November 14, 2016

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, 2016.

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

11-15-2016

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

Department of Health & Human Services
DHHS
NEBRASKA

This report serves as the Department of Health and Human Services' (DHHS) report on the status of Alternative Response implementation pursuant to Nebraska Revised Statute 28-712. DHHS Division of Children and Family Services (DCFS) implemented an Alternative Response pilot project October 1, 2014 in five counties across Nebraska (Scotts Bluff, Hall, Lancaster, Dodge and Sarpy). Throughout 2016, Alternative Response expanded and is currently operational in 57 counties (Refer to attachment 1, Alternative Response Expansion Plan). Alternative Response is one intervention DCFS implemented as part of the Title IV-E Wavier Demonstration Project awarded by the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) in 2013. As part of the terms and conditions of the demonstration project, DHHS was required to secure a third party, independent evaluator to assess the process, outcomes and costs of the project. The University of Nebraska- Lincoln's Center on Children, Families, and the Law (CCFL) was awarded the contract for the program evaluation. The interim evaluation report will be completed in March 2017. Due to the time frame in which the formal interim evaluation will be completed, DCFS requested CCFL to provide a preliminary analysis on Alternative Response (Refer to attachment 2, Interim Analyses of the Alternative Response Program for Nebraska Children's Commission) in an effort to share evaluative data for inclusion in this report.

I. Alternative Response Outcome Evaluation

The Alternative Response (AR) evaluation will consist of three components: 1. process evaluation; 2. outcome evaluation; and, 3. a cost study. The terms of the evaluation were agreed upon between CCFL, Nebraska DHHS and the Administration for Children, Youth and Families. DHHS will receive two formal evaluative reports from CCFL in March 2017 (Interim Report) and in December 2019 (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, and 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 screening process used to determine which cases shall be assigned to Alternative Response.
    - The number and proportion of repeat maltreatment allegations within a specified period of time following initial intake.
    - The number and proportion of substantiated child abuse and neglect allegations within a specified period of time following initial intake.
    - The number and proportion of families with any child entering out-of-home care within a specified period of time following initial intake.
    - 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.

- The number and proportion of families assigned AR who are re-assigned to Traditional Response (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.

Due to the method in which b) The number and proportion of repeat maltreatment allegations within a specified period of time following initial intake, c) The number and proportion of substantiated child abuse and neglect allegations within a specified period of time following initial intake, and d) The number and proportion of families with any child entering out of home care within a specified period of time following initial intake, in statute 28-712(2), are calculated, distributing outcome data analyses wouldn't provide an accurate depiction of the Alternative Response program. Moreover, the limited amount of time the pilot has been implemented, as well as the limited number of families who have received AR add additional challenges for the sample size to produce statistically significant outcome data. The CCFL Interim Analyses of the Alternative Response Program for Nebraska Children's Commission (CCFL Interim Analysis, refer to attachment 2) does include data analysis related to the number and proportion of families who changed tracks from AR to TR, well-being and timeliness of service delivery. However, while the limited data impedes an analysis on all long-term outcomes, the CCFL Interim Analysis includes an examination of the hypothesized interim outcomes:

- Families can safely care for their children in home.
- Protective factors are enhanced.
- Families receive services/supports to address specific needs.
- Collaborative problem solving and learning occurs.
- Families and workers share valuable information.
- Families feel respected and engage with AR worker.
- AR workers have the flexibility to tailor services to meet family needs.

In summary:

- Children in AR are as safe as children in TR (attachment 2 pg. 23).
- Parenting skills, a child's emotional and or behavioral adjustment and mental health of a child were the most prevalent needs identified. Moreover, AR families were more likely to have needs related to mental health of a child (attachment 2 pg. 5).
- Families receiving AR are more likely to receive services than families in TR (attachment 2 pgs. 28-31).
- The CFS case manager survey indicated families in AR receive services more timely than families in TR (attachment 2 pg. 31).
- According to the CFS case manager survey, families receiving AR have a higher level of overall engagement than families in TR, and families in TR rated higher levels of mistrust than families in AR (attachment 2 pgs. 37-38).
- At this time, no significant differences emerged for the enhancement of parental protective factors for families in AR versus TR (attachment 2 pgs. 38-93).

- A significant difference in child well-being was identified for children in Alternative Response, which included lower hyperactivity and peer relationship problems, and higher prosocial behaviors (attachment 2 pg. 39-41).

DCFS utilizes a Continuous Quality Improvement (CQI) framework to compliment the CCFL evaluation, as well as to monitor implementation, AR model fidelity, demographic outcome data and to provide opportunities for formal feedback from internal and external partners.

