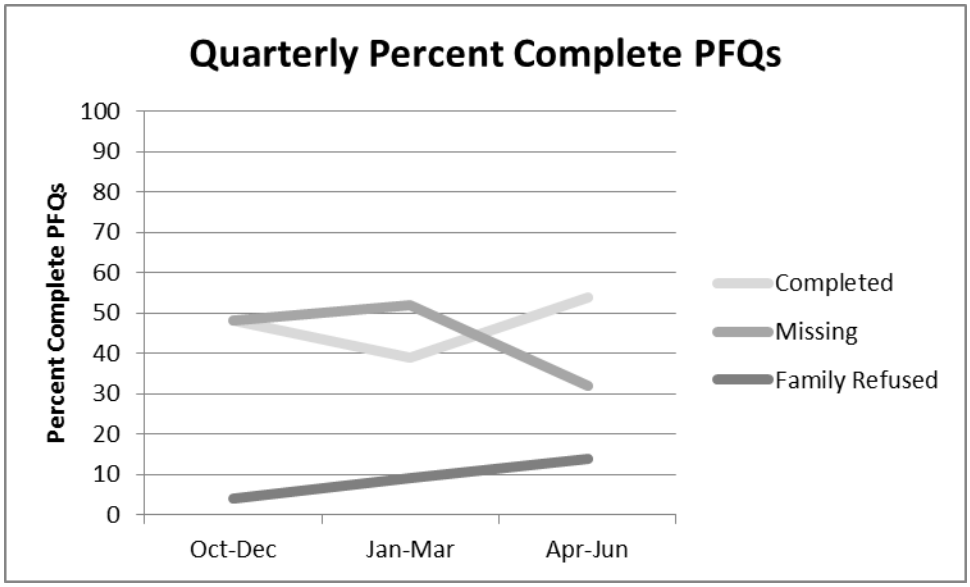
Ultimately, a total of 139 AR cases remained AR and were closed between October 2014 and July 2015. Of those 139 cases, 64 cases (46%) had completed PFQ data, 11 families refused to provide responses (8%), and 64 (46%) did not have a PFQ attached to the case. This distribution is illustrated in the chart below.



In order to examine the fluctuation in completion rates since implementation, the data were split into quarters based on the acceptance date: October through December 2014, January through March 2015,

and April through June 2015. July data was not included in these comparisons so that the quarters were equal; however, this only excluded one case.

In October through December 2014, 27 cases (48%) had completed PFQ data, 27 cases (48%) did not have a PFQ attached, and 2 cases (4%) had families refuse to complete the PFQ. In January through March 2015, 21 cases (39%) had completed PFQ data, 28 cases (52%) had missing PFQ data, and 5 cases (9%) had families refuse to complete the PFQ. In April through June 2015, there were 15 cases (54%) with completed PFQ data, 9 cases (32%) without PFQ data, and 4 cases (14%) had families refuse to complete the PFQ. Because these quarters were defined by when the case was accepted, as cases continue to close, the percentages represented for each quarter will continue to fluctuate. However, on average it appears about half of AR cases have a PFQ attached and the other half is not completed. Additionally, the percentage of families refusing to complete the PFQ appears to be on the rise. The following graph and table summarize the PFQ completion rates over the last three quarters.

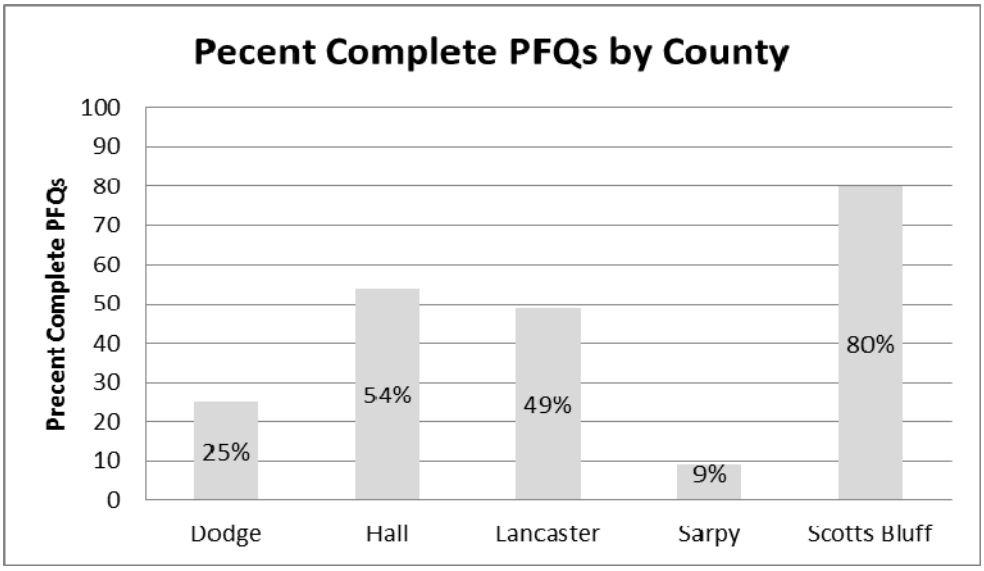


	Oct-Dec	Jan-Mar	Apr-Jun
Completed PFQs	27	21	15
Missing PFQs	27	28	9
Family Refused	2	5	4
Total Closed AR Cases	56	54	28

PFQ completion by pilot county

The percent of completed PFQs varies by pilot county. However, the populations and subsequent number of AR cases also varies meaningfully by county. Due to the small number of cases in the pilot counties

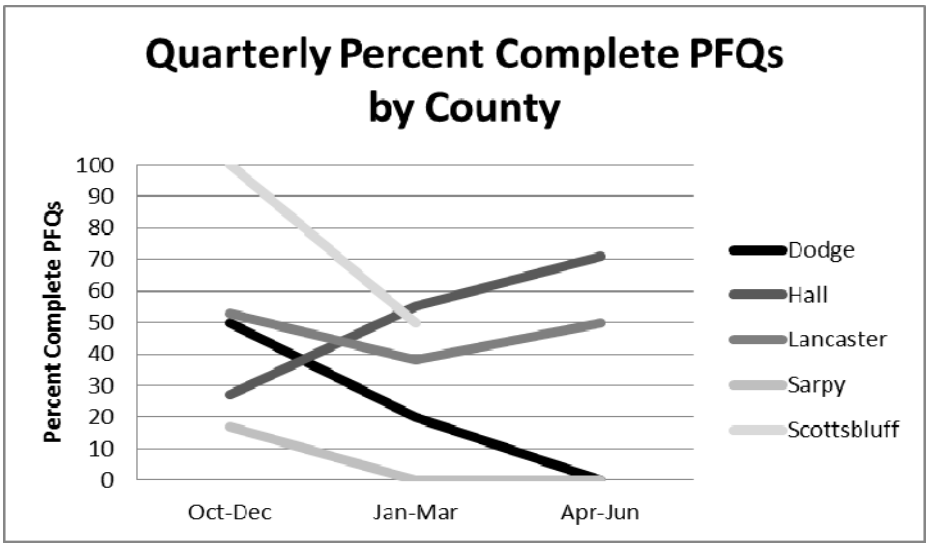
(except for Lancaster), it should be noted that completion rates are impacted heavily by a single PFQ being completed or not completed. Therefore, these percentages should be considered accordingly. The following graph and table summarize the overall PFQ completion rates for each pilot county from October 2014 through July 2015.



	Dodge	Hall	Lancaster	Sarpy	Scotts Bluff
Completed PFQs	3	14	42	1	4
Total AR Cases	12	26	85	11	5
Percent Complete	25	54	49	9	80

In order to examine the fluctuation in completion rates over time, data were split by county and then into quarters based on the acceptance date: October through December 2014, January through March 2015, and April through June 2015. July data was not included in these comparisons so that the quarters were equal; however, this only excluded one case from Lancaster County. Because these data were split into such small groupings, these percentages should be considered cautiously and not absolutely. For example, the numbers are so few in Scotts Bluff County that the completion rate appears to have fallen from 100% to 50%, and while numerically this is true, practically speaking, this is only one case. Furthermore, Scotts Bluff County didn't have a single AR case included in the third quarter data. However, these data still highlight some meaningful trends. For Dodge County, while the number of closed AR cases has remained relatively steady, the completion rate appears to be falling. Additionally, Sarpy County completed 1 PFQ during the first quarter, but no other closed cases have had PFQ data attached since. Bearing in mind that these numbers are low, it may still be advisable to communicate further with these specific counties to promote the completion of the PFQ. On the other hand, Hall County appears to continually be improving on their PFQ completion and Lancaster County is remaining relatively stable with nearly half of their

cases including PFQ data. Generally speaking, all counties need to improve their completion of the PFQ, especially if the goal is 100% completion, which no county is currently achieving. The following graph and table summarize the PFQ completion rates over the last three quarters.



	Oct-Dec					Jan-Mar					Apr-Jun				
	Dodge	Hall	Lancaster	Sarpy	Scotts Bluff	Dodge	Hall	Lancaster	Sarpy	Scotts Bluff	Dodge	Hall	Lancaster	Sarpy	Scotts Bluff
Completed PFQs	2	3	18	1	3	1	6	13	0	1	0	5	10	0	0
Total AR Cases	4	11	34	6	3	5	11	34	3	2	3	7	20	2	0
Percent Complete	50	27	53	17	100	20	55	38	0	50	0	71	50	0	-

Issues with Completed PFQ Data

Different forms

The preliminary PFQ report revealed that two versions of the PFQ form were being used. This issue appears to have been resolved; however, a new version of the PFQ was implemented on July 1, 2015. The new form includes well-being items and is titled the *Nebraska DCFS Protective Factors and Well-Being Questionnaire*. Future reports will examine the use of this new form.

Scanning issues

The preliminary PFQ report stated that three questionnaires had either only the first or only the second page of the PFQ form scanned into N-FOCUS. This issue appears to be resolved.

Noncompliance with AR policy

Family refusal

The preliminary PFQ report noted 1 family refusing to complete the PFQ. The current data includes 10 additional families refusing to fill out the PFQ, for a total of 11. As depicted above, the percentage of families refusing to fill out the PFQ appears to be on the rise. Per AR policy, the CFS Specialist is to ensure the completion of these questionnaires. Further clarity may be necessary to ensure this message is consistently understood by workers (i.e., this questionnaire is mandatory).

Lacking multiple PFQ measures

For the cases included in this report, AR policy stated that the PFQ was to be completed at the beginning of the case and at case closure. The preliminary PFQ report stated that only 1 case had 2 PFQs associated with it. The current data includes 7 additional cases with 2 PFQs, for a total of 8 out of 139 cases (6%). These cases with multiple measures were in Lancaster and Hall Counties. It appears greater communication is needed to ensure workers are completing these questionnaires according to the frequency outlined in policy.

Incomplete header information

There were 8 PFQs with incomplete information or blank headers. Some of the missing information included master case numbers (which were able to be provided by Sheralynn) and not providing the date the PFQ was completed. Omitting the date is a bigger concern, as this prohibits us from knowing when in the case the PFQ was completed. This is meant to be filled out multiple times to track changes in protective factors throughout an AR case. Therefore, it is important to be able to identify when each PFQ was completed.

Alternative Response Stakeholder Survey: Year 1

Submitted to
The Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Submitted by
The University of Nebraska–Lincoln
Center on Children, Families, and the Law
206 S. 13th Street, Suite 1000
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Draft submitted April 7, 2015

University of Nebraska Lincoln | Center on Children, Families, and the Law

Executive Summary

As a part of the Alternative Response (AR) program evaluation, CCFL created and distributed a survey to gather information about the experiences and perceptions of AR stakeholders. This 45-item survey was developed in collaboration with the DCFS AR Program Administrator and was comprised of the following dimensions: Purpose of the Group, Meeting Schedule, Meeting Processes (Agendas, Minutes, Action Items), Participation, History of Collaboration, Appropriate Cross Section of Members, Perceived Utility, Inclusiveness in Process, Open Communication, Appropriate Pace of Development, Political and Social Climate for AR, and Perceptions of AR Program Elements.

Contact information was provided by DCFS to CCFL for all individuals that DCFS considered to be AR stakeholders. This included a broad range of individuals internal and external to the department. A total of 166 individuals participated in this online survey. This survey was the first formal gathering of stakeholders' input on the AR implementation process thus far. AR was implemented in 5 pilot counties in October of 2014. This survey was emailed to participants on December 3, 2014, just shortly after initial AR implementation. Responses were collected between December 3, 2014 and December 19, 2014. Therefore, these responses are reflective of the early implementation period. This survey will be administered again midway through the demonstration and near the end of the project.

Responses to this survey were separated into three main groups for comparison purposes: statewide external stakeholders, internal workgroup and subgroup members, and local implementation team members. Most of the average ratings did not vary significantly between groups. Generally, AR stakeholders agreed or strongly agreed with the statements in the survey, meaning most AR stakeholders had generally favorable perceptions of the AR implementation process so far. However, there were some (8 items) significant differences between groups, mostly in regards to perceptions of specific AR program elements. These significant findings, along with comments, indicate that future efforts should be directed at actively involving stakeholders (both currently participating and possibly inviting additional stakeholders to attend AR meetings), examining or reexamining AR program elements with stakeholders, and communicating field-level experiences of AR implementation so far to stakeholders.

About "Title IV-E Child Welfare Waiver Demonstration Project Evaluation"

Through a Title IV-E waiver, the Nebraska Division of Children and Family Services (DCFS) plans to improve contractor accountability and child and family outcomes by conducting a demonstration project with two interventions: Results-Based Accountability™ (RBA) and Alternative Response (AR). RBA provides a framework and process for measuring and improving the performance of contracted service providers, which in turn is expected to improve the outcomes of children and families receiving these services. AR allows for Nebraska's child welfare system to engage with families in a non-investigative and more collaborative way, based on the severity of allegations received at initial intake. It is also expected that this family-centered response will lead to improved outcomes for children and families participating in this approach. The evaluation of these two interventions will contribute to an understanding of whether and how the demonstration accomplished its goals by assessing the planning and implementation process, contextual factors, and barriers and facilitators; achievement of intended outcomes; and the cost effectiveness of each intervention. DCFS has contracted with the UNL-Center on Children, Families and the Law (CCFL) to conduct the program evaluation.

Purpose of AR Stakeholder Survey

As a part of the AR program evaluation, CCFL created and distributed a survey to gather information about the experiences and perceptions of AR stakeholders. Specifically, this survey sought to address stakeholder's perceptions of the following:

- Group functioning and effectiveness
- Effectiveness of local and statewide advisory structure
- Adequacy of meeting frequency and type of interactions
- Opportunities to provide meaningful input into development and implementation of AR
- Inclusiveness of advisory group process and resultant decisions and products
- Ongoing monitoring and revision of implementation plans
- The availability and utility of AR program data
- The extent of partnership with DCFS to expand services and results of those efforts, and perceived changes in level of partnership over time
- Stakeholder and community member knowledge of AR elements
- Stakeholder, community member, and CFS staff support/ endorsement of AR program

This survey was developed in collaboration with the DCFS AR Program Administrator and comprised of the following dimensions: Purpose of the Group, Meeting Schedule, Meeting Processes (Agendas, Minutes, Action Items), Participation, History of Collaboration, Appropriate Cross Section of Members, Perceived Utility, Inclusiveness in Process, Open Communication, Appropriate Pace of Development, Political and Social Climate for AR, and Perceptions of AR Program Elements. Possible respondents included a broad range of AR stakeholders, including statewide external stakeholders (Director's Steering Committee and the Statewide Alternative Response Advisory Board), internal workgroups and subgroups (Alternative Response Internal Workgroup and Alternative Response Internal Subgroup), and local implementation teams from the initial 5 pilot counties (Alternative

Response External Leadership Team for the Southeast Service Area, Fremont Alternative Response External Team, Hall County Alternative Response External Stakeholder Group, Hall County Community Collaboration, Sarpy County Alternative Response External Steering Committee, Scotts Bluff County Alternative Response Advisory Team, and Internal Alternative Response Pilot Site Leadership Team). Because some of the survey items specifically addressed meeting effectiveness, which may vary from group to group, participants were asked to identify the one group with which they felt most strongly affiliated or attended most regularly, and respond to the survey items with that group in mind.

This survey was the first formal evaluation of stakeholders' input on the AR implementation process thus far. This survey will be conducted again midway through the demonstration (April-June 2016) and near the end of the project (January-March 2019). The purpose of this survey is to address a number of short term and intermediate outcomes on the DCFS AR Program Logic Model:

- Stakeholders and community members are engaged and offer meaningful input in AR program development, including initial implementation and the ongoing monitoring and revision of implementation plans
- Building an understanding and buy-in for the AR program
- Community providers work together and with DCFS to expand or enhance services/supports

Ultimately, these outcomes are expected to lead to the long term outcome of strengthened partnership between DCFS, provider agencies, and community stakeholders.

Method

Participants

DCFS provided CCFL with email contact information for all individuals that they considered to be AR stakeholders. This included a broad range of individuals internal and external to the department. In total, DCFS provided 477 names and email addresses. All of these individuals were invited to participate in the AR stakeholder survey. However, six individuals contacted the researchers and asked to be removed from the mailing list because they did not consider themselves to be involved in AR. Additionally, 94 respondents reported that they did not consider themselves a member of any of the groups listed in the survey, and thus did not complete the remaining survey items. Considering nearly 20% of stakeholders did not identify with the groups listed in the survey, future survey efforts will be more inclusive and designed to accommodate an even broader range of individuals participating in AR discussions (i.e., not exclusive to specific AR groups). For this survey, the resulting pool of valid respondents included 377 individuals. Of those, 166 completed the survey for a response rate of 44%. This included 23 statewide external stakeholders, 27 internal workgroup and subgroup members, and 116 local implementation team members.

Procedure

This survey was administered by CCFL using Qualtrics, an online survey site. Invitations asking stakeholders to complete an online survey were emailed on December 3, 2014. A reminder email was sent to individuals who had

not yet completed the survey as of December 10, 2014 and again if they still had not completed the survey as of December 17, 2014. The survey was closed February 10, 2015; however, the last responses were received on December, 19, 2014.

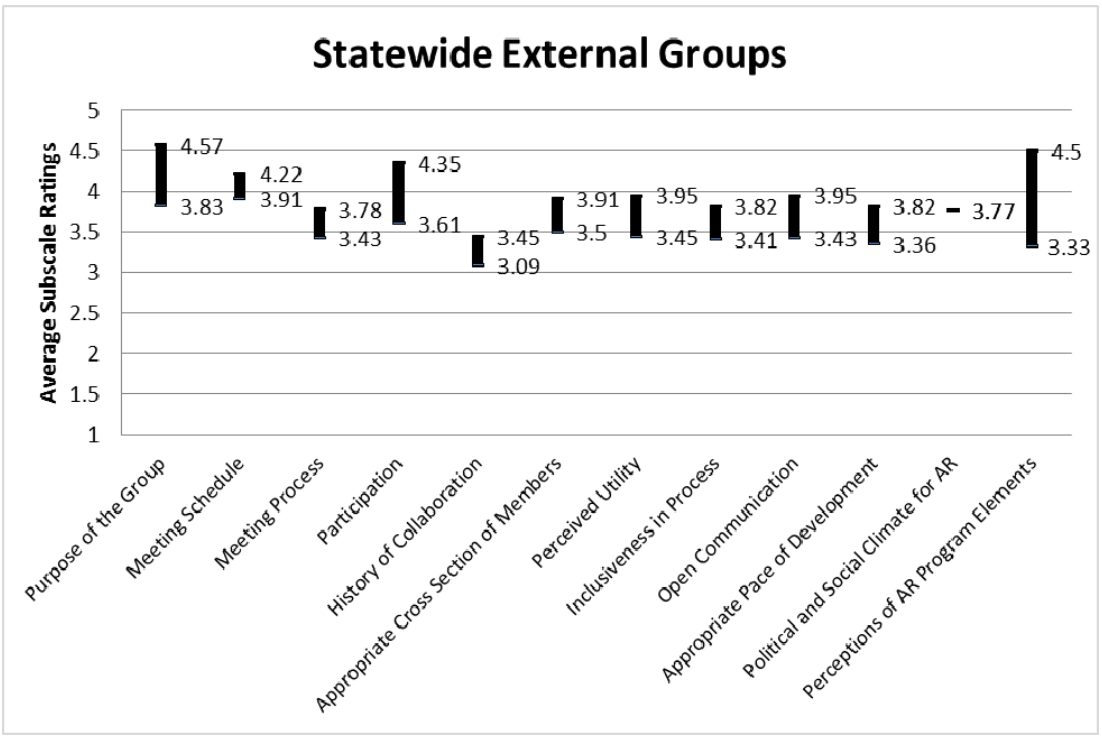
Results

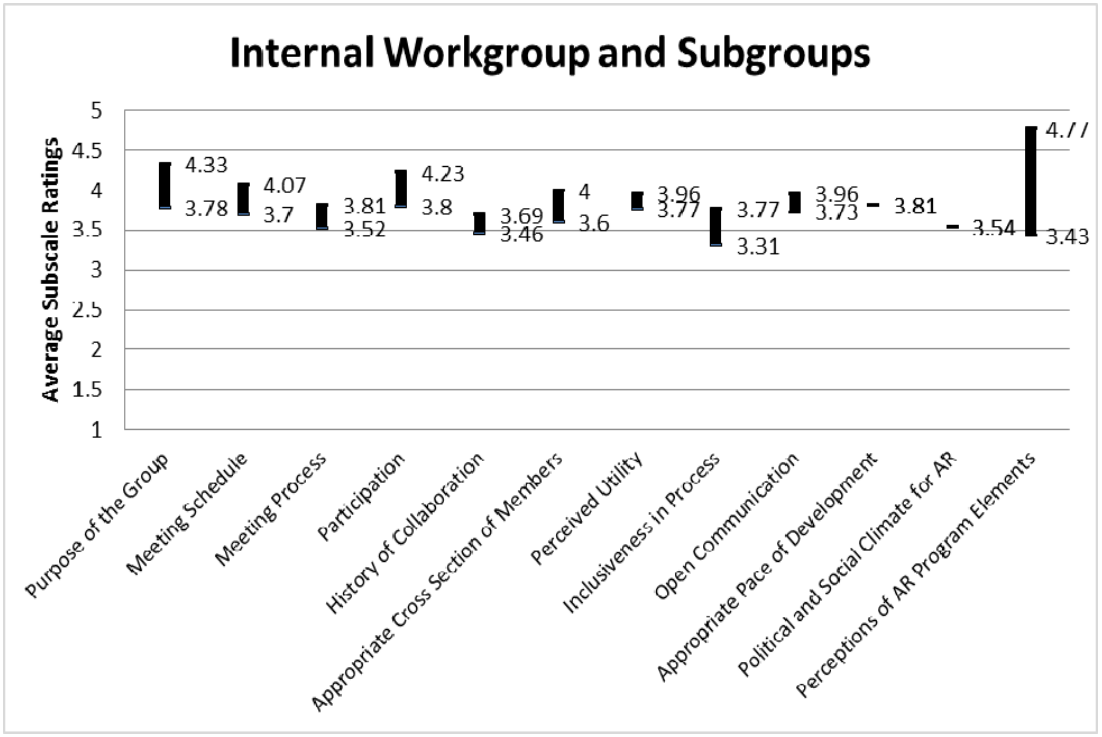
Summary of Responses

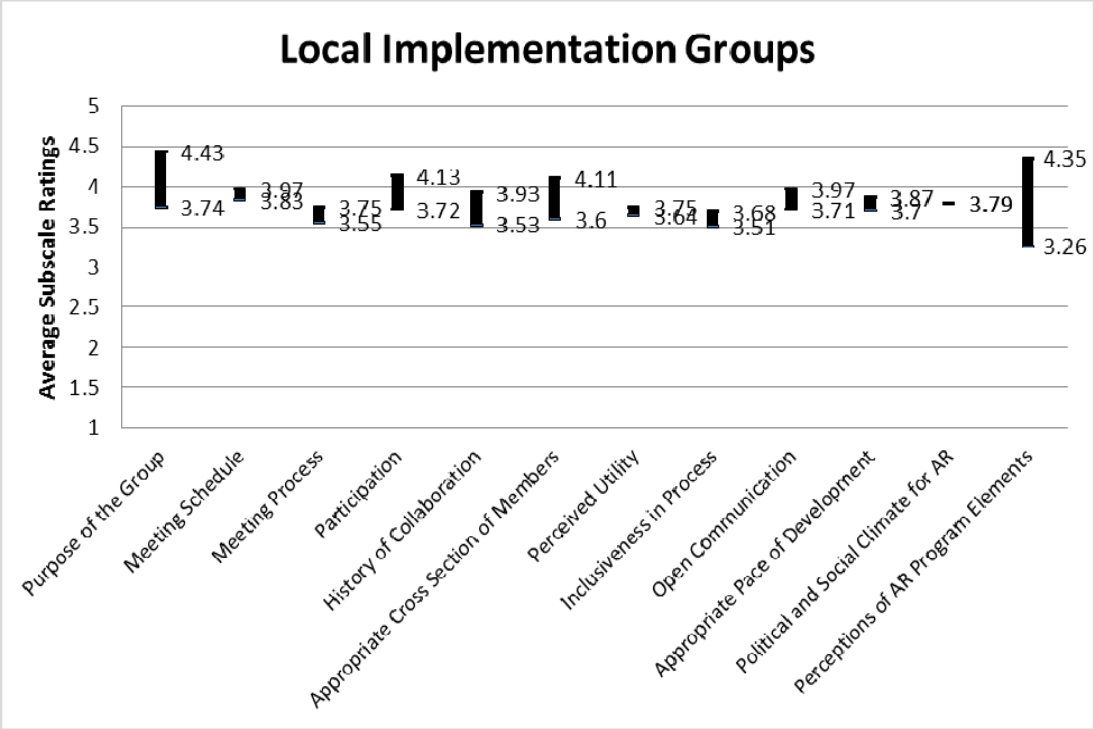
The AR stakeholder survey included 45 items across 12 dimensions: Purpose of the Group (4 items), Meeting Schedule (2 items), Meeting Processes (4 items), Participation (6 items), History of Collaboration (2 items), Appropriate Cross Section of Members (2 items), Perceived Utility (3 items), Inclusiveness in Process (4 items), Open Communication (5 items), Appropriate Pace of Development (2 items), Political and Social Climate for AR (1 item), and Perceptions of AR Program Elements (10 items). Respondents included a broad range of AR stakeholders, which for the purpose of comparisons were grouped into three categories: 1) statewide external stakeholders (Director's Steering Committee and the Statewide Alternative Response Advisory Board), 2) internal workgroup and subgroups (Alternative Response Internal Workgroup and Alternative Response Internal Subgroups), and 3) local implementation teams (Alternative Response External Leadership Team for the Southeast Service Area, Fremont Alternative Response External Team, Hall County Alternative Response External Stakeholder Group, Hall County Community Collaboration, Sarpy County Alternative Response External Steering Committee, Scotts Bluff County Alternative Response Advisory Team, and Internal Alternative Response Pilot Site Leadership Team). Ultimately, this included 23 statewide external stakeholders, 27 internal workgroup and subgroup members, and 116 local implementation team members.

Respondents rated each survey item on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*). Generally, respondents indicated that they either agreed or strongly agreed with the survey items, indicating that AR stakeholders had favorable perceptions of the AR implementation process so far, overall. The only exception was the item, "law enforcement should be involved in AR cases." Responses for this item were more moderate, tending towards neutral. Detailed information about the number and percentage of responses for each item can be found in Appendix A, *Overall AR Stakeholder Item Frequencies*. In order to make comparisons, participants were grouped according to membership (statewide external stakeholders, internal workgroup and subgroup members, and local implementation team members). Rating averages for each question by group membership are included in Appendix B, *Average AR Stakeholder Item Ratings*.

The following graphs display the range of average ratings for each dimension by group (statewide external groups, internal workgroup and subgroups, and local implementation groups). For example, the first vertical line on the left represents the range of averages for the *Purpose of the Group* dimension; for the statewide external groups, the lowest question average was 3.83 and the highest questions average was 4.57.


Statewide External Groups
Average Subscale Ratings
5
4.5
4
3.5
3
2.5
2
1.5
1
4.57
3.83
4.22
3.91
3.78
3.43
4.35
3.61
3.45
3.09
3.91
3.5
3.95
3.45
3.82
3.41
3.95
3.43
3.82
3.36
3.77
4.5
3.33
Purpose of the Group
Meeting Schedule
Meeting Process
Participation
History of Collaboration
Appropriate Cross Section of Members
Perceived Utility
Inclusiveness in Process
Open Communication
Appropriate Pace of Development
Political and Social Climate for AR
Perceptions of AR Program Elements


Internal Workgroup and Subgroups
Average Subscale Ratings
5
4.5
4
3.5
3
2.5
2
1.5
1
4.33
3.78
4.07
3.7
3.81
3.52
4.23
3.8
3.69
3.46
4
3.6
3.96
3.77
3.77
3.31
3.96
3.73
3.81
3.54
4.77
3.43
Purpose of the Group
Meeting Schedule
Meeting Process
Participation
History of Collaboration
Appropriate Cross Section of Members
Perceived Utility
Inclusiveness in Process
Open Communication
Appropriate Pace of Development
Political and Social Climate for AR
Perceptions of AR Program Elements



Significant Results

A one-way analysis of variance (ANOVA) was conducted to compare item means between the three overall groups: 1) statewide external stakeholders, 2) internal workgroup and subgroups, and 3) local implementation teams. For statistically significant differences, a Tukey post-hoc test was used to examine the specific group differences observed. For the 45-item survey, responses were generally positive and did not vary significantly between groups. This means that stakeholders generally feel positive about the AR implementation so far. However, significant differences were observed between groups on 8 items, most of which were in the *Perceptions of AR Program Elements* dimension. For these, the two main suggested strategies are 1) greater communication to convey DCFS's intent with the program element and/or a need to better understand stakeholders' insight about the program element, or 2) a need to better explain how DCFS intends to accomplish specific outcomes through AR. Statistically significant differences and potential strategies to address these items are discussed below.

Participation

I regularly participate in the discussions during our meetings, F(2,156) = 4.60, *p* = 0.01

The average rating from the local implementation teams (3.83) was significantly lower than that from the statewide external stakeholders (4.35). This indicates a need to elicit greater participation from members of the local implementation teams. Because ratings were higher among statewide external stakeholders, perhaps strategies used to engage these members could also be helpful in raising the perceived level of participation for local implementation team members.

History of Collaboration

Trying to solve problems through collaboration has been common in this local community, F(2,159) = 3.34, *p* = 0.04

The average rating from the local implementation teams (3.95) was significantly higher than that from the statewide external stakeholders (3.45). Meaning, local implementation team members perceive greater levels of community collaboration than statewide members. Perhaps this is due to the composition of the statewide external groups (if there were more members from areas with less community collaboration), or may simply be due to the fact that there is greater variety of members participating on the statewide groups.

Perceptions of AR Program Elements

AR families should not be placed on the Central Registry, F(2,149) = 4.67, *p* = 0.01

The average rating from the local implementation teams (4.19) was significantly lower than that from the internal group (4.76). Meaning, while both groups tended to agree with this statement, local implementation team members were less likely to agree that AR families should not be placed on the Central Registry. Given that this is a central tenant of Nebraska's AR model, it appears greater communication may be necessary to convey the State's intent with this program element.

Law enforcement should be involved in AR cases, F(2,147) = 7.15, *p* = 0.001

The average rating from the local implementation teams (3.26) was significantly lower than those from the statewide (4.06) and internal (3.88) groups. Although this question is worded in the positive, responses were reverse-coded (meaning, *Strongly Agree = 1 and Strongly Disagree = 5*), as DCFS has indicated potential issues with law enforcement involvement in AR cases. Therefore, these ratings indicate a more moderate viewpoint on behalf of the local implementation teams. This may indicate a need for greater communication on behalf of DCFS to convey the importance of this program element or perhaps the local implementation teams have greater insight about how law enforcement could be incorporated within the AR program model without issue.

Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement, F(2,147) = 3.25, *p* = 0.04

The average rating from the internal groups (4.60) was significantly higher than that from the local implementation teams (4.11) and approached significance with the statewide external stakeholders (4.00). Meaning, statewide and local stakeholders were less likely to agree with the need to contact parents prior to interviewing children in AR. Although this program element is considered to be best practice, it is understood that safety must be assessed within the required timeframes. This nuance is not explicit in the survey item. Therefore lower agreement levels could be due to respondents thinking less about the ideal and more about the relative importance of safety. However, it may also be possible that stakeholders have suggestions about how interviews can be accomplished without prior parental

notification. Greater communication may be needed from DCFS to convey the importance of this program element.

Nebraska's AR model is designed to serve families with less severe allegations, $F(2,155) = 4.42$, $p = 0.01$

The average rating from the internal groups (4.77) was significantly higher than those from the statewide (4.23) and local (4.35) groups. Meaning, while all three groups generally agreed with the statement, statewide and local groups are less likely to agree that AR serves families with less severe allegations. This indicates a potential need for DCFS to better communicate their intentions with the AR model and explain to stakeholders how it has been designed to serve families with less severe allegations.

Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution, $F(2,136) = 4.96$, $p = 0.01$

The average rating from the internal groups (4.71) was significantly higher than those from the statewide (3.89) and local (4.16) groups. This means that statewide and local stakeholders are less likely to agree that AR will lead to better outcomes and quicker resolution for families as a result of more frequent contact with a caseworker. Further communication from DCFS may be necessary to explain to external stakeholders how this will be accomplished through AR.

Concrete supports will be better addressed through AR as compared to Traditional Response, $F(2,140) = 6.26$, $p = 0.002$

The average rating from the statewide external stakeholders (3.33) was significantly lower than those from the internal (4.29) and local (3.92) groups. Meaning, statewide external group members were less likely to agree that concrete supports will be better addressed through AR (as compared to TR). This indicates a need to better inform statewide external stakeholders on how DCFS plans to accomplish this outcome through AR. Perhaps strategies used to communicate with the local implementation teams would be helpful to raise statewide stakeholders' level of agreement with this statement.

Summary of Comments

The AR Stakeholder survey included areas for participants to write comments after each dimension and one general comment section. Out of 166 respondents, a total of 283 comments were provided by 108 individuals. These comments were reviewed overall and are summarized below.

Meeting Processes

Conversations appear to be open and honest between the different agencies and representatives that attend the various AR meetings. Some respondents also indicated a diligent effort on behalf of DCFS to keep stakeholders informed. However, others indicated that DCFS' style of communication has been too focused on the delivery of information, rather than asking questions or providing stakeholders with options to advise on the direction of the AR program. One respondent said, "I felt like I was there for show and tell only." This appears to be leading some stakeholders to view AR meetings as an inefficient use of their time, as they would like to more clearly see the

effect of their input and observe more productivity result from these meetings. One respondent stated their sense was, "DHHS was going to go this direction despite the feedback." Another felt AR decisions were "driven internally and we were given documents to respond to, but often the feedback provided resulted in no changes." It was noted that apparent decision-makers are not always present at meetings; although stakeholders want to understand how their participation is impacting the final decisions being made by DCFS. One respondent said:

> "At times it feels as though decisions can't be made without certain people present and yet those folks aren't always available to attend the meeting, in turn decisions aren't made timely. I feel as though the meeting becomes stagnant at times and we circle around the same information with no clear decision even when the people at the table can make the decision."

Considering this feedback, it may be beneficial to provide stakeholders with a written summary or documentation of clear action items, details about how past action items have been addressed, or decisions that have been made since the last meeting. A possible solution would be for DCFS to more clearly communicate through the use of agendas (prior to meetings) and the distribution of meeting minutes (after meetings), as comments suggested these are not consistently being used. Stakeholders also commented on how they have assumed additional AR duties voluntarily and in addition to their regular responsibilities. One respondent suggested that if or when meetings are just to share information; email may be a better medium. It also appears that clearer communication is needed for some stakeholders regarding when meetings are scheduled or canceled.

While comments indicated that the level of collaboration within communities is perceived to be strong, some comments indicated a lack of trust in DCFS to follow through with AR as discussed at meetings. Additionally, some are concerned about AR continuing to be made a priority through leadership changes. Comments suggest the need for greater collaboration between DCFS and the community to create more service links, breakdown divisions, and create sustainable change for families needing services after DCFS involvement ends. However, several respondents also remarked on the developing relationships between DCFS and community partners, indicating a recent shift in collaboration and that trust is evolving. On stakeholder remarked that "it was good to see them ask for stakeholder input and participation." Another said, "I think working collaboratively is something we are striving towards and becoming better at. Over the last 5 years we have broken down many silos and are doing a much better job." Stakeholders appear to see the need for AR and feel like progress has been made regarding the relationships and level of trust in DCFS. Some commented on the level of community involvement in AR thus far and feel that collaboration between DCFS and most agencies is good. One respondent indicated:

> "This is the great thing we have accomplished! Before starting this process we had numerous local agencies and non-profit organizations working on the same issues but not communicating or working hand in hand. This resulted in too much redundancy in many areas and huge gaps of need in others. Getting everyone on the same page has resulted in a much more effective use of our time, our energy and our resources."

Moving forward, participants would like to hear more about how the AR program is progressing, especially as it rolls out to additional sites and the model is adjusted from the original implementation plans. External stakeholders are requesting more communication about what is being experienced by workers in the field, while

some internal DCFS staff commented on their desire to be more involved regarding the current and ongoing status of the AR program. As implementation progresses, it may also be necessary to revisit the purpose of the different AR groups, as some respondents expressed a need for more defined roles and group direction. One stakeholder indicated that "it would be beneficial to regroup and ensure each party is aware of their role within the group and within AR as a whole. At times it feels as though people are unsure of their role and the goals of what DHHS is attempting to accomplish with this initiative." A local stakeholder stated, "I think the group is still trying to 'form' and see their purpose. People are interested, but don't yet see their own roles, responsibilities, and how each can contribute." Additionally, there may be a need to reach out to other stakeholders to make sure all necessary system partners are involved. Comments suggested the following stakeholders should be included in AR discussions: more people that are familiar with the research, additional provider agencies, faith-based community partners, cultural centers (including tribal), educational personnel, mental health professionals, law enforcement, legal partners (attorneys, CASA, GAL, judges), and youth and families.

Overall AR Program

Several respondents remarked that AR is a "move in the right direction" and commented on the potential benefits of AR being implemented. One stakeholder commented, "I am excited about the potential outcomes for families serviced in AR." Another stated, "CFS is definitely on the right track with AR. AR should prove to keep families out of the system and address their needs in a much more proactive manner." It appears that stakeholders believe AR can be successful and are eager to see how AR is impacting families. Negative program comments were minimal and appeared to be specific to particular program features (e.g., contact requirements, interview protocol). Several comments expressed a need to figure out the specifics for funding, including funding services in the community, and how workers can access flexible funding sources for AR families. There were also concerns about AR overloading IA workers, especially with the requirement for more frequent family contacts and managing a mixed (AR and TR) caseload. More supports may be necessary to fully, or at least more quickly, realize some of the outcomes proposed to be associated with AR.

Stakeholders would like to see future efforts focused on providing additional training or more comprehensive training for future sites. Stakeholders would also like to further review and consider the exclusionary criteria. Comments indicated that there are too many criteria excluding families from AR, in other words the current criteria are too restrictive. Additionally, some comments underlined a need to manage external perceptions of the AR program, as not all conditions are within the department's control, nor can all conditions be predicted or managed. Respondents expressed recognition that some of the outcomes proposed will take a long time to occur, if at all. A couple of comments highlighted concerns about the evaluation, specifically the use of the randomizer. These comments indicated that the randomizer is "just not right" and "is going to hurt people in the short run." Further communication about the value of the evaluation and how it can be informative, not hurtful, may be necessary.

Conclusion

AR began implementation in 5 pilot counties on October 1, 2014. This survey was the first formal gathering of stakeholders' input on the AR implementation process thus far. Contact information was provided by DCFS to CCFL for all individuals that DCFS considered to be AR stakeholders. This included individuals internal and external

to the department. A total of 166 individuals participated in this online survey. The survey was emailed to participants on December 3, 2014. Responses were received between December 3, 2014 and December 19, 2014. Therefore, these responses are reflective of the early implementation period.

For comparison purposes, respondents were separated into three main groups: statewide external stakeholders, internal workgroup and subgroup members, and local implementation team members. Generally, AR stakeholders agreed or strongly agreed with the statements in the survey and most of the average ratings did not vary significantly between groups. Significant findings, along with comments, indicate that future efforts should be directed at actively involving stakeholders (both current and possibly inviting more stakeholders to attend AR meetings), examining or reexamining AR program elements, and communicating field-level experiences of AR implementation so far.

The purpose of this survey was to address a number of short term and intermediate outcomes:

- Stakeholders and community members are engaged and offer meaningful input in AR program development, including initial implementation and the ongoing monitoring and revision of implementation plans
- Building an understanding and buy-in for the AR program
- Community providers work together and with DCFS to expand or enhance services/supports

Although respondents generally agreed with the survey statements, it appears there is room for improvement with regards to these outcomes. Future survey efforts will examine any increases or changes in respondent ratings as well as the frequency and valence of comments. This survey will be conducted again midway through the demonstration (April-June 2016) and near the end of the project (January-March 2019). Ultimately, these outcomes are expected to lead to the long term outcome of strengthened partnership between DCFS, provider agencies, and community stakeholders.

Appendix A:
Overall AR Stakeholder Item Frequencies

For each survey item, the following tables detail the number and percentage of responses selected for each response option. *SD* = strongly disagree (1), *D* = disagree (2), *N* = neutral (3), *A* = agree (4), *SA* = strongly agree (5). *Total* represents the total number of respondents that provided a rating for that item. For the *Perceptions of AR Program Elements* dimension, *Don't Know* was also included as a response option. For these items *DK* = Don't Know. If a different rating scale was used for an item, it is defined within the table. Percentages may not total 100% due to rounding.