A. DCFS Continuous Quality Improvement:

The monthly CQI data report is directly related to the AR core outcomes. This data is used to continually analyze aspects of programmatic performance. Examples of data included in the monthly data report are:

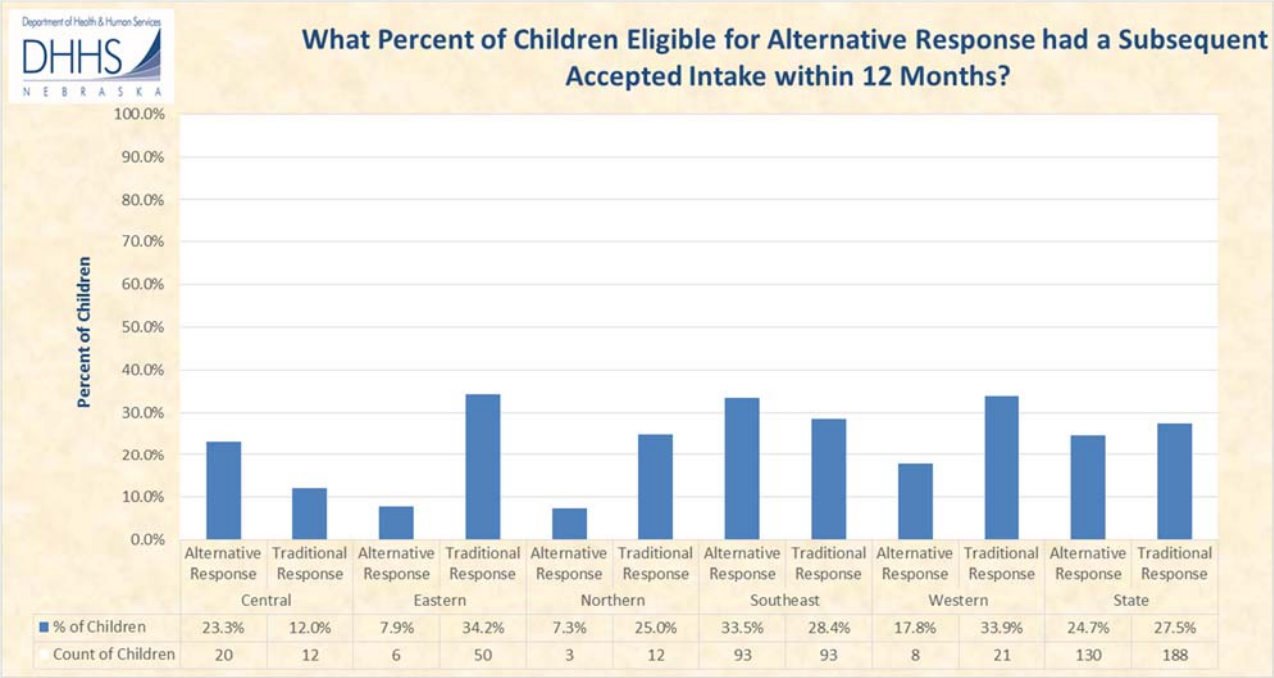
- The number of children and families eligible for AR;
- The number of children and families served;
- Child demographics (age, gender, and ethnicity);
- Types of allegations associated with intakes eligible for AR;
- Response reassignment data;
- The number of children removed from their family home;
- 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 report is shared with and analyzed by the AR Director's Steering Committee, the AR Statewide Advisory Committee and the AR Internal Workgroup. These team members played a significant role in identifying the priority data elements to be analyzed each month.

Monitoring the outcome data through CQI enables DCFS to assess data to make practice improvements. These data sets are used to ignite questions and conversations with internal and external partners and to prioritize case reviews. One of the goals of AR is to keep families together. It is pertinent to assess if AR is impacting a subsequent accepted intake (Diagram 1), a subsequent substantiated intake (Diagram 2), and out-of-home placement (Diagram 3).