Purpose of the Group	*SD*	*D*	*N*	*A*	*SA*	Total
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	3 (2%)	6 (4%)	7 (4%)	95 (57%)	55 (33%)	166
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	1 (1%)	8 (5%)	13 (8%)	105 (63%)	39 (24%)	166
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	2 (1%)	14 (8%)	38 (23%)	80 (48%)	32 (19%)	166
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	1 (1%)	1 (1%)	14 (9%)	65 (39%)	84 (51%)	165

Meeting Schedule	*SD*	*D*	*N*	*A*	*SA*	Total
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	2 (1%)	10 (6%)	14 (9%)	96 (58%)	43 (26%)	165
6. Meetings occur with the right amount of frequency.	2 (1%)	6 (4%)	35 (21%)	99 (60%)	23 (14%)	165

If respondents did not agree or strongly agree with item 6, the following question was displayed:

	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	Total
7. How frequently should these meetings take place?	-	1 (2%)	16 (38%)	24 (57%)	1 (2%)	42

Meeting Process (Agendas, Minutes, Action Items)	*SD*	*D*	*N*	*A*	*SA*	Total
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	5 (3%)	23 (14%)	27 (17%)	86 (53%)	22 (14%)	163
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	2 (1%)	17 (10%)	44 (27%)	85 (52%)	16 (10%)	164

Meeting Process (Agendas, Minutes, Action Items)	*SD*	*D*	*N*	*A*	*SA*	Total
10. Commitments made at our meetings are followed up and not forgotten.	2 (1%)	10 (6%)	35 (22%)	96 (59%)	20 (12%)	163
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3 (2%)	15 (9%)	41 (25%)	86 (53%)	17 (11%)	162

Participation	*SD*	*D*	*N*	*A*	*SA*	Total
12. The organizations that attend these meetings invest the right amount of time and effort.	0 (0%)	9 (6%)	39 (24%)	92 (58%)	20 (13%)	160
13. I feel involved in what's going on during our meetings.	2 (1%)	13 (8%)	23 (14%)	93 (58%)	29 (18%)	160
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	0 (0%)	6 (4%)	15 (9%)	87 (54%)	53 (33%)	161
15. I regularly participate in the discussions during our meetings.	1 (1%)	8 (5%)	28 (18%)	83 (52%)	39 (25%)	159
16. Other's participation is usually energetic and stimulating.	0 (0%)	8 (5%)	42 (26%)	90 (56%)	20 (13%)	160
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	1 (1%)	6 (4%)	21 (13%)	104 (65%)	29 (18%)	161

History of Collaboration	*SD*	*D*	*N*	*A*	*SA*	Total
18. Trying to solve problems through collaboration has been common in this local community.	1 (1%)	16 (10%)	25 (15%)	86 (53%)	34 (21%)	162
19. Agencies in our local community have a history of working collaboratively with DCFS.	3 (2%)	27 (17%)	39 (24%)	73 (45%)	19 (12%)	161

Appropriate Cross Section of Members	*SD*	*D*	*N*	*A*	*SA*	Total
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	1 (1%)	5 (3%)	17 (11%)	97 (61%)	39 (25%)	159
21. All the organizations that need to be members of this group have become members of this group.	3 (2%)	18 (11%)	37 (23%)	87 (55%)	13 (8%)	158

Perceived Utility	*SD*	*D*	*N*	*A*	*SA*	Total
22. The quality of our discussions is high (e.g., issues are examined in depth; problems are addressed and not skirted).	3 (2%)	17 (11%)	25 (16%)	91 (57%)	24 (15%)	160
23. Our meetings are a valuable use of my time because we deal with important content.	4 (3%)	11 (7%)	29 (18%)	93 (58%)	23 (14%)	160

Perceived Utility	*SD*	*D*	*N*	*A*	*SA*	Total
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	4 (3%)	15 (9%)	39 (24%)	82 (51%)	20 (13%)	160

Inclusiveness in Process	*SD*	*D*	*N*	*A*	*SA*	Total
25. The processes used to elicit the group's input are effective.	3 (0%)	11 (6%)	36 (24%)	96 (58%)	14 (13%)	160
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	6 (4%)	7 (4%)	44 (28%)	77 (48%)	25 (16%)	159
27. When major decisions are made about AR program design and implementation, we are always informed.	4 (3%)	26 (16%)	38 (24%)	76 (48%)	16 (10%)	160
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	4 (3%)	19 (12%)	35 (22%)	87 (55%)	13 (8%)	158

Open Communication	*SD*	*D*	*N*	*A*	*SA*	Total
29. People really listen to each other during our meetings.	0 (0%)	4 (3%)	24 (15%)	107 (67%)	25 (16%)	160
30. There is a high level of trust between participants in our meetings.	3 (2%)	13 (8%)	40 (25%)	80 (50%)	24 (15%)	160
31. People feel comfortable challenging the ideas and comments of others in our meetings.	1 (1%)	11 (7%)	40 (25%)	87 (54%)	21 (13%)	160
32. Different ideas and perspectives are often explored in our meetings.	3 (2%)	11 (7%)	34 (21%)	91 (57%)	20 (13%)	159
33. Other members in this group value my opinion.	2 (1%)	4 (3%)	46 (29%)	86 (55%)	19 (12%)	157

Appropriate Pace of Development	*SD*	*D*	*N*	*A*	*SA*	Total
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	0 (0%)	7 (4%)	38 (24%)	88 (55%)	26 (16%)	159
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	4 (3%)	14 (9%)	35 (22%)	85 (53%)	22 (14%)	160

Political and Social Climate for AR	*SD*	*D*	*N*	*A*	*SA*	Total
36. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	4 (3%)	8 (5%)	33 (21%)	94 (59%)	21 (13%)	160

Perceptions of AR Program Elements	*DK*	*SD*	*D*	*N*	*A*	*SA*	Total
37. AR will be able to keep kids as safe as Traditional Response.	14 (9%)	1 (1%)	5 (3%)	14 (9%)	48 (30%)	76 (48%)	158
38. Nebraska's AR model is designed to serve families with less severe allegations.	0 (0%)	1 (1%)	3 (2%)	7 (4%)	67 (42%)	80 (51%)	158

Perceptions of AR Program Elements	*DK*	*SD*	*D*	*N*	*A*	*SA*	Total
39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	21 (13%)	4 (3%)	13 (8%)	28 (18%)	70 (44%)	23 (14%)	159
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4 (3%)	0 (0%)	3 (2%)	18 (11%)	64 (40%)	70 (44%)	159
41. AR families should not be placed on the Central Registry.	7 (4%)	1 (1%)	8 (5%)	16 (10%)	43 (27%)	84 (53%)	159
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	19 (12%)	2 (1%)	7 (4%)	15 (9%)	50 (32%)	65 (41%)	158
43. Families will receive services faster in AR as compared to Traditional Response.	22 (14%)	0 (0%)	13 (8%)	36 (23%)	51 (32%)	37 (24%)	159
44. Concrete supports will be better addressed through AR as compared to Traditional Response.	16 (10%)	2 (1%)	11 (7%)	27 (17%)	63 (39%)	40 (25%)	159
45. Law enforcement should be involved in AR cases.*	9 (6%)	5 (3%)	23 (14%)	48 (30%)	46 (29%)	28 (18%)	159
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	8 (5%)	2 (1%)	9 (6%)	15 (9%)	58 (37%)	66 (42%)	158

**This item was reverse coded*

Appendix B:
Average AR Stakeholder Item Ratings

Respondents rated each survey item on a 5-point scale of agreement (*1 = Strongly Disagree, 5 = Strongly Agree*). The following tables display the average item ratings for each group of stakeholders (statewide external groups, internal workgroup and subgroups, and local implementation groups). For the following tables, *Average* = average item rating, *SD* = standard deviation, and *N* = number of responses. For the *Perceptions of AR Program Elements* dimension, *Don't Know* was included as a response option. For purposes of calculating the mean, these responses were treated as missing data.

Statewide External Groups

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	4.04	1.07	23
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	3.96	0.98	23
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.83	1.07	23
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	4.57	0.66	23

Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	4.22	0.74	23
6. Meetings occur with the right amount of frequency.	3.91	0.79	23

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	-	50%	50%	-	6

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.43	1.31	23
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.57	0.95	23
10. Commitments made at our meetings are followed up and not forgotten.	3.65	1.07	23
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.78	1.00	23

Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.61	0.72	23
13. I feel involved in what's going on during our meetings.	4.13	0.69	23
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.22	0.90	23
15. I regularly participate in the discussions during our meetings.	4.35	0.78	23
16. Other's participation is usually energetic and stimulating.	3.87	0.82	23
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	4.09	0.67	23

History of Collaboration	Average	*SD*	N
18. Trying to solve problems through collaboration has been common in this local community.	3.45	1.06	22
19. Agencies in our local community have a history of working collaboratively with DCFS.	3.09	1.11	22

Appropriate Cross Section of Members	Average	*SD*	N
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	3.91	1.11	22
21. All the organizations that need to be members of this group have become members of this group.	3.50	1.01	22

Perceived Utility	Average	*SD*	N
22. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.77	1.11	22
23. Our meetings are a valuable use of my time because we deal with important content.	3.95	1.05	22
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.45	1.22	22

Inclusiveness in Process	Average	*SD*	N
25. The processes used to elicit the group's input are effective.	3.82	1.05	22
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.68	1.17	22
27. When major decisions are made about AR program design and implementation, we are always informed.	3.41	1.18	22
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.82	1.01	22

Open Communication	Average	*SD*	N
29. People really listen to each other during our meetings.	3.95	0.84	22
30. There is a high level of trust between participants in our meetings.	3.45	1.06	22
31. People feel comfortable challenging the ideas and comments of others in our meetings.	3.82	0.59	22
32. Different ideas and perspectives are often explored in our meetings.	3.68	0.95	22
33. Other members in this group value my opinion.	3.43	0.68	21

Appropriate Pace of Development	Average	*SD*	N
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	3.82	1.10	22
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.36	1.22	22

Political and Social Climate for AR	Average	*SD*	N
36. The political and social climate seems to be "right" for AR to be successful.	3.77	1.02	22

Perceptions of AR Program Elements	Average	*SD*	N
37. AR will be able to keep kids as safe as Traditional Response.	4.11	1.15	22
38. Nebraska's AR model is designed to serve families with less severe allegations.	4.23	0.81	22
39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	3.68	0.95	22
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4.18	0.91	22
41. AR families should not be placed on the Central Registry.	4.50	0.76	22
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	3.89	1.15	22
43. Families will receive services faster in AR as compared to Traditional Response.	3.47	1.22	22
44. Concrete supports will be better addressed through AR as compared to Traditional Response.	3.33	1.07	22
45. Law enforcement should be involved in AR cases.*	4.06	1.11	22
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	4.00	1.17	22

**This item was reverse coded*

Internal Workgroup and Subgroups

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	4.33	0.62	27
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	4.22	0.64	27
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.78	0.85	27
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	4.11	0.93	27

Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	4.07	0.68	27
6. Meetings occur with the right amount of frequency.	3.70	0.91	27

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	11%	22%	56%	11%	9

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.74	0.94	27
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.52	0.89	27
10. Commitments made at our meetings are followed up and not forgotten.	3.81	0.74	27
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.70	0.91	27

Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.84	0.69	25
13. I feel involved in what's going on during our meetings.	3.80	0.96	25
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.23	0.71	26
15. I regularly participate in the discussions during our meetings.	4.12	0.73	25
16. Other's participation is usually energetic and stimulating.	3.96	0.60	26
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	4.00	0.49	26

History of Collaboration	Average	*SD*	N
18. Trying to solve problems through collaboration has been common in this local community.	3.69	0.79	26
19. Agencies in our local community have a history of working collaboratively with DCFS.	3.46	0.76	26

Appropriate Cross Section of Members	Average	*SD*	N
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	4.00	0.76	25
21. All the organizations that need to be members of this group have become members of this group.	3.60	0.87	25

Perceived Utility	Average	*SD*	N
22. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.96	0.92	26
23. Our meetings are a valuable use of my time because we deal with important content.	3.77	0.95	26
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.85	0.88	26

Inclusiveness in Process	Average	*SD*	N
25. The processes used to elicit the group's input are effective.	3.69	0.84	26
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.77	0.82	26
27. When major decisions are made about AR program design and implementation, we are always informed.	3.31	1.01	26
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.31	0.97	26

Open Communication	Average	*SD*	N
29. People really listen to each other during our meetings.	3.96	0.60	26
30. There is a high level of trust between participants in our meetings.	3.77	0.82	26
31. People feel comfortable challenging the ideas and comments of others in our meetings.	3.77	0.82	26
32. Different ideas and perspectives are often explored in our meetings.	3.88	0.82	26
33. Other members in this group value my opinion.	3.73	0.92	26

Appropriate Pace of Development	Average	*SD*	N
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	3.81	0.63	26
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.81	0.80	26

Political and Social Climate for AR	Average	*SD*	N
36. The political and social climate seems to be "right" for AR to be successful.	3.54	0.71	26

Perceptions of AR Program Elements	Average	*SD*	N
37. AR will be able to keep kids as safe as Traditional Response.	4.54	0.58	26
38. Nebraska's AR model is designed to serve families with less severe allegations.	4.77	0.43	26
39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	3.43	0.99	26
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4.56	0.65	26
41. AR families should not be placed on the Central Registry.	4.76	0.44	26
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	4.71	0.55	26
43. Families will receive services faster in AR as compared to Traditional Response.	3.82	1.01	26
44. Concrete supports will be better addressed through AR as compared to Traditional Response.	4.29	0.69	26
45. Law enforcement should be involved in AR cases.*	3.88	1.05	26
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	4.60	0.58	26

**This item was reverse coded*

Local Implementation Groups

Purpose of the Group	Average	*SD*	N
1. I have a good understanding of the purpose of the group. I know what we are trying to accomplish.	4.15	0.79	116
2. My ideas about what we want to accomplish with this group seem to be the same as the ideas of others.	4.02	0.72	116
3. People in this group have a clear sense of their roles and responsibilities with regard to the AR initiative.	3.74	0.89	116
4. What we are trying to accomplish with this initiative would be difficult for any single organization to accomplish by itself.	4.43	0.66	115

Meeting Schedule	Average	*SD*	N
5. The meeting format (e.g., location, time) makes it easy for me to attend in person.	3.97	0.89	115
6. Meetings occur with the right amount of frequency.	3.83	0.72	115

If respondents did not agree or strongly agree with item 6, the following question was displayed:

7. How frequently should these meetings take place?	Never	Semi-Annually	Once a Quarter	Once a Month	2-3 Times a Month	N
	-	-	41%	59%	-	27

Meeting Process (Agendas, Minutes, Action Items)	Average	*SD*	N
8. All relevant materials needed for our meetings (e.g., draft policies, sample communications) are distributed in advance, enabling us to read and digest the information before we meet or to share input when we are unable to attend in person.	3.59	0.93	113
9. Meetings are well documented so that we have clear accountability, a reference point when we have questions and a history that keeps us from revisiting territory we have already covered.	3.61	0.83	114
10. Commitments made at our meetings are followed up and not forgotten.	3.75	0.75	113
11. When considering meeting to meeting, there are tangible accomplishments and substantive progress that reinforces the sense that these meetings are effective and productive.	3.55	0.83	112

Participation	Average	*SD*	N
12. The organizations that attend these meetings invest the right amount of time and effort.	3.79	0.75	112
13. I feel involved in what's going on during our meetings.	3.79	0.86	112
14. I am well informed about the AR initiative (why AR is necessary, how the AR model fits within current child welfare practice, major policy decisions, how community and provider agencies will be affected, etc.)	4.13	0.72	112
15. I regularly participate in the discussions during our meetings.	3.87	0.83	111
16. Other's participation is usually energetic and stimulating.	3.72	0.74	111
17. During our meetings, people are generally focused on the task at hand (e.g., minimal sidebars, no passing notes or reading e-mails).	3.95	0.77	112

History of Collaboration	Average	*SD*	N
18. Trying to solve problems through collaboration has been common in this local community.	3.93	0.86	114
19. Agencies in our local community have a history of working collaboratively with DCFS.	3.53	0.97	113

Appropriate Cross Section of Members	Average	*SD*	N
20. The people that attend these meetings represent a cross section of those who have a stake in what we are trying to accomplish.	4.11	0.63	112
21. All the organizations that need to be members of this group have become members of this group.	3.60	0.85	111

Perceived Utility	Average	*SD*	N
22. The quality of our discussions is high (e.g., issues are examined in depth, problems are addressed and not skirted).	3.70	0.87	112
23. Our meetings are a valuable use of my time because we deal with important content.	3.75	0.82	112
24. People feel that our meetings are worthwhile because their participation makes a difference in the outcomes, decisions, and results.	3.64	0.84	112

Inclusiveness in Process	Average	*SD*	N
25. The processes used to elicit the group's input are effective.	3.68	0.75	112
26. It is clear that the group's input is heard and serves a valuable role in the decisions made by DCFS.	3.68	0.90	111
27. When major decisions are made about AR program design and implementation, we are always informed.	3.51	0.91	112
28. Progress updates are regularly shared so that this group is informed about the current status and ongoing direction of the AR initiative.	3.55	0.85	110

Open Communication	Average	*SD*	N
29. People really listen to each other during our meetings.	3.97	0.61	112
30. There is a high level of trust between participants in our meetings.	3.74	0.88	112
31. People feel comfortable challenging the ideas and comments of others in our meetings.	3.71	0.84	112
32. Different ideas and perspectives are often explored in our meetings.	3.71	0.83	111
33. Other members in this group value my opinion.	3.81	0.71	110

Appropriate Pace of Development	Average	*SD*	N
34. DCFS has tried to take on the right amount of work at the right pace with this AR initiative.	3.87	0.69	111
35. In my opinion, DCFS is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.70	0.86	112

Political and Social Climate for AR	Average	*SD*	N
36. The political and social climate seems to be "right" for AR to be successful.	3.79	0.83	112

Perceptions of AR Program Elements	Average	*SD*	N
37. AR will be able to keep kids as safe as Traditional Response.	4.33	0.83	111
38. Nebraska's AR model is designed to serve families with less severe allegations.	4.35	0.74	110
39. The exclusionary and RED (review, evaluate, and decide) team criteria DCFS is using to identify AR-eligible families are the right criteria.	3.75	0.95	111
40. An important feature of AR is to avoid the use of labels like "perpetrator" or "victim," but rather, use "caregiver" and "child."	4.26	0.73	111
41. AR families should not be placed on the Central Registry.	4.19	0.98	111
42. Families in AR will receive more frequent contact with their caseworker, which will allow for better outcomes and quicker resolution.	4.16	0.92	110
43. Families will receive services faster in AR as compared to Traditional Response.	3.89	0.86	111
44. Concrete supports will be better addressed through AR as compared to Traditional Response.	3.92	0.93	111
45. Law enforcement should be involved in AR cases.*	3.26	1.00	111
46. Contacting parents prior to interviewing their children is an important feature of AR practice for enhancing family engagement.	4.11	0.93	110

**This item was reverse coded*

AR Family Experience Survey
Interim Results as of 9/23/15

Submitted to
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Executive Summary

This report summarizes data collected via the *Family Experience Survey* from the beginning of Alternative Response (AR) implementation (October, 2014) through September 23, 2015. The *Family Experience Survey* was designed to assess family satisfaction and relationship with their assigned worker, family engagement, the family's self-perception of their protective factors, and their overall perceptions of their outcomes as a result of involvement with the Department of Children and Family Services (DCFS). Primary caregivers for each AR-eligible family assigned to either AR or Traditional Response (TR) were sent the survey shortly after the case closed.

During this time period, 558 families received the *Family Experience Survey* via U.S. Mail or email. Of these, 78 completed surveys were received, for a 14% response rate. Of the 78 completed surveys, 33 were from AR families (42.3%) and 45 (57.7%) were from TR families. Due to the low response rate, we are unable to conduct statistical significance testing of the differences between AR and TR responses at this time; descriptive information is provided in this report to illustrate trends thus far, including:

- Both AR and TR family caregivers indicated that they primarily felt worried, stressed, hopeful, and respected after the first visit by their worker.
- AR and TR families appear to have comparable levels of family engagement, measured in terms of receptivity to help, buy-in, and relationship with their worker.
- AR family caregivers were slightly more positive than TR families in rating the services they received, in terms of the type and amount of the services.
- Both AR and TR families reported receiving the services they needed at the right time.
- Both AR and TR families indicated that the services they received helped them to feel like they became a better parent, with AR families agreeing slightly more than TR families.
- AR and TR families appeared to have similar levels of agreement that services received allowed their children to be safer, and helped them provide food, clothing and medical care.
- Both AR and TR families report high levels of social connections, and fairly high levels of knowledge of where to go for assistance with food and housing concerns, but much less confidence in where to go if they experienced financial or employment needs.
- AR family caregivers appear to report higher levels of Parental Resilience than TR families.
- Both AR and TR family caregivers report fairly comparable levels on each of the six Protective Factors.
- AR families appear to have higher levels of satisfaction with their worker than TR families, including such areas as ease of contacting the worker; understanding of the family's needs; considering the family's opinion; and encouraging the family to say what they thought.
- Overall, 47.8% of AR and 37.8% of TR family caregivers report that they are better off because of their experience with DCFS. Only 4.3% of AR and 5.4% of TR families believe they are worse off.

Caution is urged in interpretation of these very preliminary results, as it is unknown at this time if any apparent differences are statistically significant.

Family Experience Survey

Integral to the evaluation of AR implementation in Nebraska is the collection of information from workers and families about their perceptions of the family's engagement, needs, the availability and receipt of services, barriers experienced, time spent, and the extent to which services provided to the family improved the family's situation and child well-being. The most efficient and systematic way to collect this information is through end-of-case surveys completed by workers and families. Thus, as each AR-eligible case (that has been randomly assigned by N-FOCUS to AR or TR services) closes, the evaluators at the University of Nebraska Lincoln - Center on Children, Families and the Law (UNL-CCFL) send surveys to the workers and families. An email survey is sent to the worker responsible for the family, to gather perceptions for program evaluation purposes. At the same time, the family's primary caregiver receives a similar type of survey, by either U.S. Mail or email. This report summarizes data collected via the *Family Experience Survey* from the beginning of AR implementation (October, 2014) through September 23, 2015.

The purpose of the *Family Experience Survey* is to gather information about what AR families think of their experience compared to similar (AR-eligible) families who are served through TR. For example, do families in both tracks feel they received the services they needed, and in a timely way? Do families see improvement after receiving services? In the first year of the evaluation, as each AR-eligible AR or TR family case closed, the evaluators sent the primary caregiver a brief survey in U.S. Mail, along with a postage paid envelope for them to send their completed survey directly to UNL-CCFL. The mailing included an informed consent letter, and the materials were available in both English and Spanish versions. Beginning in July 2015, families with email addresses included in N-FOCUS were initially sent the survey by email with two automated reminders. This online version of the survey could be completed using a computer, tablet or smartphone. If the primary caregiver did not complete the survey online, they were then sent a paper version using U.S. Mail. As an incentive gift, the evaluators sent each family a $10 Walmart gift card immediately upon receipt of their completed survey.

The *Family Experience Survey* was designed to assess several constructs of interest: family satisfaction and relationship with their assigned worker, family engagement, the family's self-perception of their protective factors, and their overall perceptions of their outcomes as a result of involvement with DCFS. Family engagement was measured using a modification of the Yatchmenoff (2005) client engagement scale, which contains four sub-scales: receptivity, buy-in, mistrust, and working relationship, plus an overall engagement score. This measure was utilized in the cross-site evaluation of Differential Response conducted by the Quality Improvement Center on Differential Response (QIC-DR), and was further adapted for use in Nebraska based upon feedback provided by the QIC-DR project lead, Lisa Merkel-Holguin. Family protective factors were measured using an adaptation of the items contained in the *Protective Factors Survey* (Friends National Resource Center for Community Based Child Abuse Prevention). These items are identical to those included in the *Nebraska Protective Factors and Well-Being Questionnaire* utilized during case management with families assigned to AR. As sufficient numbers of surveys are completed, the responses from AR-eligible families who receive AR and TR services will be compared on these measures. In addition, these data will be linked to measures of family outcomes obtained in N-FOCUS and to the worker's perceptions obtained from the worker end-of-case survey, to obtain a more complete picture of family experiences and outcomes under AR versus TR.

Family Experience Survey Interim Findings

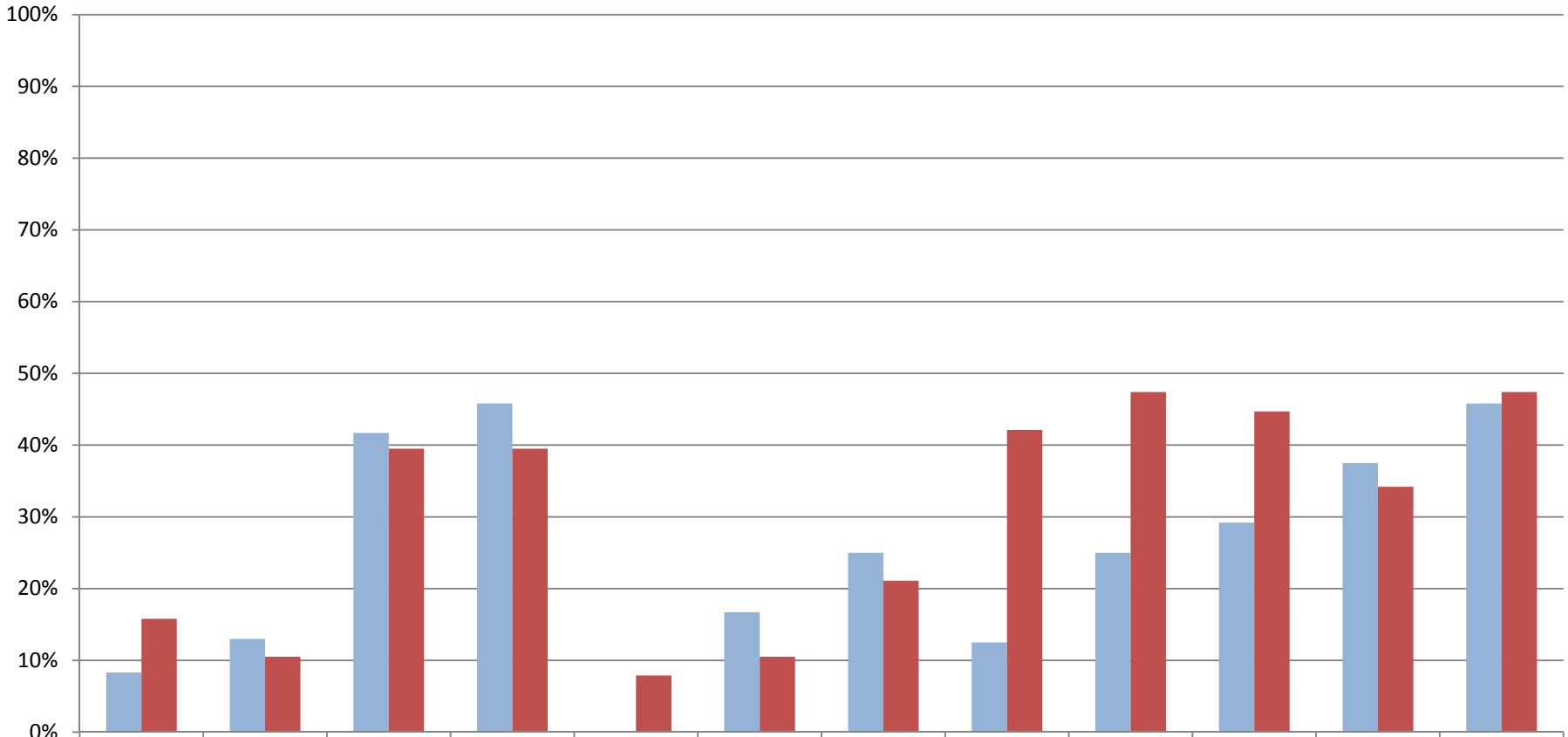
As of September 23, 2015, there were 591 families with closed AR-eligible cases. Thirty-three of these either had no mailing address listed in N-FOCUS for the primary caregiver, or the address was incorrect (survey mailing was returned to sender unopened). Thus, 558 families received the *Family Experience Survey* via U.S. Mail or email. Of these, 78 completed surveys were received, for a 14% response rate. Of these 78 completed surveys, 33 were from AR families (42.3%) and 45 (57.7%) were from TR families. Two of the surveys were completed by Spanish speaking caregivers, the rest were completed in English. Further analysis of survey returns since the July 1, 2015 implementation of the email survey option showed a slight increase in response rates, with 28 out of 172 surveys completed (16.3%). Nevertheless, these response rates are disappointing. Evaluations of Differential Response implementation in other states using a similar family survey have typically obtained response rates averaging 25 to 27% (Merkel-Holguin, Hollinshead, Hahn, Casillas & Fluke, 2015). Therefore, in October 2015, the evaluators plan to increase the incentive payment to $20, along with adding the names of completed survey respondents into a drawing for a larger incentive gift every six months.

Because the number of family survey respondents was so low during this project period, we are unable to conduct statistical significance testing of the differences between AR and TR responses. As additional data accrue, differences between AR and TR will be tested. The following charts illustrate descriptive information about the family survey results thus far.

Perceptions of first visit

The following chart illustrates family caregivers' responses to the question "how did you feel after the first time your worker came to your home?" Both AR and TR family caregivers indicated that they primarily felt worried, stressed, hopeful, and respected. It appears that a greater proportion of TR caregivers (compared to AR caregivers) felt thankful, relieved and comforted. However, these differences may not be statistically significant, and so caution is advised in interpreting the small number of responses received at this time. The following graph displays the percentage of responses for each option.

How did you feel after the first time the DCFS worker came to your home?



	Afraid	Angry	Worried	Stressed	Disrespected	Discouraged	Encouraged	Comforted	Relieved	Thankful	Hopeful	Respected
AR (N = 24)	8.3%	13.0%	41.7%	45.8%	0.0%	16.7%	25.0%	12.5%	25.0%	29.2%	37.5%	45.8%
TR (N = 38)	15.8%	10.5%	39.5%	39.5%	7.9%	10.5%	21.1%	42.1%	47.4%	44.7%	34.2%	47.4%

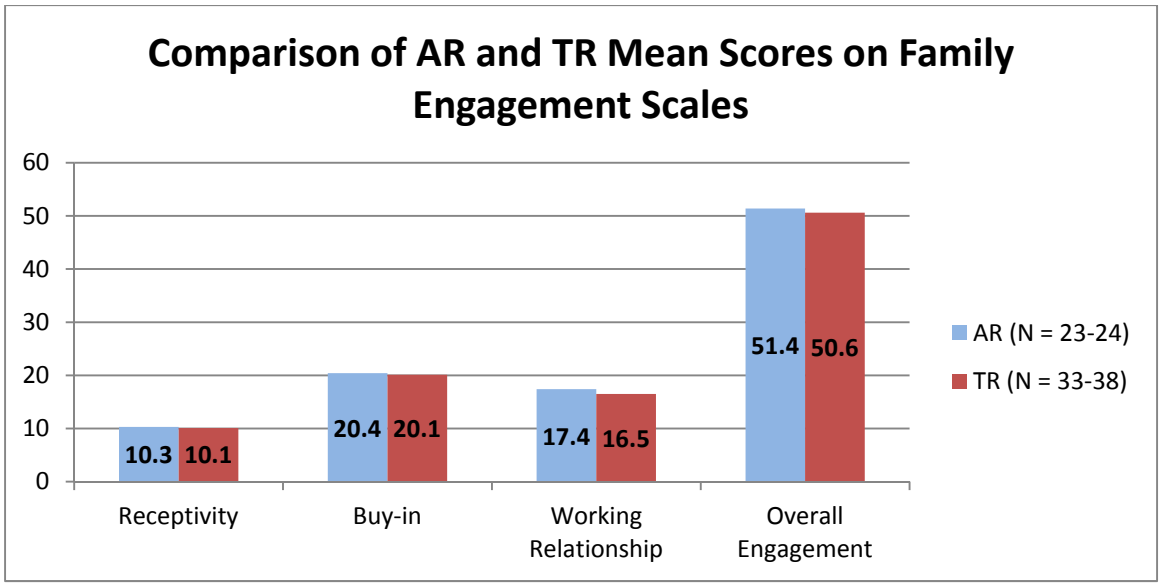
Family Engagement

Sub-scales were developed by Yatchmenoff (2005) to assess affective dimensions of family engagement. Their definitions are as follows:

1) *Receptivity*: "openness to receiving help, characterized by recognition of problems or circumstances that resulted in agency intervention and by a perceived need for help" (Yatchmenoff, 2005, p. 87).
2) *Buy-in*: "perception of benefit; the sense of being helped or the expectation of receiving help through agency involvement; a commitment to the helping process characterized by active participation in planning or services, goal ownership, and initiative in seeking and using help" (Yatchmenoff, 2005, p. 87-93).
3) *Working Relationship*: "interpersonal relationship with the worker characterized by a sense of reciprocity or mutuality and good communication" (Yatchmenoff, 2005, p. 87).
4) *Mistrust*: "the belief that the agency or worker is manipulative, malicious, or capricious, with intent to harm the client" (Yatchmenoff, 2005, p. 87).

The summed score of all items can be used as overall measure of engagement, although it is recommended to use the sub-scale scores, as they are more readily interpretable. Some evidence suggests these attitudinal dimensions may be predictors of client behaviors such as service usage, duration, and completion of case plans, although further research is needed (Yatchmenoff, 2005).

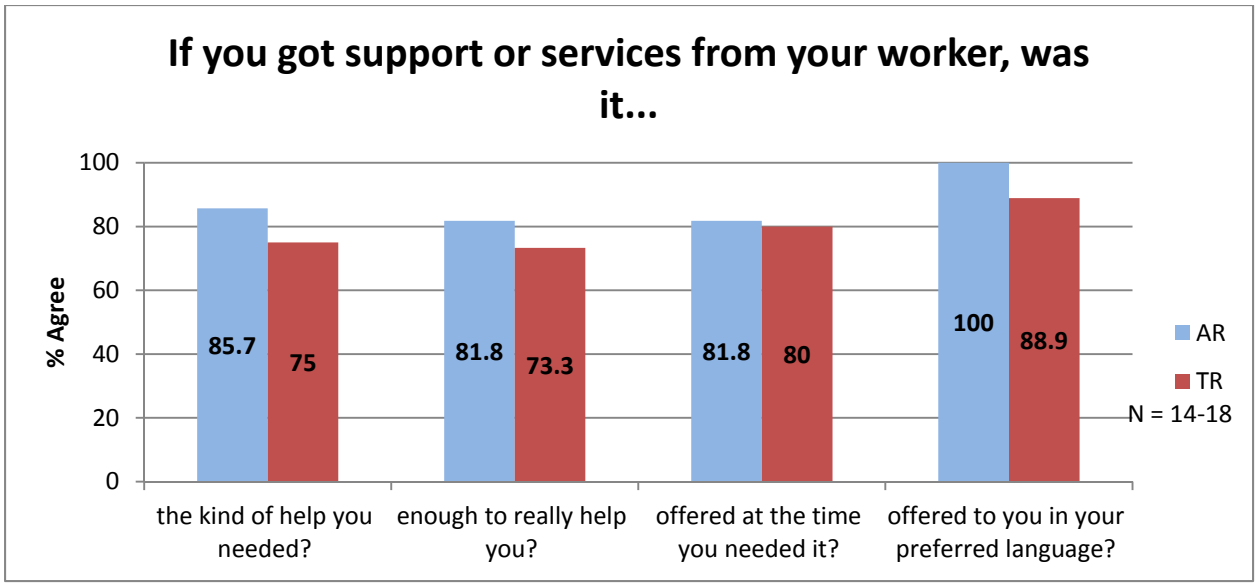
Reliability of the overall score and sub-scales of the Family Engagement measure was assessed. These preliminary analyses indicate that, in the present study, all of the scales had adequate internal consistency (ranging from .70 to .92) except for the *Mistrust* scale (which was .55). We will continue to monitor the reliability of this scale as more data are accrued. Analyses also suggested that we could improve the reliability of some of the sub-scales by removing items, which we will consider in the coming year. For this interim report, subscale scores were computed for each reliable subscale (i.e., except for the *Mistrust* scale) for each respondent family. It appears that the level of affective engagement in the case process is similar for those families assigned AR versus TR. However, due to the small number of responses, tests of statistical significance were not conducted at this time. The following graph presents the means for each sub-scale and the overall scale.

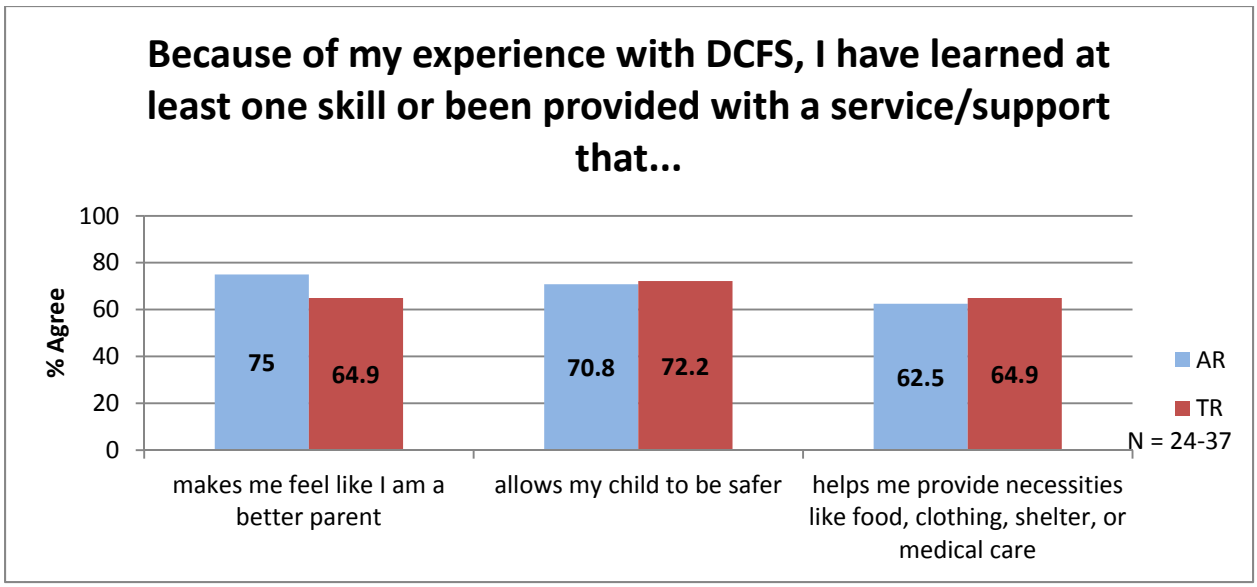


Perceptions of supports and services received

Families were asked about their perceptions of the supports and services they received during their involvement with DCFS. AR family caregivers were slightly more positive than TR families in rating the services they received, in terms of the type and amount of the services. Both AR and TR families reported receiving the services they needed at the right time. All AR and most TR families reported receiving services in their preferred language. Both AR and TR families indicated that the services they received helped them to feel like they became a better parent, with AR families agreeing slightly more than TR families. AR and TR families appeared to have similar levels of agreement that services received allowed their children to be safer, and helped them provide necessities like food, clothing, and medical care.

Again, the observed differences could not be tested for statistical significance at this time, due to the small number of responses. Thus, these interpretations must be viewed as tentative. The following two charts summarize family caregivers' perceptions of the supports and services they received.

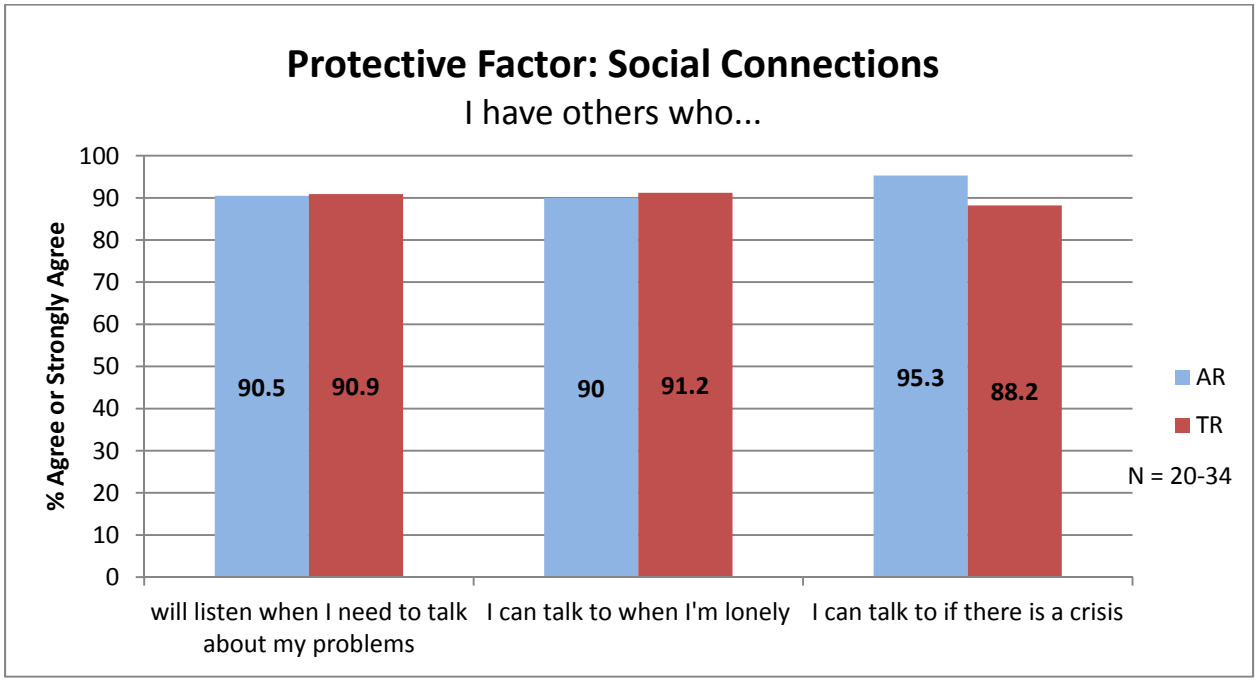


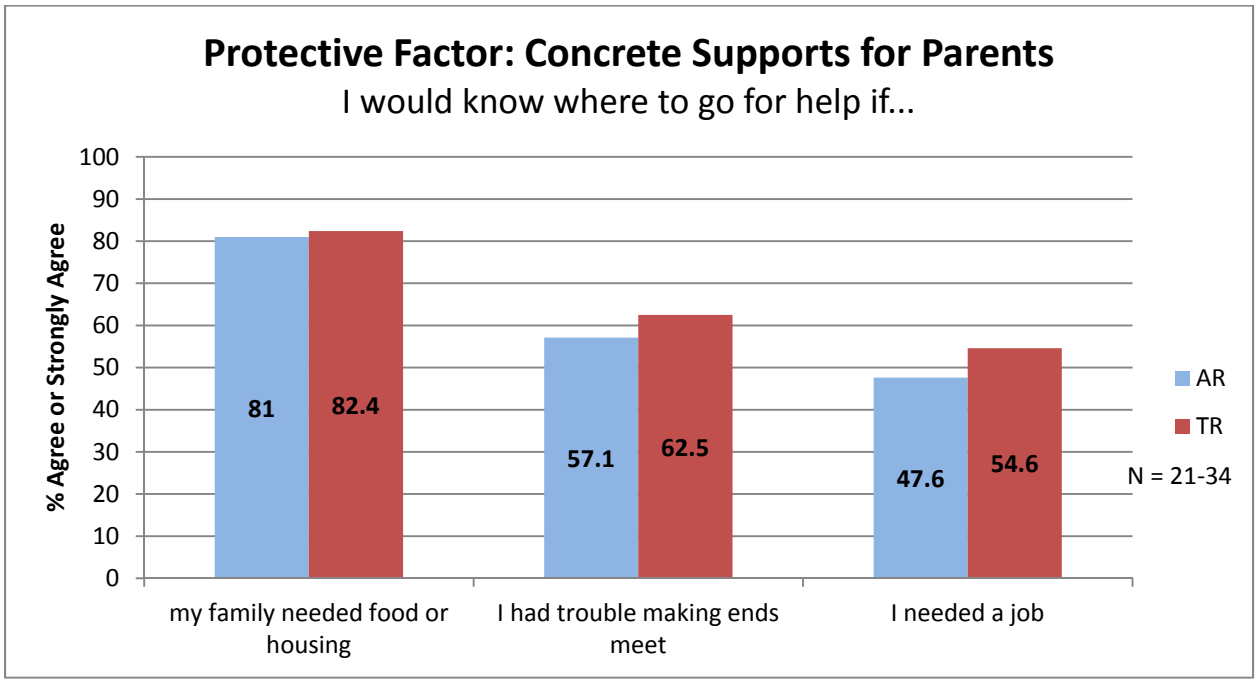


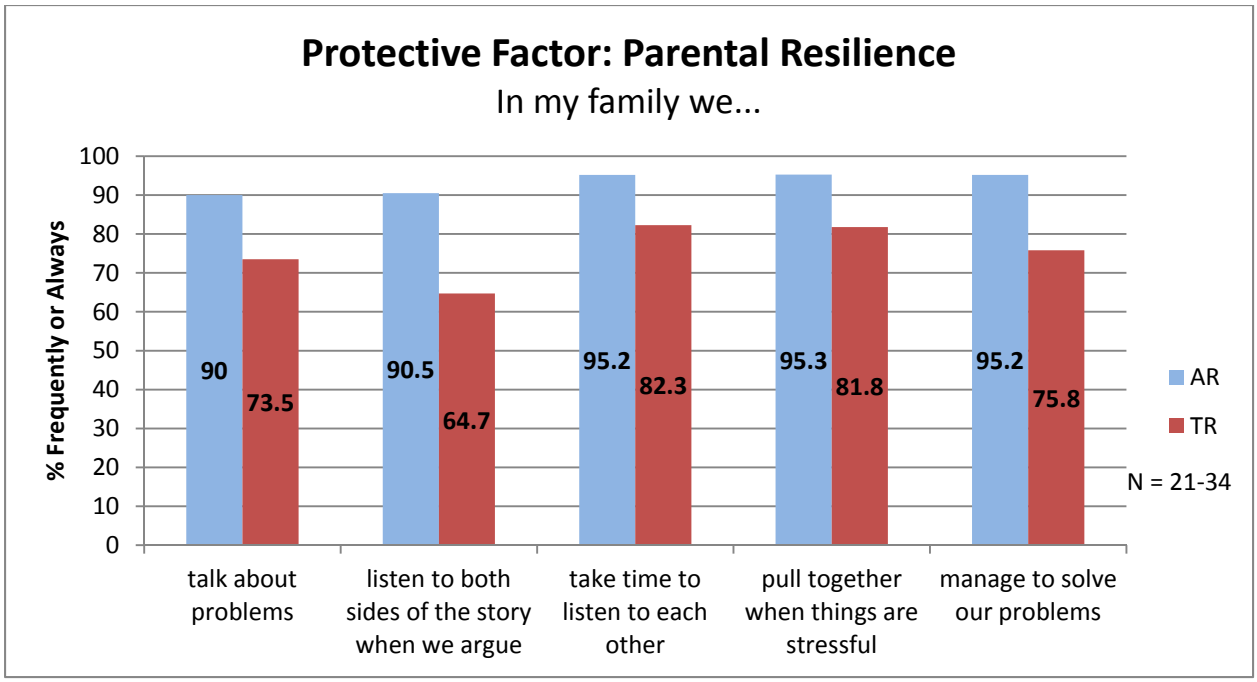
Family Protective Factors

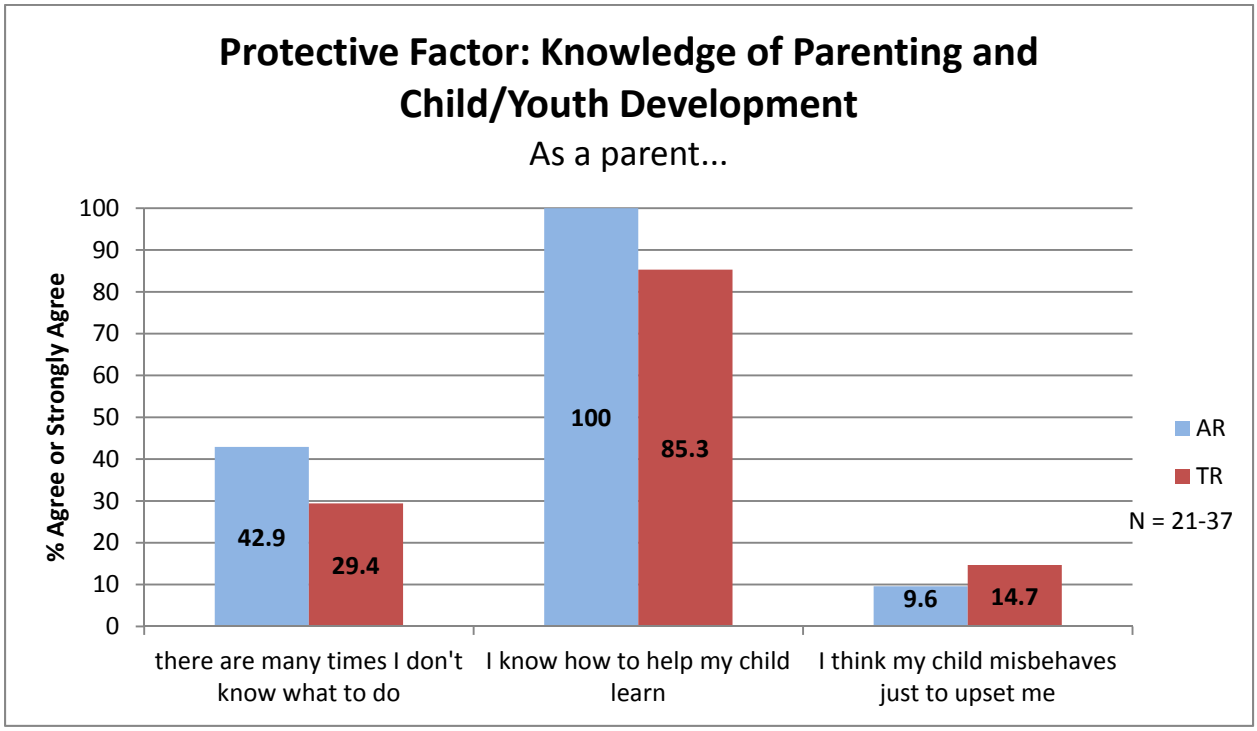
The primary caregiver responding to the survey provided self-ratings on each of the six Protective Factors. In general, it appears that both AR and TR families report high levels of social connections. Regarding Concrete Supports for Parents, both AR and TR families report fairly high levels of knowledge regarding where to go for assistance with food and housing concerns, but much less confidence in where to go if they experienced financial or employment needs. AR family caregivers appear to report higher levels of Parental Resilience than TR families, although it is unknown at this time if this difference is statistically significant. Both AR and TR family caregivers report fairly high levels of Knowledge of Child Development and Parenting, with some potential differences observed. Levels of Nurturing and Attachment appear fairly high for both AR and TR groups as well. Similarly, levels of Social and Emotional