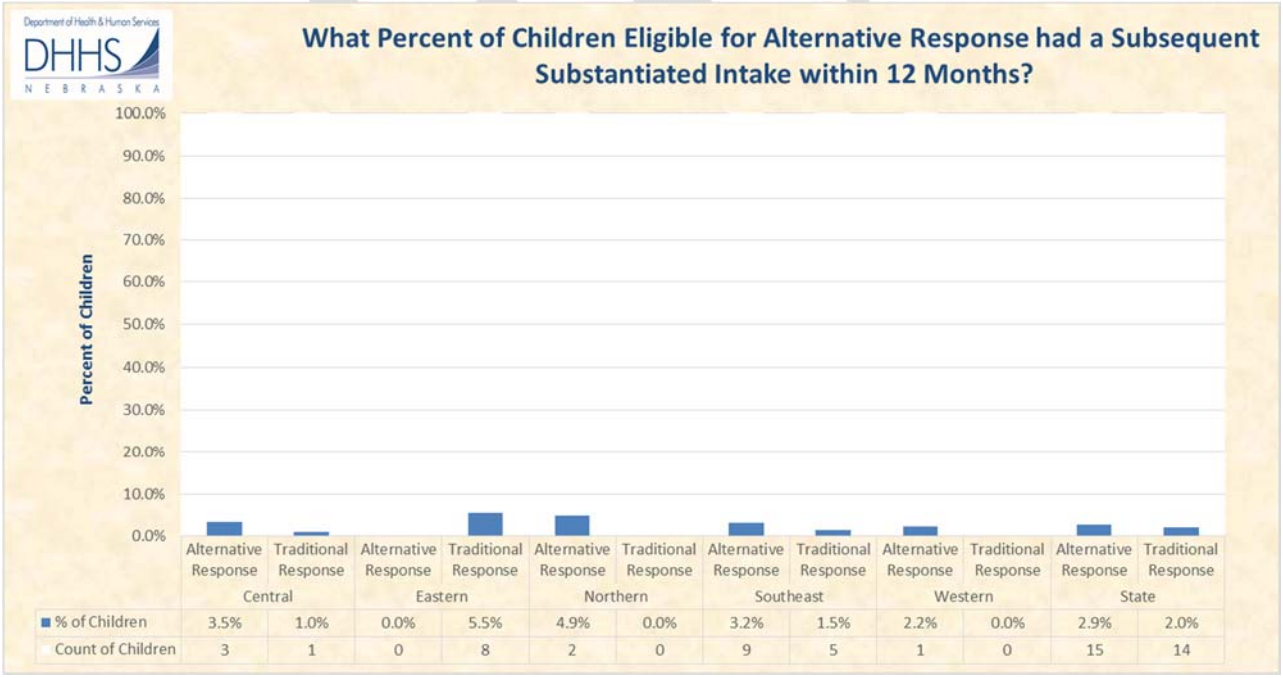
While the 'Percent of Children Eligible for Alternative Response that had a Subsequent Accepted Intake within 12 Months' is higher for families who received AR than expected, DCFS has taken the opportunity to learn from this data (Diagram 1). Through case reviews and conversations during internal meetings, DCFS continues to learn what impacts a family that leads to another accepted intake. Moreover, connecting this data with the average number of days a family is active in AR and services provided to a family can aid DCFS in the ability to identify best practices. For example, the service areas with the highest Percentage of Children Eligible for AR that had a Subsequent Intake within 12 Months (Diagram 4) also had the lowest Average Number of Days a Family is Receiving AR (Diagram 3, pg. 8). Furthermore, DCFS is beginning to link this data to services delivered and assess if specific services delivered mitigate the likelihood of a subsequent accepted intake.

Diagram 1



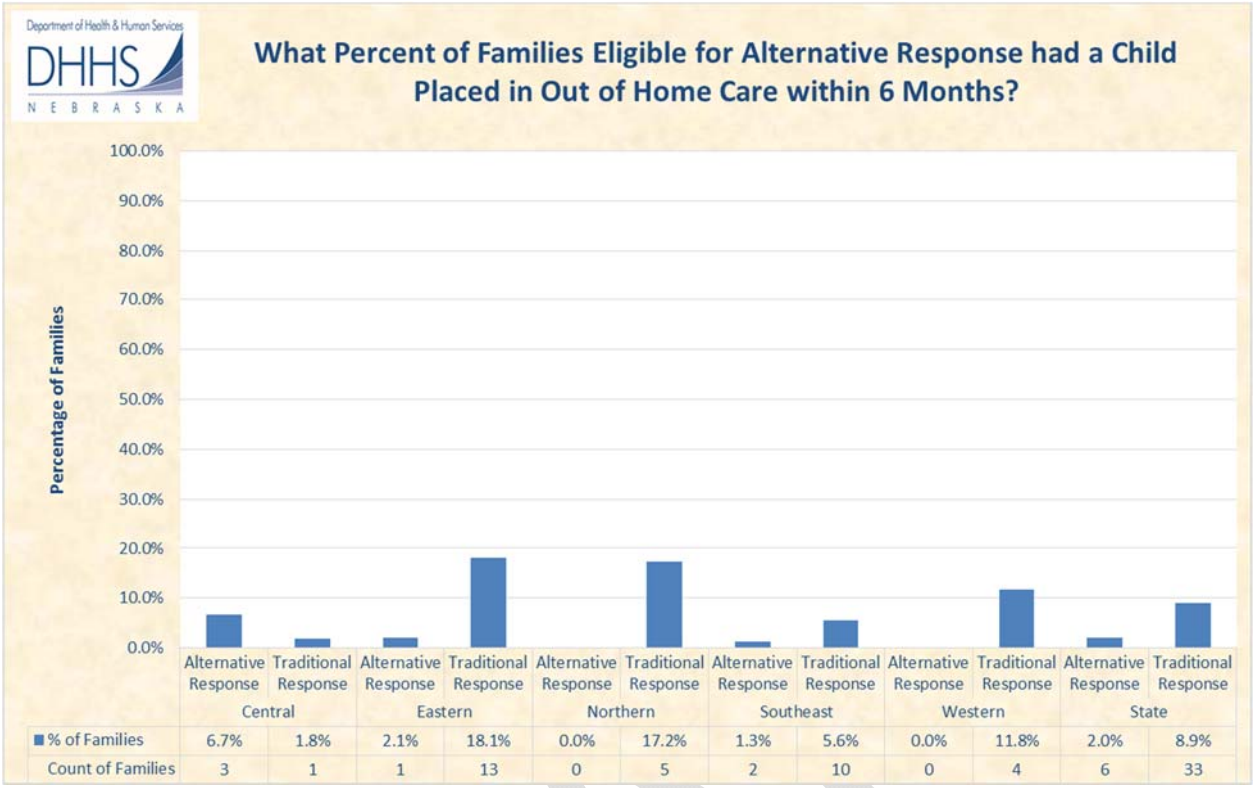
* Data Source, **Alternative Response IV-E Pilot Project Statistics from Oct. 2014-July 2016 (Data was taken 07.07.2016)**