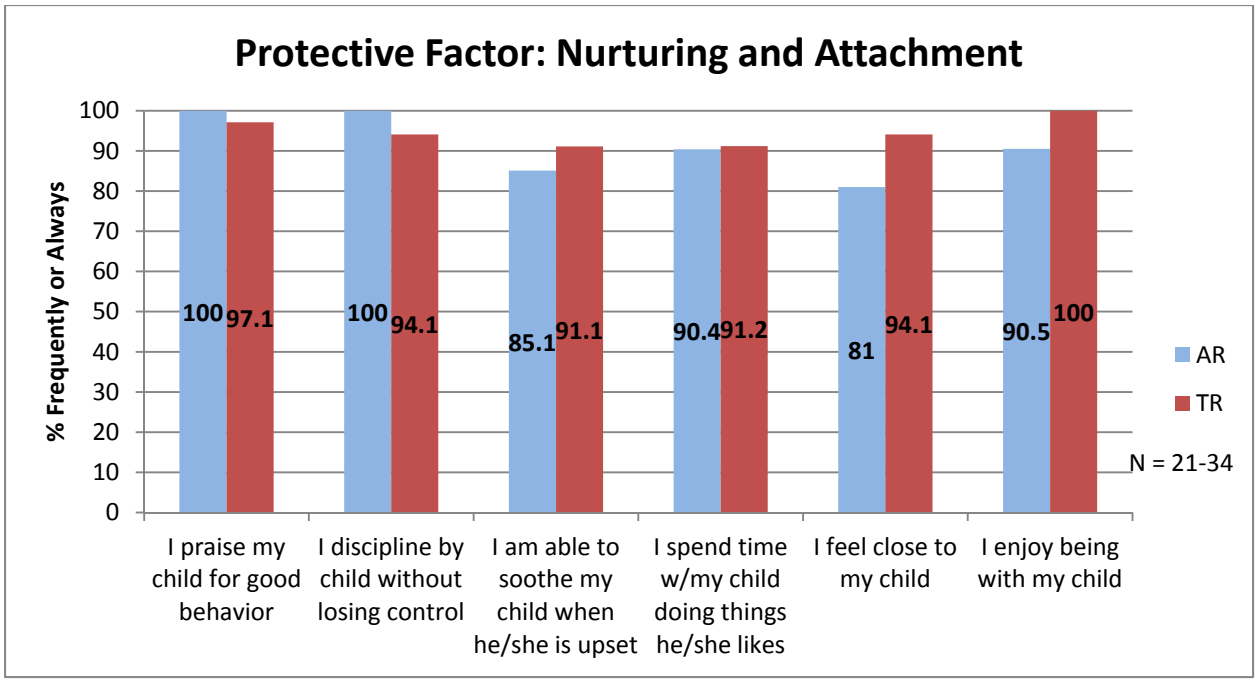
Competence of Children appear comparable on most items for the AR and TR groups. Potential differences between the AR and TR groups will be more fully explored as additional data are received in the coming year. However, due to the low response rate, tests of statistical significance were not completed at this time. The following six charts present the responses received thus far, organized by each of the six Protective Factors.

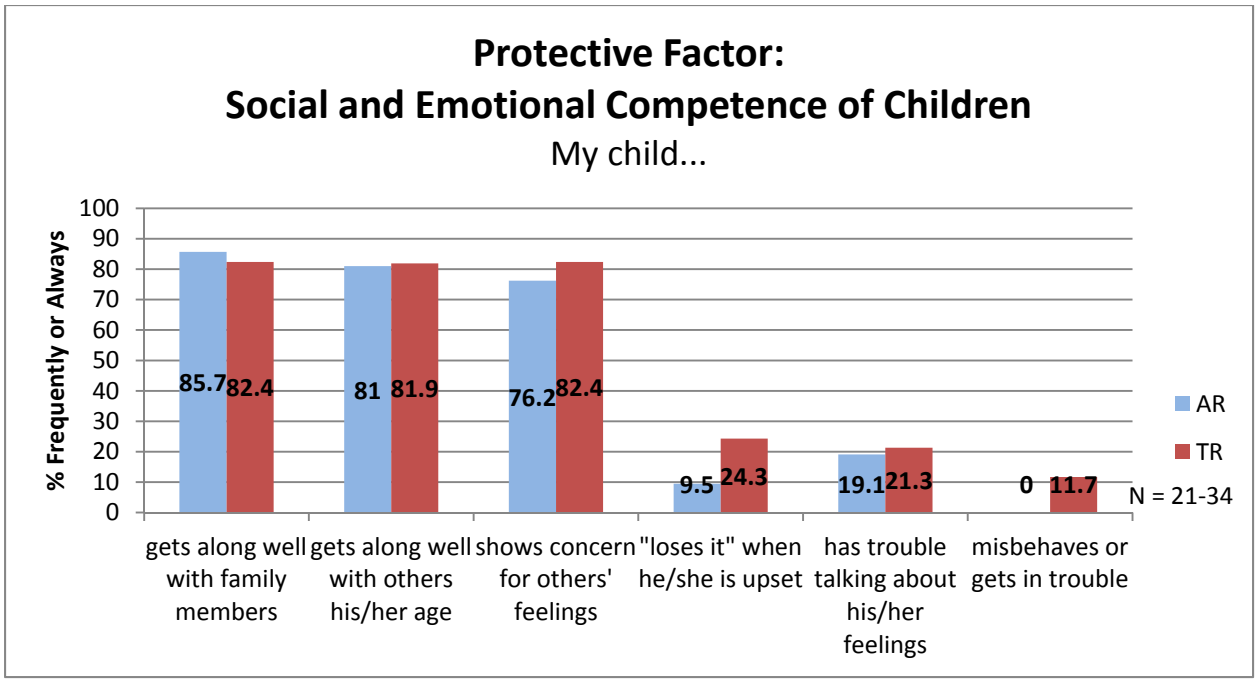





Protective Factor: Parental Resilience
In my family we...
% Frequently or Always
100
90
80
70
60
50
40
30
20
10
0
90
73.5
90.5
64.7
95.2
82.3
95.3
81.8
95.2
75.8
talk about problems
listen to both sides of the story when we argue
take time to listen to each other
pull together when things are stressful
manage to solve our problems
AR
TR
N = 21-34


Protective Factor: Knowledge of Parenting and Child/Youth Development
As a parent...
% Agree or Strongly Agree
100
90
80
70
60
50
40
30
20
10
0
42.9
29.4
100
85.3
9.6
14.7
there are many times I don't know what to do
I know how to help my child learn
I think my child misbehaves just to upset me
AR
TR
N = 21-37

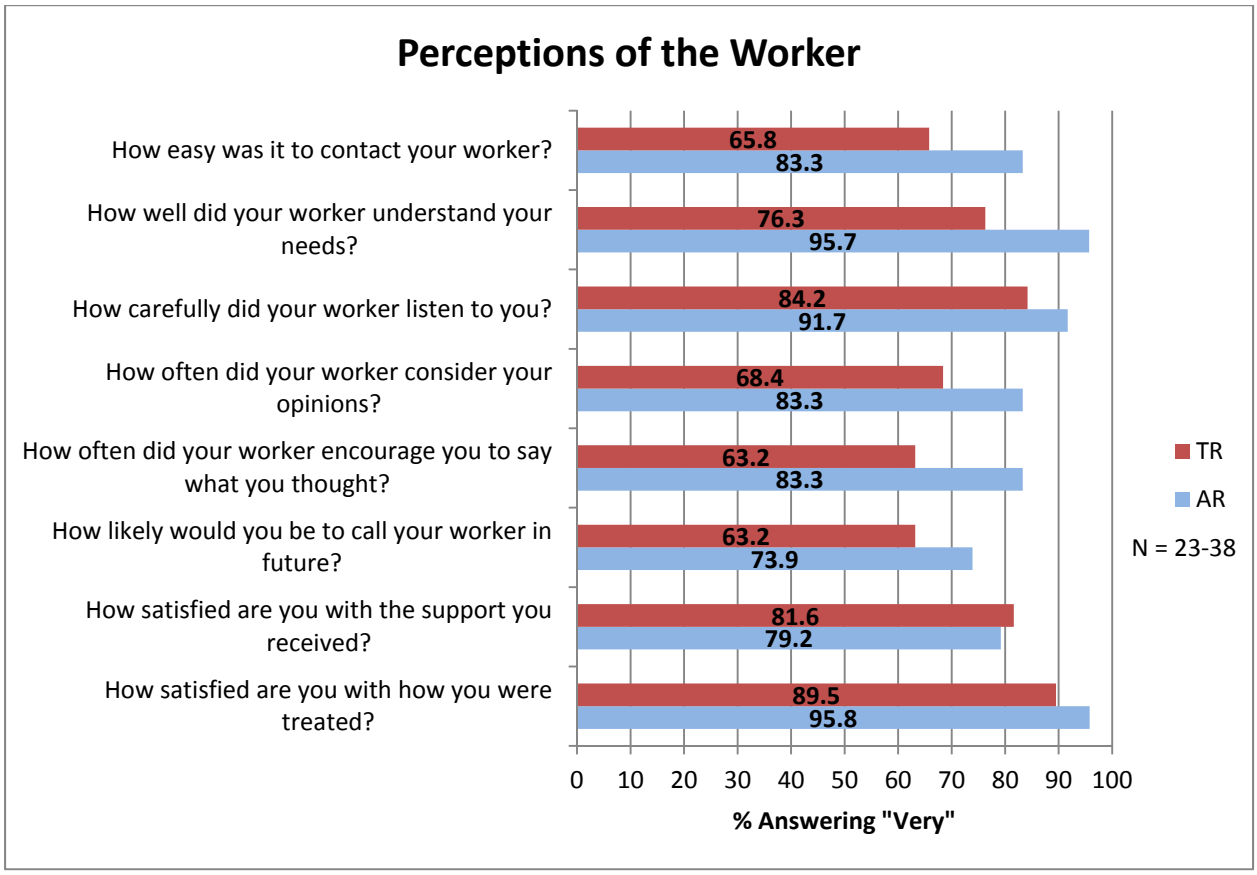




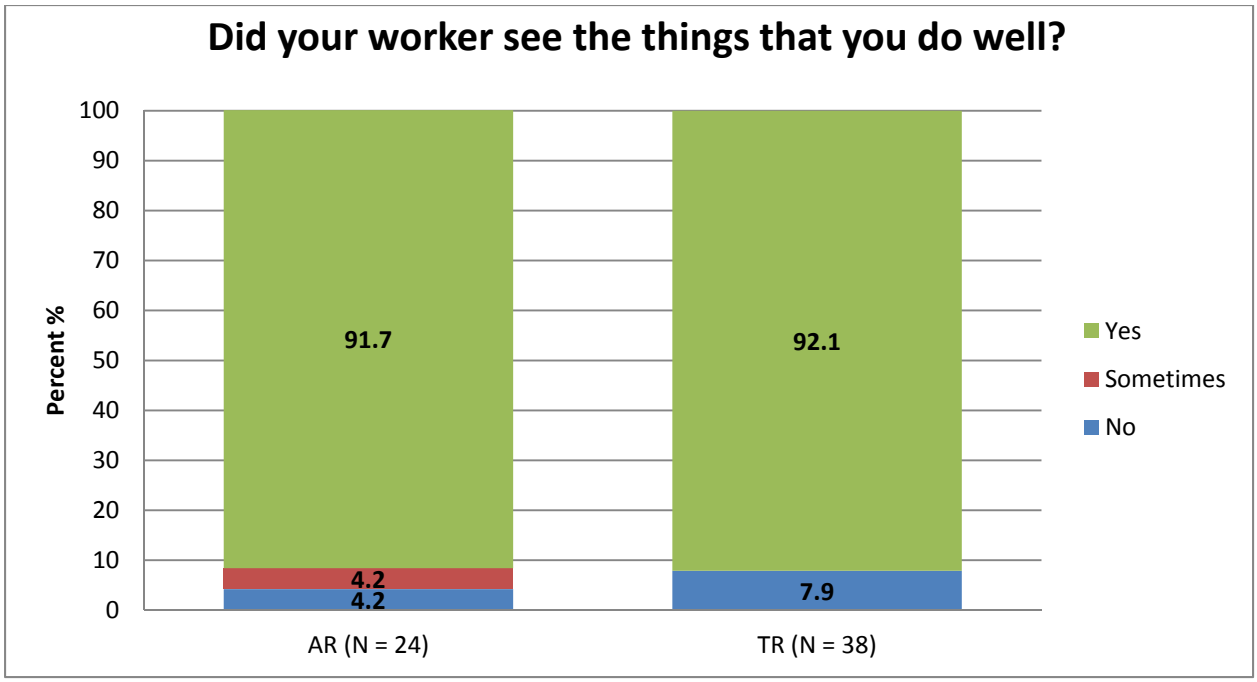
Perceptions of the Worker

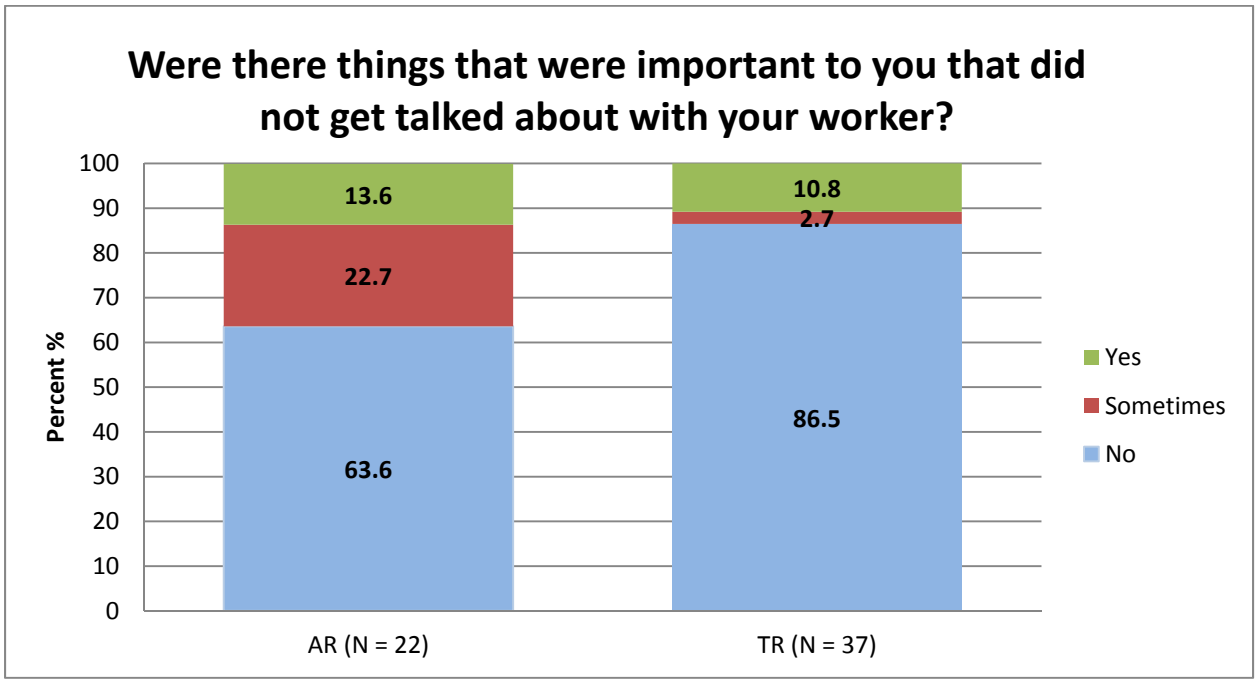
The primary caregiver also rated their worker on a number of items relating to their contacts and perceptions of satisfaction with the services provided. It appears that AR families may have higher levels of satisfaction with their worker than TR families, including such areas as ease of contacting the worker; understanding of the family's needs; considering the family's opinion; and encouraging the family to say

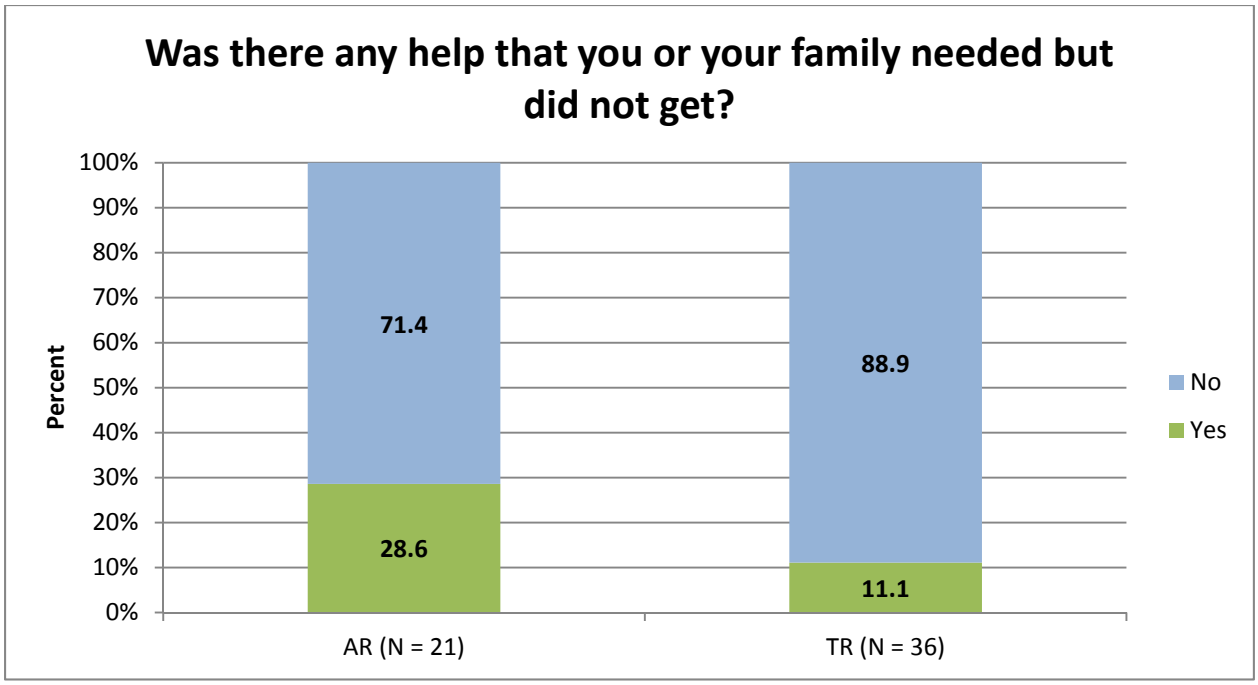
what they thought. However, due to the low number of responses, we are unable to test whether these differences are statistically significant at this time. The following chart summarizes responses for AR and TR families on each of these questions.



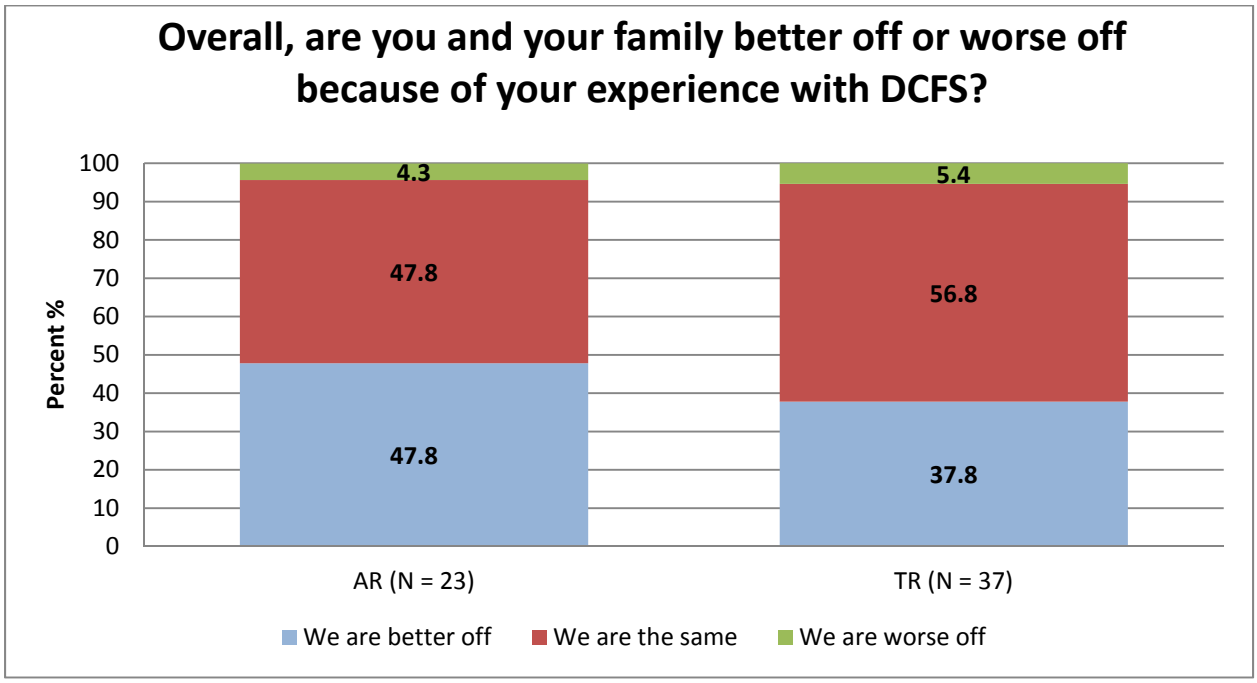
Additional questions asked families if their worker saw the things they do well, if there were things that were important that did not get talked about, and if there was any help their family needed but did not get. Over 90% of AR and TR families reported that their worker saw the things that they did well. There appear to be some potential differences between AR and TR families on the other two items; some AR family caregivers report having important issues that were not discussed with their worker and needs that did not get met. However, the low number of responses received thus far precludes statistical tests of any apparent differences between AR and TR families. Thus caution is recommended in the interpretation of these preliminary data. The following three charts summarize these additional questions for AR and TR cases.


Did your worker see the things that you do well?
Percent %
100
90
80
70
60
50
40
30
20
10
0
91.7
4.2
4.2
92.1
7.9
AR (N = 24)
TR (N = 38)
Yes
Sometimes
No


Were there things that were important to you that did not get talked about with your worker?
Percent %
100
90
80
70
60
50
40
30
20
10
0
13.6
22.7
63.6
10.8
2.7
86.5
AR (N = 22)
TR (N = 37)
Yes
Sometimes
No



Overall, 47.8% of AR and 37.8% of TR family caregivers report that they are better off because of their experience. More TR than AR families appear to feel they are unchanged by their interaction with DCFS. Only 4.3% of AR and 5.4% of TR families believe they are worse off as a result of their experience. Low response rates preclude us from determining whether these are statistically significant differences, but we will examine this as additional responses are received in the coming year.



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Yatchmenoff, D.K. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice, 15*, 84-96.

Preliminary Analyses of the Case-Specific Worker Survey: October 2014 – July 2015

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University of Nebraska Lincoln | CENTER ON CHILDREN, FAMILIES, AND THE LAW

Executive Summary

Workers receive the *Case-Specific Worker Survey* (worker survey) at the close of all Alternative Response (AR)-eligible cases. The purpose of this survey is to collect detailed case-level information on all AR-eligible cases. Workers respond to questions about their perceptions of family engagement, protective factors, services received, barriers to service provision, and estimates of time spent on the specific case. Workers are encouraged to consult N-FOCUS to refresh their memory about the case if needed.

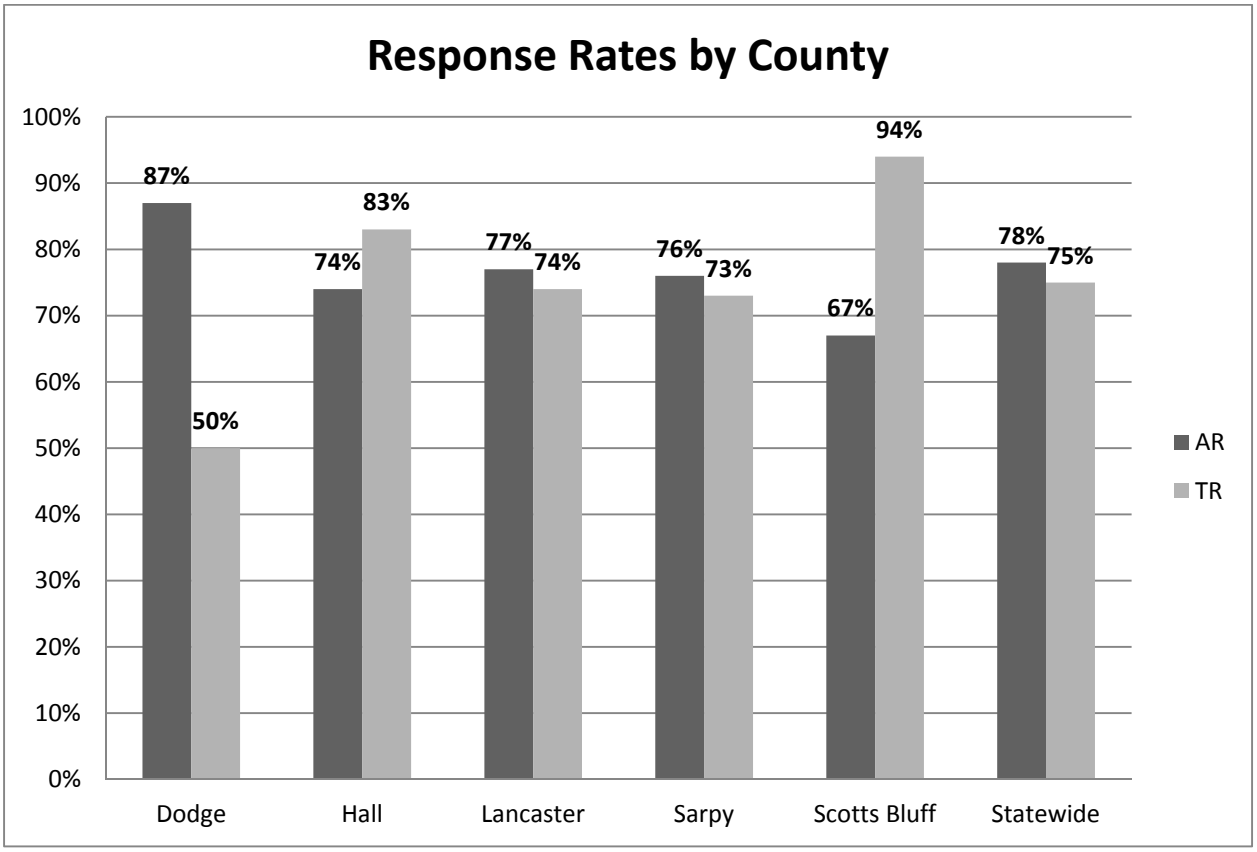
The worker survey was amended in July 2015 to better capture the services and needs of AR-eligible families and several questions were reworded for clarity. To ensure all cases are accurately represented, the current report only reports on questions that were unchanged in the July 2015 edits. Future reports will include all questions as they are currently worded.

The current report summarizes data from October 1, 2014 through July 31, 2015. The main conclusions of these analyses are:

- Overall, the response rate for the survey is 77%. In order to best reflect the AR program, the response rate should ideally be 100%. This would allow for every case to be represented in the final analyses.
- Two-thirds of workers believed they had a good relationship with the primary caretakers and that the primary caretakers trusted the Department of Child and Family Services (DCFS) to be fair. However, three-quarters of workers did not believe primary caretakers thought they had a problem that needed to be fixed or that DCFS helped improve their family. These results were the same for workers in both tracks.
- Families randomly assigned to both AR and TR had similar needs present at the beginning of the case; this demonstrates that random assignment forms comparable groups. The most common needs were parenting skills, child's emotional and behavioral adjustment, material needs, mental health of a child, and social supports.
- Slightly more AR workers than TR workers report their families received supports from relatives or friends and that they utilized no-cost or community resources.
- Families in both tracks received similar types of services from similar types of providers. The most common services provided to families were mental health services, services to address material needs, and social support services.
- The most commonly reported barriers to families receiving services were due to worker time constraints (size of worker caseload, limited staff time to work with family, and other pressing cases on the caseload). However, over a third of workers reported they did not experience any barriers to families receiving services.
- Approximately one-third of both AR and TR workers reported that the services provided to families were not applicable to improving protective factors. This indicates a possible need to communicate how services can help improve protective factors to both AR and TR workers.

Survey Response Rates

This report includes responses from workers on all AR-eligible cases (randomly assigned to AR or TR) that completed the survey on or before July 31st, 2015. A total of 472 surveys were emailed to workers through the second week of July; 229 surveys were sent to AR workers and 243 surveys were sent to TR workers. Overall, 362 surveys were completed as of July 31st, 2015 for a response rate of 77%. 179 surveys were completed by AR workers for a response rate of 78% and 183 surveys were completed by TR workers for a response rate of 75%. The graph below shows the response rates for each county and statewide. Scotts Bluff County had the highest overall response rate of 81% and Dodge County had the lowest overall response rate of 68%.



The worker survey provides vital information to the evaluation that is not available from any other data source. Ideally, the overall response rate would be 100% so all cases could be accurately represented in the analyses. DCFS has communicated the importance of completing this survey to workers. In June 2015, another survey invitation was sent to all workers who had not completed past surveys from the start of AR implementation (October 1, 2014) as of June 10, 2015. This resulted in an additional 30 completed surveys.

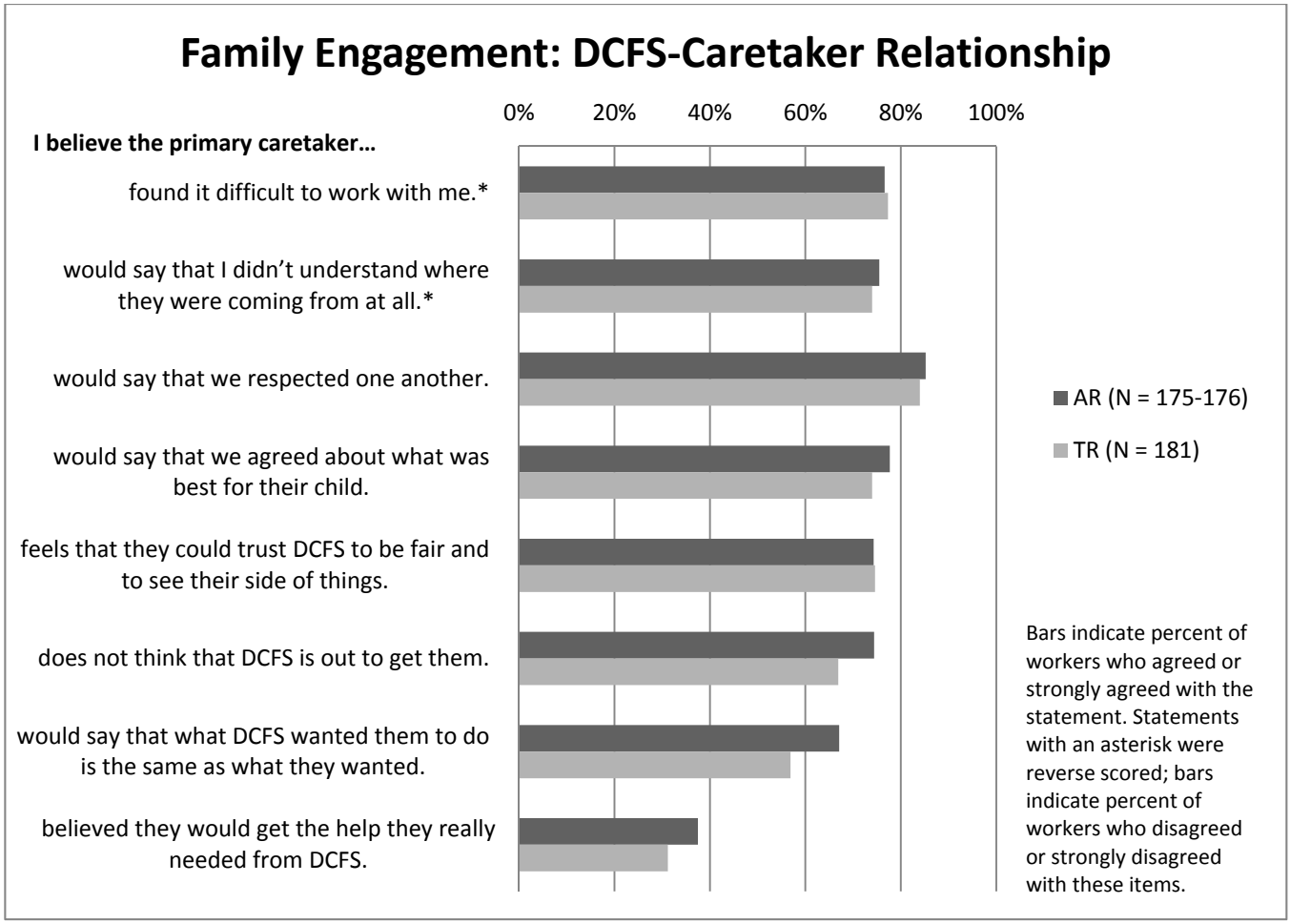
Family Engagement

The worker survey asks questions about the family's engagement with DCFS. Workers answer sixteen questions about the primary caretaker's perceptions of DCFS, the relationship with the worker, and family outcomes. All of these items are worded as statements that workers rate on an agreement scale (*1 = Strongly Disagree, 5 = Strongly Agree*). A complete summary of workers' responses is included in Appendix A, *Worker Perceptions of Family Engagement*.

Worker Perceptions of Relationship between Caretaker and DCFS

Workers in both tracks had similar perceptions of the primary caretaker's relationship with the worker. Overall, approximately two-thirds of workers reported a very positive relationship between the primary caretaker and the worker. More than three-quarters of workers stated the primary caretaker did not find it difficult to work with them. More than 80% of workers also believe that parents sensed the worker could see the caretaker's point of view and perceived mutual respect and agreement with primary caretakers.

Workers for both AR and TR also generally believed that caretakers had trust in DCFS. Three-quarters of both AR and TR workers agreed or strongly agreed that the primary caretaker felt that they could trust DCFS to be fair and to see their side of things. However, less than 40% of workers agreed that the primary caretaker would say that they got the help they really needed from DCFS. The following graph displays the percent of workers who agreed or strongly agreed with statements regarding the primary caretakers' perceptions of the relationship between the primary caretaker and DCFS.

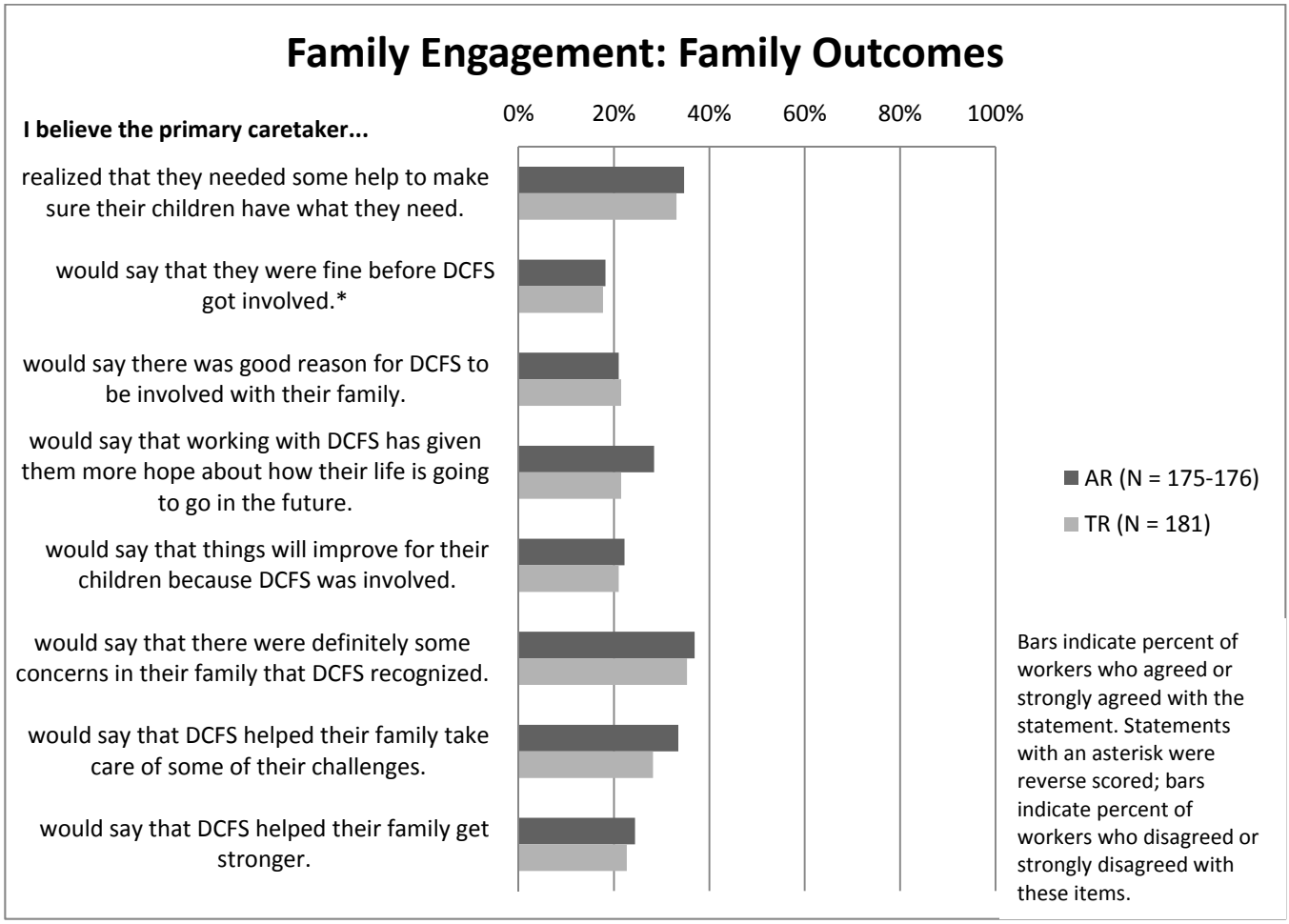


Worker Perceptions of Family Outcomes

In general, workers in both tracks did not believe that primary caretakers thought they needed help. About one-third of workers for both AR and TR cases disagreed or strongly disagreed that the primary caretaker realized that they needed some help to make sure their children had what they needed. Less than a quarter of

workers in both tracks believed the primary caretaker would say there was a good reason for DCFS to be involved with their family. These responses indicate workers believe caretakers do not believe they need help from DCFS.

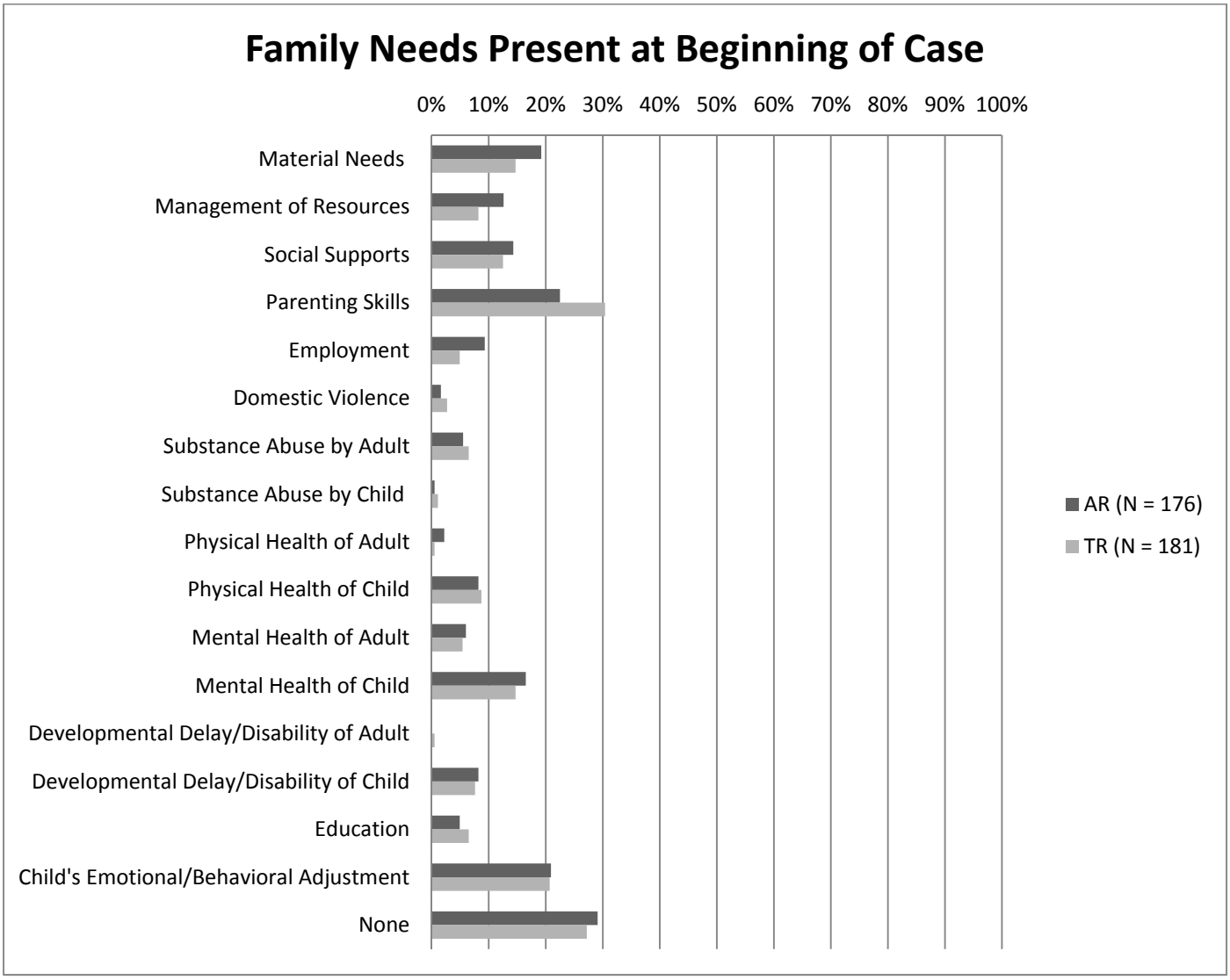
Approximately only one quarter of workers indicated the primary caretaker believed DCFS helped improve their family. Additionally, less than one-third of workers for both AR and TR agreed that the primary caretaker would say that DCFS helped their family take care of some of their challenges. These responses show that, while workers believe caretakers trust DCFS to be fair, workers do not perceive caretakers feel that DCFS had an impact on their family. The below graph depicts the percent of workers who agreed or strongly agreed with statements regarding primary caretakers' perceptions of outcomes.



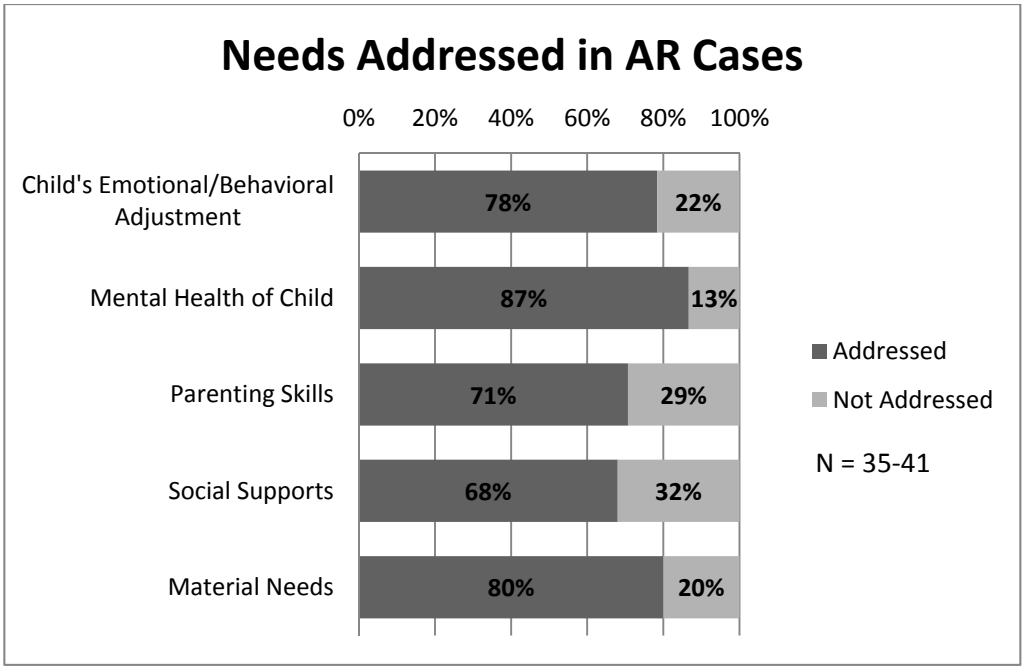
Family Needs

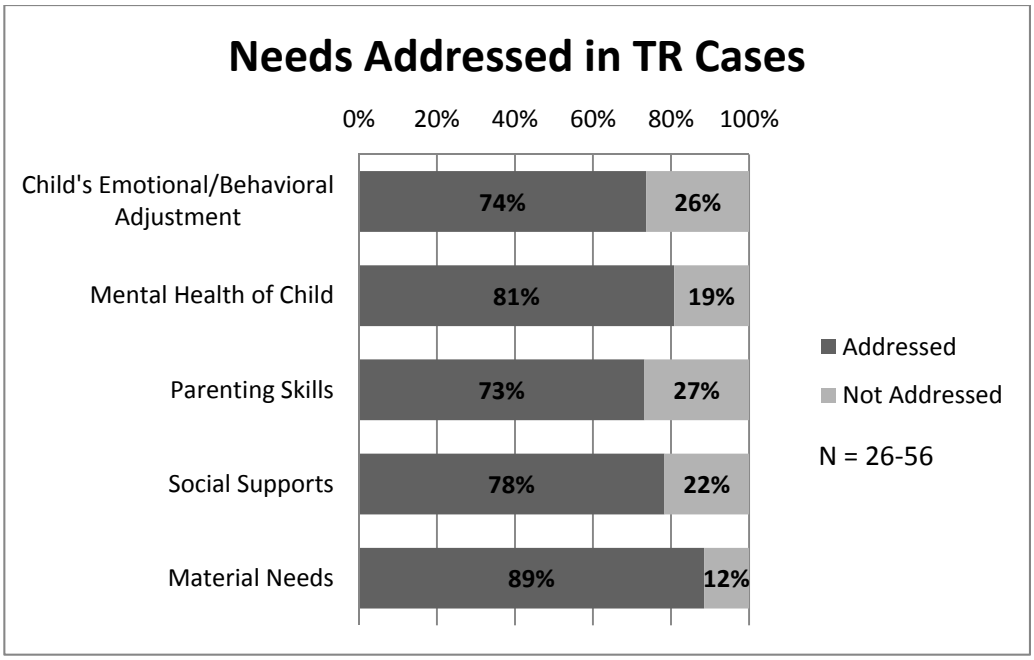
Workers were asked to identify the various needs present in the family at the beginning of the case. The most commonly identified need was parenting skills for both AR and TR. Other common needs selected by at least 10% of both AR and TR workers included the child's emotional and behavioral adjustment, material needs, mental health of the child, and social supports. Approximately one-quarter of workers indicated that the families did not have any needs present at the beginning of the case.

Looking at the selected needs of the families, AR and TR families appear to be presenting with the same needs; this also confirms that random assignment is working to create comparable groups. The below graph shows the percent of needs selected for AR and TR cases.

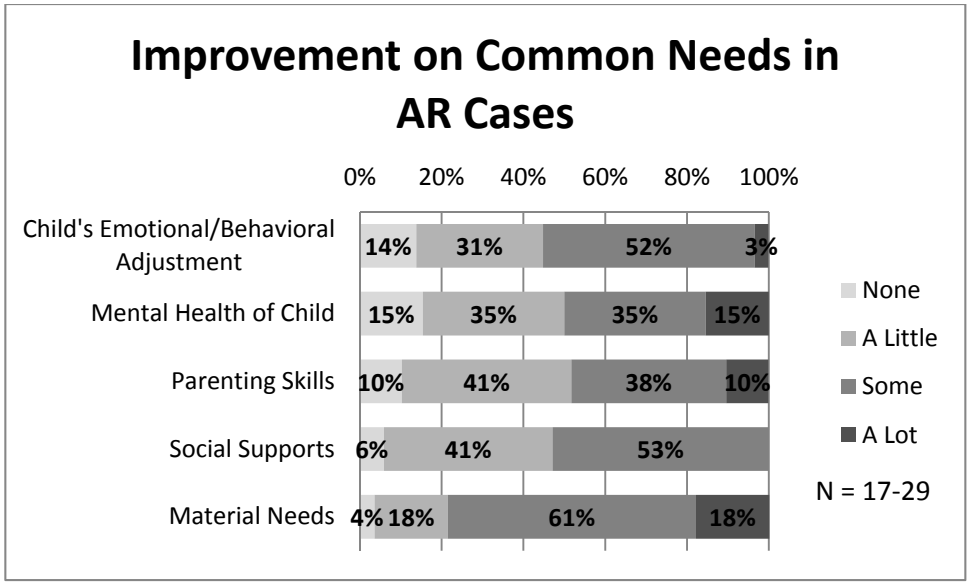


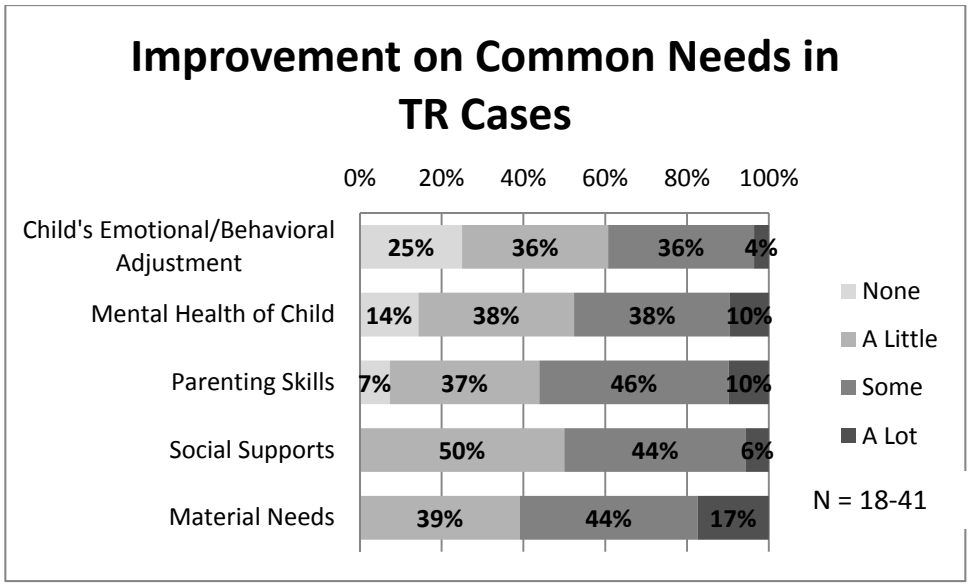
For each need the worker identified, the worker was then asked whether or not they were able to address that need with the family while the case was open. The majority of workers reported that they were able to address these needs during the case, regardless of track assignment. The following graphs display the percentage of cases that were able to address the 5 most common needs. For example, 80% of AR workers and 89% of TR workers reporting the family required material needs also reported that they were able to address that need during the case.





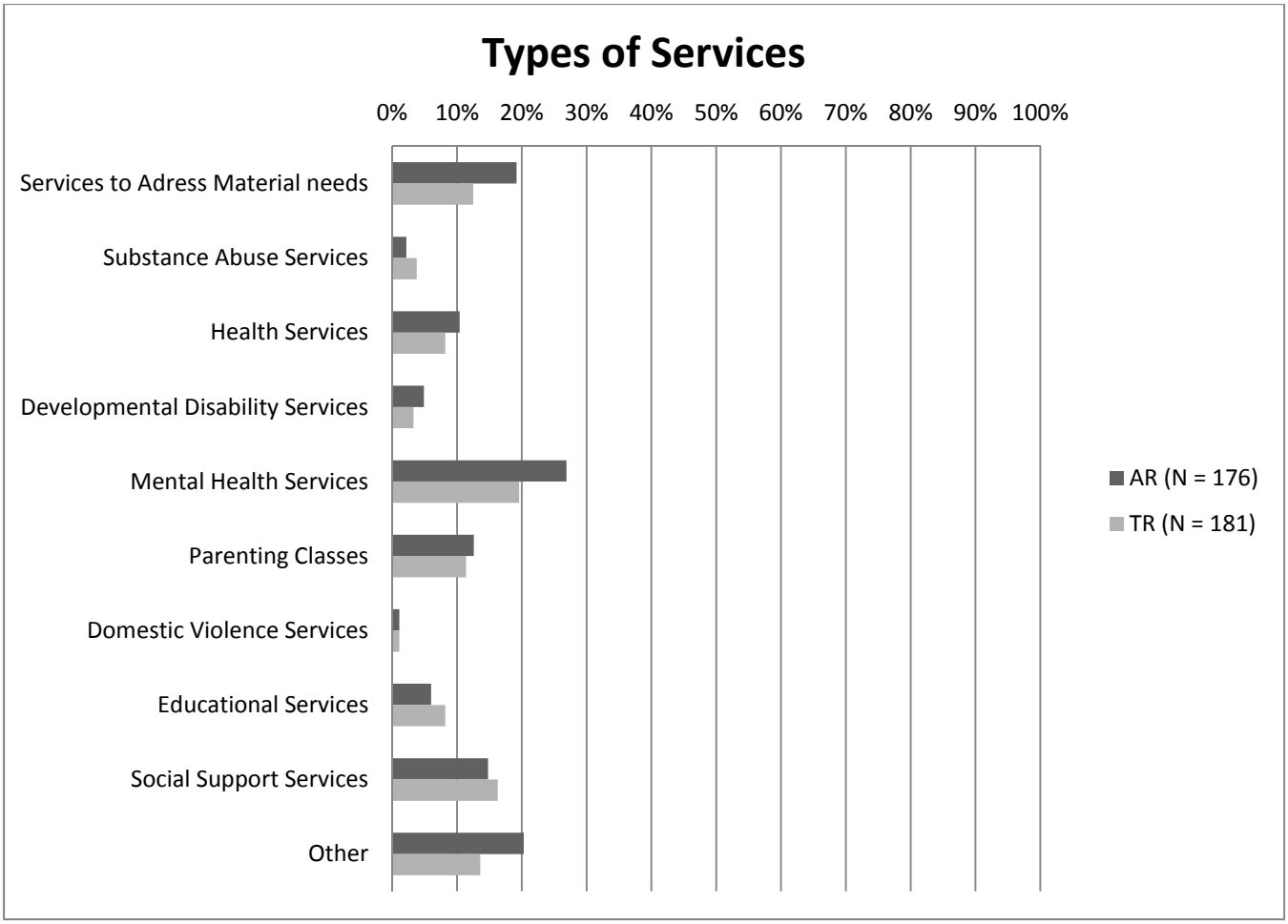
For each need workers were able to address during the case, workers were then asked whether or not that need improved while the case was open. More than three-quarters of workers reported that needs improved in both AR and TR cases. The following graph displays the percentage of improvement for the five most common family needs. For example, 96% of AR workers and 100% of TR workers reported that families requiring material needs were able to improve this need during their work with the family, at least a little.



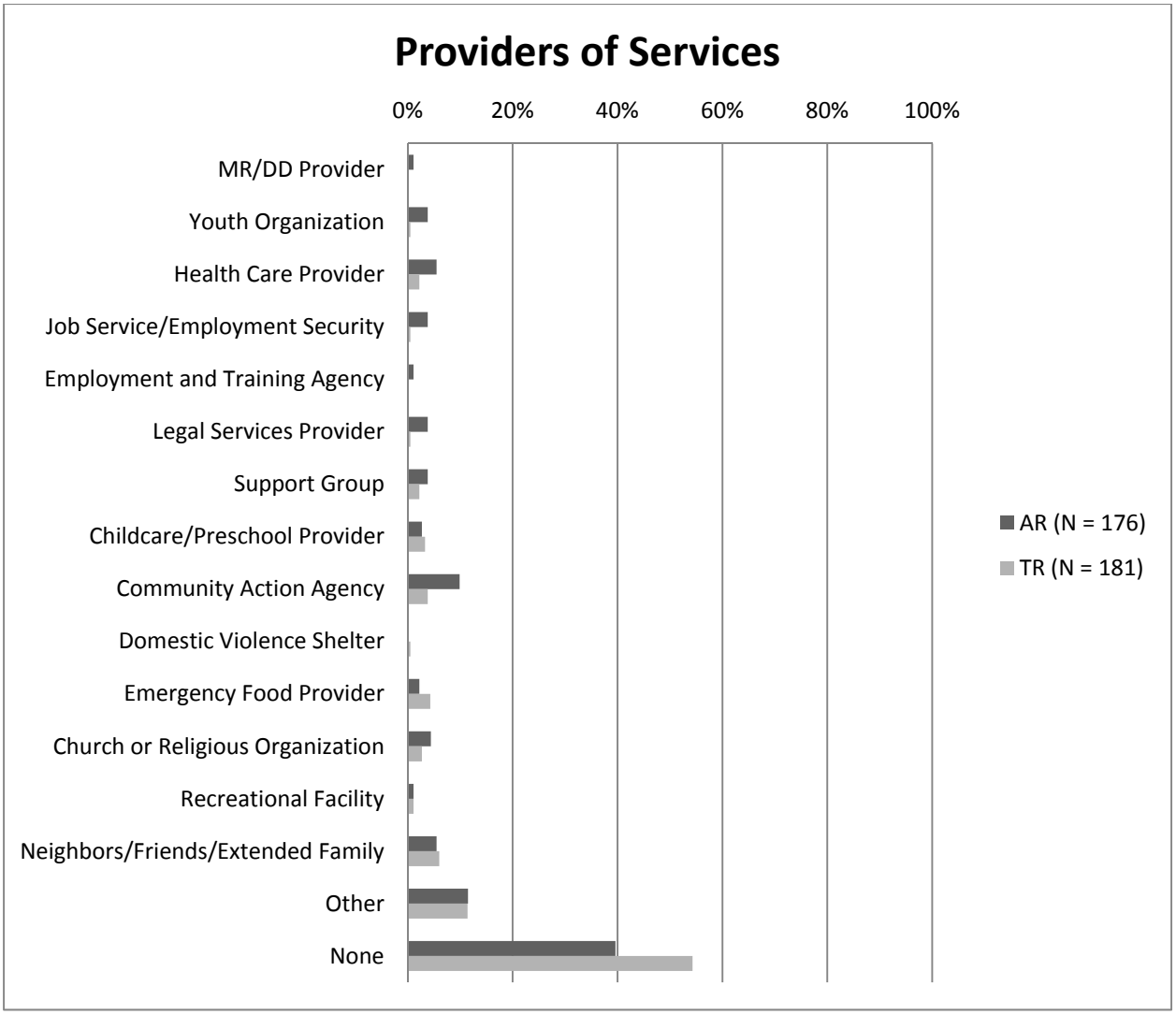


Services Provided to Families

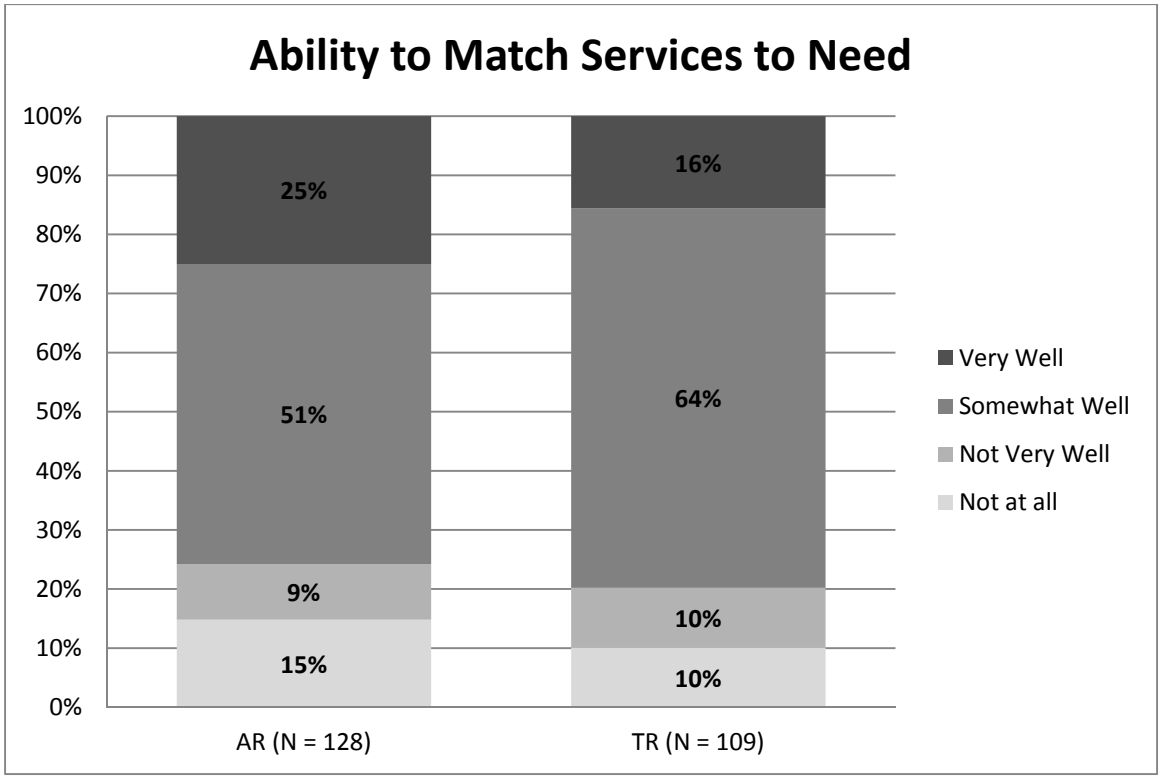
Workers reported information about the types of services provided to families, general providers of those services, and families' participation in those services. For the types of services that workers either gave the family information about or directly provided, the most common type of service (selected by about one-quarter of both AR and TR workers) was mental health services. Other common types of services were those to address material needs and social support services. If other services were provided that were not listed, workers were asked to provide information about those services. Other services provided to both tracks included day care providers, Intensive Family Preservation, and Legal Aid. Additionally, AR families were provided with Medicaid. These preliminary data indicate AR and TR cases are receiving similar types of services. The following graph displays the types of services received by AR and TR families.



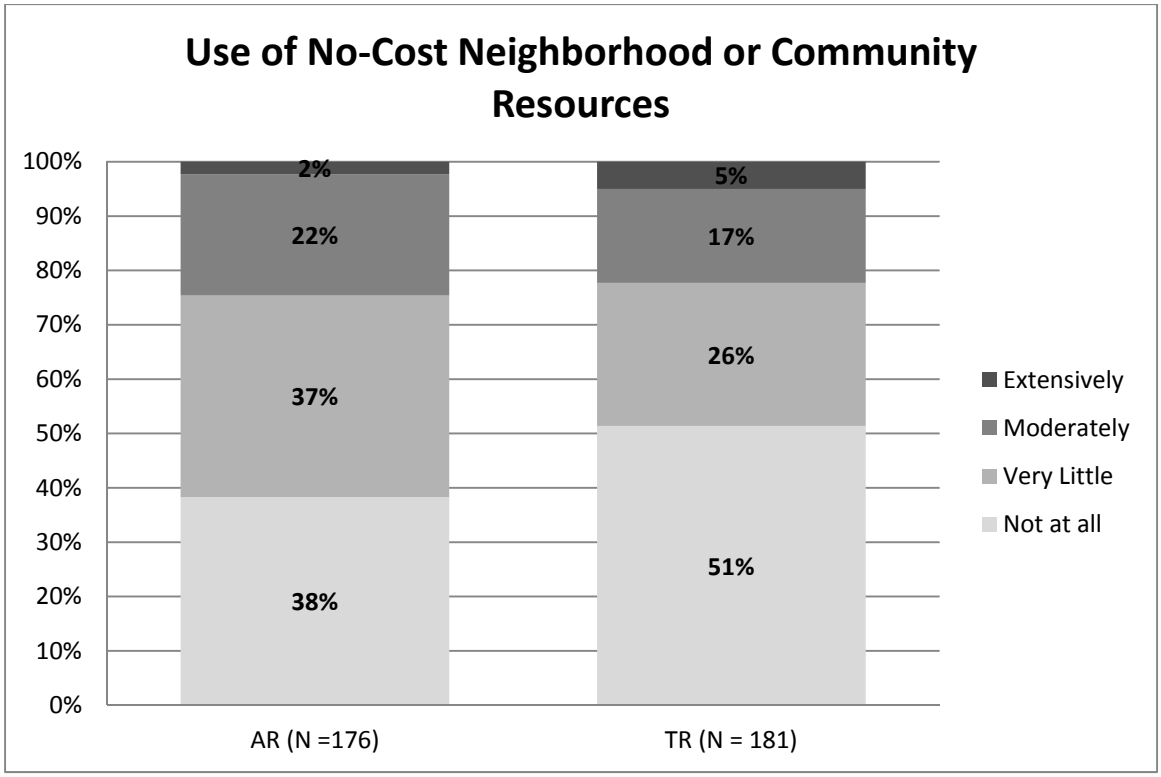
For the categories of service providers, most families appear to not have received services from any providers, as “None” was the most commonly selected response. However, of the selected providers, the most common were community action agencies, neighbors/friends/family, and health care providers. The following graph displays the types of service providers involved with AR and TR families.

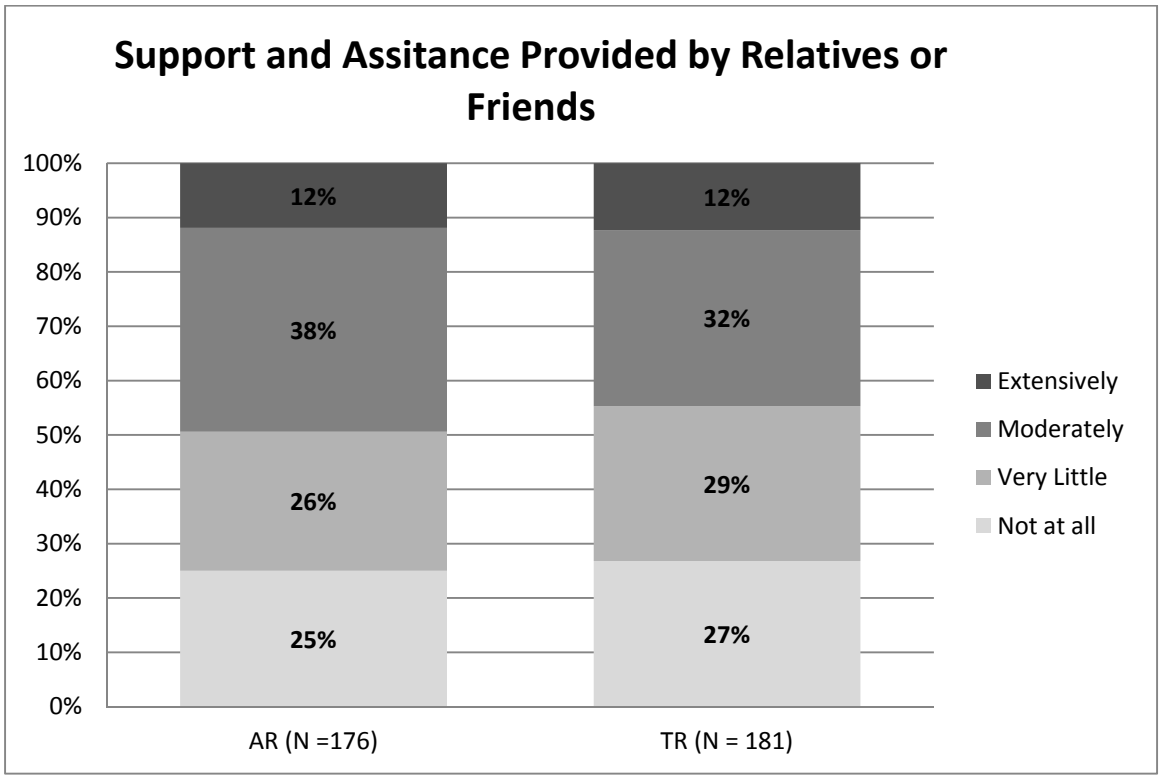


If a service was provided to a family, workers were then asked to indicate how well they believed they were able to match that service to the need of the family. As shown in the following graph, most workers reported that they were able to match the services provided to the service needs of the family; indicating that workers are mostly able to find services to address the needs of families in both AR and TR cases.



Because AR is particularly focused on addressing needs through low- or no-cost methods whenever possible, workers were specifically asked about these types of services. Less than half of TR cases utilized a no-cost neighborhood or community resource. Additionally, nearly half of all cases received at least moderate support or assistance from relatives or friends, regardless of track assignment. Overall, it appears slightly more AR cases utilized some sort of no-cost resource. The below graphs depict the use of no-cost resources, provided by either neighborhood or community resources, or relatives or friends, for both tracks.

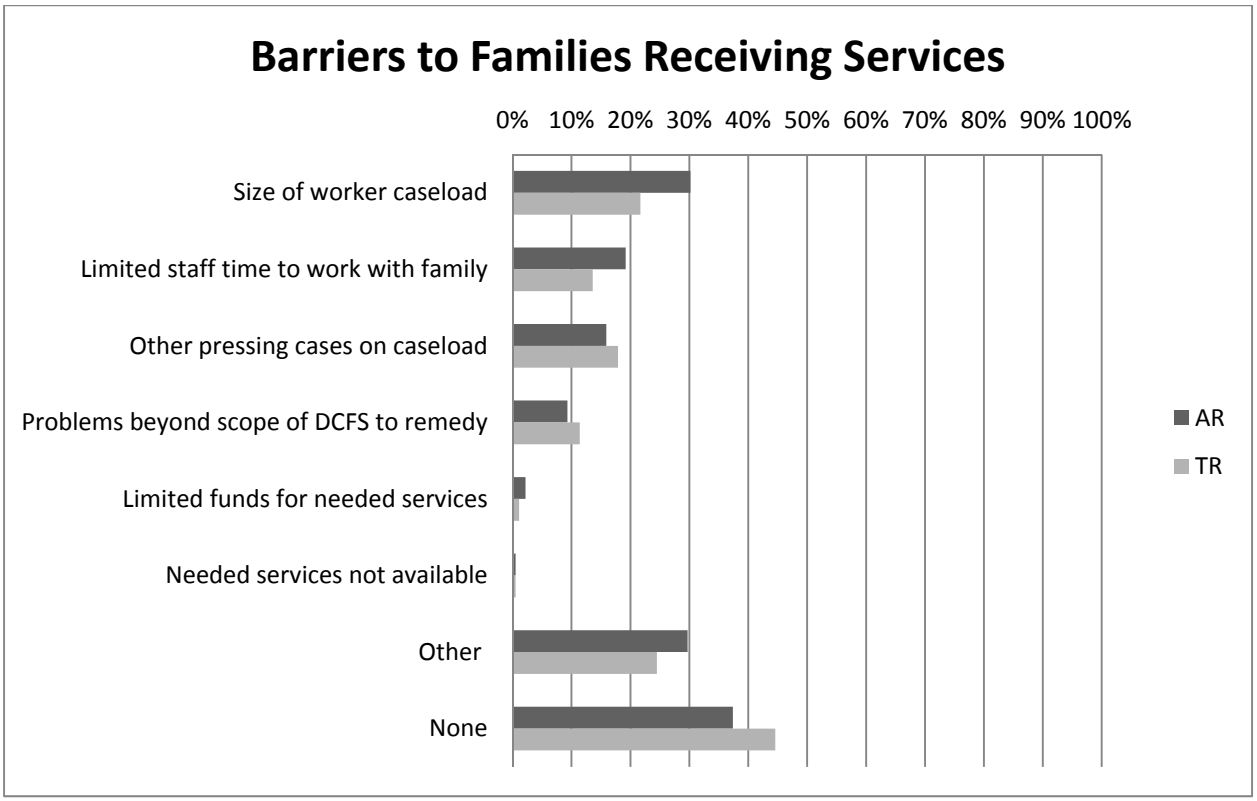




Barriers to Families Receiving Services

Workers were asked to provide information about the barriers they may have experienced in providing services to families. Workers identified similar barriers, regardless of track assignment. Generally, most workers did not experience barriers to families receiving services; a slightly larger proportion of TR workers

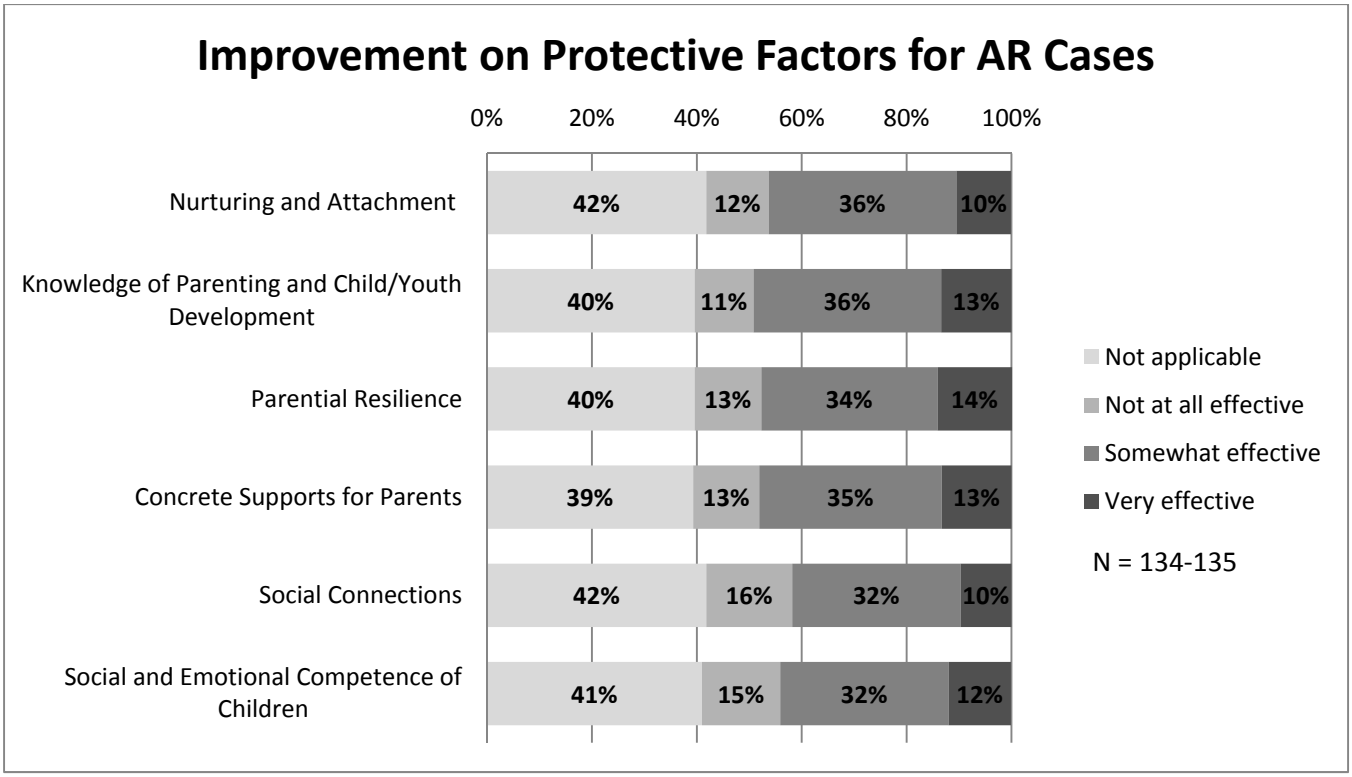
(45%) reported that they experienced no barriers when compared to AR workers (37%). However, for the barriers selected, the most common barrier was the size of the worker caseload, followed by limited staff time to work with families, and other pressing cases on their caseload. If a barrier was not listed, workers selected "other" and were then asked to provide a text response. Workers on both tracks reported additional barriers such as cultural or language issues, problems with the family refusing to engage or being uncooperative, and custody issues between parents. Overall, these data indicate that both AR and TR workers appear to be experiencing the same barriers. The following graph displays the barriers experienced by AR and TR workers.

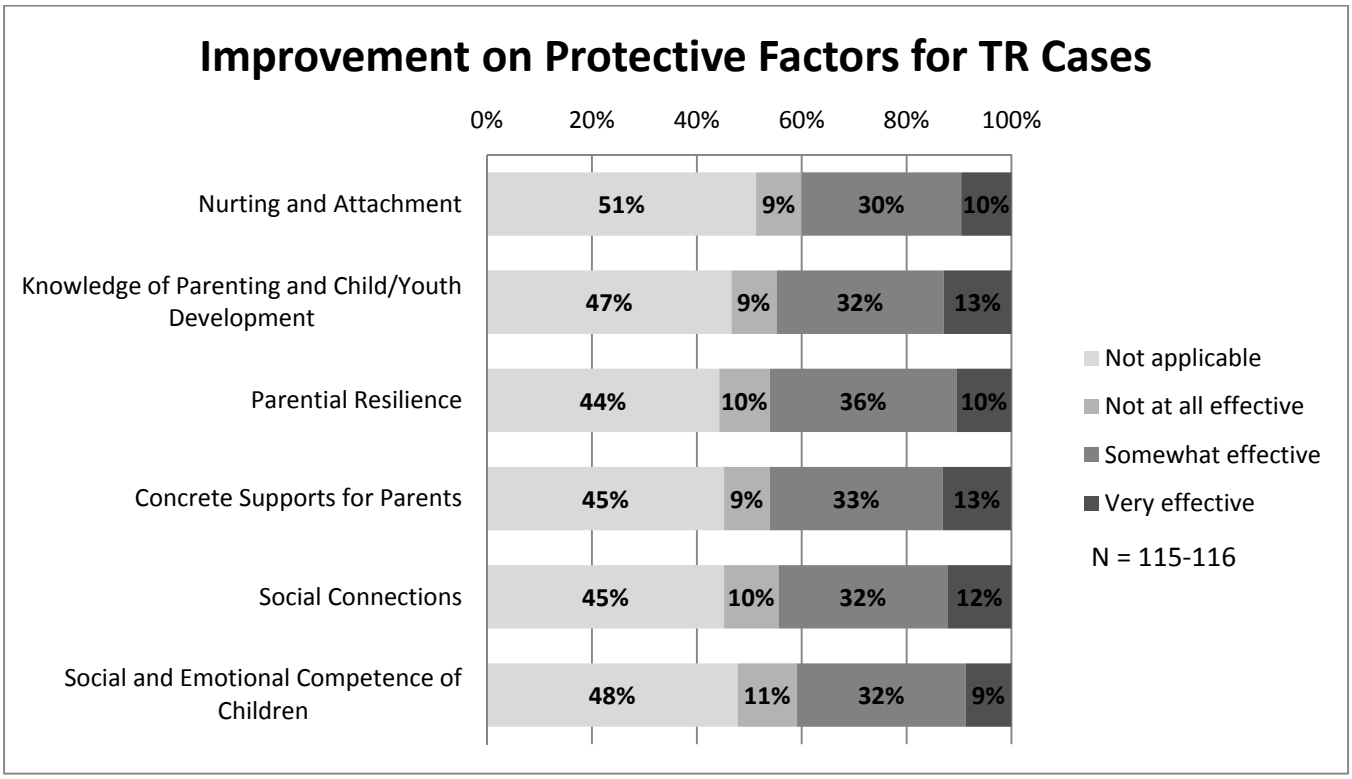


Protective Factors

Finally, workers were asked about whether the services provided to the family improved the family's protective factors. For more detailed information about the family's perceptions of protective factors, see *Protective Factors Questionnaire: October 2014-July 2015*; however, this report simply covers the workers' perceptions about whether or not the services provided were able to improve each of the protective factors.

All six protective factors appear to have similarly improved for all cases. Less than 15% of workers in both AR and TR reported services were very effective at improving the protective factors; between 8% and 17% of workers reported services did not improve protective factors at all. Importantly, between one-third and one-half of all workers reported that services were not applicable to protective factors, indicating that a substantial proportion of both AR and TR workers do not recognize the connection between services and protective factors. The following graphs display the effectiveness of services on each of the protective factors for both AR and TR.


Improvement on Protective Factors for AR Cases
0%
20%
40%
60%
80%
100%
Nurturing and Attachment
42%
12%
36%
10%
Knowledge of Parenting and Child/Youth Development
40%
11%
36%
13%
Parental Resilience
40%
13%
34%
14%
Concrete Supports for Parents
39%
13%
35%
13%
Social Connections
42%
16%
32%
10%
Social and Emotional Competence of Children
41%
15%
32%
12%
Not applicable
Not at all effective
Somewhat effective
Very effective
N = 134-135


Improvement on Protective Factors for TR Cases
0%
20%
40%
60%
80%
100%
Nurting and Attachment
51%
9%
30%
10%
Knowledge of Parenting and Child/Youth Development
47%
9%
32%
13%
Parental Resilience
44%
10%
36%
10%
Concrete Supports for Parents
45%
9%
33%
13%
Social Connections
45%
10%
32%
12%
Social and Emotional Competence of Children
48%
11%
32%
9%
Not applicable
Not at all effective
Somewhat effective
Very effective
N = 115-116

Appendix A: Worker Perceptions of Family Engagement

Worker Perceptions of Family Engagement for AR Cases

I think the primary caretaker…	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	N/A
Believed they would get the help they really needed from DCFS.	5 (2.8%)	41 (23.3%)	54 (30.7%)	51 (29.0%)	15 (8.5%)	10 (5.7%)
Realized that they needed some help to make sure their children have what they need.	15 (8.5%)	63 (35.8%)	27 (15.3%)	45 (25.6%)	16 (9.1%)	10 (5.7%)
Would say that they were fine before DCFS got involved.	1 (.6%)	31 (17.6%)	28 (15.9%)	66 (37.5%)	46 (26.1%)	4 (2.3%)
Found it difficult to work with me.	40 (22.9%)	94 (53.7%)	27 (15.4%)	8 (4.6%)	2 (1.1%)	4 (2.3%)
Would say there was good reason for DCFS to be involved with their family.	20 (11.4%)	69 (39.2%)	43 (24.4%)	32 (18.2%)	5 (2.8%)	7 (4.0%)
Would say that working with DCFS has given them more hope about how their life is going to go in the future.	9 (5.1%)	45 (25.6%)	62 (35.2%)	48 (27.3%)	2 (1.1%)	10 (5.7%)
Would say that we respected one another.	1 (.6%)	1 (.6%)	20 (11.4%)	100 (56.8%)	50 (28.4)	4 (2.3%)
Would say that we agreed about what was best for their child.	3 (1.7%)	4 (2.3%)	28 (16.0%)	104 (59.4%)	32 (18.3%)	4 (2.3%)
Feels that they could trust DCFS to be fair and to see their side of things.	3 (1.7%)	9 (5.1%)	29 (16.6%)	105 (60.0%)	25 (14.3%)	4 (2.3%)
Would say that things will improve for their children because DCFS was involved.	7 (4.0%)	41 (23.3%)	79 (44.9%)	36 (20.5%)	3 (1.7%)	10 (5.7%)
Would say that what DCFS wanted them to do is the same as what they wanted.	5 (2.8%)	14 (8.0%)	33 (18.1%)	98 (55.7%)	20 (11.4%)	6 (3.4%)
Would say that there were definitely some concerns in their family that DCFS recognized.	13 (7.4%)	47 (26.7%)	44 (25.0%)	60 (34.1%)	5 (2.8%)	7 (4.0%)
Would say that I didn't understand where they were coming from at all.	27 (15.3%)	106 (60.2%)	31 (17.6%)	7 (4.0%)	1 (.6%)	4 (2.3%)
Would say that DCFS helped their family take care of some of their challenges.	7 (4.0%)	47 (26.7%)	53 (30.1%)	56 (31.8%)	3 (1.7%)	10 (5.7%)
Would say that DCFS helped their family get stronger.	8 (4.5%)	40 (22.7%)	74 (42.0%)	41 (23.3%)	2 (1.1%)	11 (6.3%)
Does not think that DCFS is out to get them.	2 (1.1%)	8 (4.5%)	30 (17.0%)	105 (59.7%)	26 (14.8%)	5 (2.8%)

Worker Perceptions of Family Engagement for TR Cases

I think the primary caretaker…	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	N/A
Believed they would get the help they really needed from DCFS.	8 (4.4%)	34 (18.8%)	68 (37.6%)	44 (24.3%)	13 (7.2%)	14 (7.7%)
Realized that they needed some help to make sure their children have what they need.	13 (7.2%)	60 (33.1%)	33 (18.2%)	48 (26.5%)	12 (6.6%)	15 (8.3%)
Would say that they were fine before DCFS got involved.	6 (3.3%)	26 (14.4%)	34 (18.8%)	71 (39.2%)	41 (22.7%)	3 (1.7%)
Found it difficult to work with me.	50 (27.6%)	90 (49.7%)	26 (14.4%)	10 (5.5%)	0 (0%)	5 (2.8%)
Would say there was good reason for DCFS to be involved with their family.	30 (16.6%)	70 (38.7%)	38 (21.0%)	35 (19.3%)	4 (2.2%)	4 (2.2%)
Would say that working with DCFS has given them more hope about how their life is going to go in the future.	12 (6.6%)	50 (27.2%)	72 (39.8%)	33 (18.2%)	6 (3.3%)	8 (4.4%)
Would say that we respected one another.	2 (1.1%)	2 (1.1%)	21 (11.6%)	104 (57.5%)	48 (26.5%)	4 (2.2%)
Would say that we agreed about what was best for their child.	5 (2.8%)	8 (4.4%)	29 (16.0%)	96 (53.0%)	38 (21.0%)	5 (2.8%)
Feels that they could trust DCFS to be fair and to see their side of things.	2 (1.1%)	12 (6.6%)	27 (14.9%)	102 (56.4%)	33 (18.2%)	5 (2.8%)
Would say that things will improve for their children because DCFS was involved.	10 (5.5%)	30 (22.1%)	80 (44.2%)	31 (17.1%)	7 (3.9%)	13 (7.2%)
Would say that what DCFS wanted them to do is the same as what they wanted.	3 (1.7%)	16 (8.8%)	47 (26.0%)	80 (44.2%)	23 (12.7%)	12 (6.6%)
Would say that there were definitely some concerns in their family that DCFS recognized.	11 (6.1%)	49 (27.1%)	51 (28.2%)	54 (29.8%)	10 (5.5%)	6 (3.3%)
Would say that I didn't understand where they were coming from at all.	34 (18.8%)	100 (55.2%)	32 (17.7%)	9 (5.0%)	2 (1.1%)	4 (2.2%)
Would say that DCFS helped their family take care of some of their challenges.	6 (3.3%)	43 (23.8%)	68 (37.6%)	46 (25.4%)	5 (2.8%)	13 (7.2%)
Would say that DCFS helped their family get stronger.	9 (5.0%)	40 (22.1%)	79 (43.6%)	38 (21.0%)	3 (1.7%)	12 (6.6%)
Does not think that DCFS is out to get them.	5 (2.8%)	12 (6.6%)	39 (21.5%)	89 (49.2%)	32 (17.7%)	4 (2.2%)