Diagram 2



* Data Source, **Alternative Response IV-E Pilot Project Statistics from Oct. 2014-July 2016 (Data was taken 07.07.2016)**

Diagram 3



* Data Source, **Alternative Response IV-E Pilot Project Statistics from Oct. 2014-July 2016 (Data was taken 07.07.2016)**

The data reported in Diagrams 1 and 2 are related to AR eligible intakes where at least 12 months have passed since the initial AR eligible intake was received (intakes accepted 10/1/14 through 6/30/2015). Data in Diagram 3 reflects intakes where at least 6 months have passed since the initial AR eligible intake was received (Intakes Accepted 10/1/14 through 12/31/15). It is pertinent to note the parameters of these data as they reflect the practice in the first year of AR. A lesson learned through case reviews was that reviewing recent cases led to more meaningful reviews as AR practice has improved throughout implementation. Moreover, an increase in thorough documentation and familial information was noted in recent case reviews. As AR expands, the skills and abilities of the workforce continue to be enhanced.

B. Case Reviews

Throughout 2016, case reviews have been completed by the AR Internal Workgroup. Prior to each meeting, the CQI data prioritize the types of cases to be reviewed. Examples of reviewed cases include: a) Intakes randomized to Alternative Response that had a second accepted intake received at the hotline; b) Children eligible for Alternative Response that experience a subsequent substantiated intake; and c) Children eligible for Alternative Response that experience a subsequent placement out of the home.

The case review process is conducted to enhance peer-to-peer learning. Five growth opportunities have been identified by the case reviews:

- Enhance case documentation;
- Increase engagement;
- Build family sustainability;

- Improve linkages to resources and services; and
- Improve utilization of collateral contacts to learn about family functioning.

Through this review process, service area representatives identify challenges and brainstorm strategies to implement within their respective service area. Each service area has identified a variety of strategies to implement that are designed to address each of the five growth opportunities.

C. CCFL Evaluation

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

- The Nebraska Protective Factor and Well-being Questionnaire (PFWQ): A quarterly report assessing the implementation of the PFWQ tool and data analysis on well-being and protective factors.
- AR Family Experience Survey summarizes data collected from families who are eligible for AR.
- Worker End of Case Survey: summarizing data collected from case managers who were assigned a family eligible for AR.

Aggregated data from these reports are included in the CCFL Interim Analyses (attachment 2).

D. Citizen Review Panel

A Citizen Review Panel consists of community members who examine DCFS policies and practices through case reviews to evaluate the effectiveness of AR. The Alternative Response Citizen Review Panel began meeting quarterly in 2016. To date, the Citizen Review Panel has convened three times to review cases. The reports and recommendations generated from this panel will be utilized to identify areas of strength and areas of challenges. A written report summarizing the trends and recommendations will be submitted to DCFS in spring 2017.

II. Alternative Response Program

Alternative Response was developed collaboratively with internal and external stakeholders. To obtain feedback on the planning and implementation of AR, various committees and workgroups were created and continue to operate:

- The Alternative Response Internal Workgroup is comprised of DCFS field staff and administrators. Model and practice recommendation from this workgroup are shared with the Director's Steering Committee and the Alternative Response Statewide Advisory Committee. In the past year, this group focused on:
    - Preparation and planning for AR expansion – Identifying barriers and brainstorming strategies to address challenges, share successes, and build on program strengths.
    - Case Reviews – Reviews of families who have received AR to identify trends, strategies and for service area representatives to integrate learning into practice.
    - Continuous Quality Improvement (CQI) – Review AR data, discuss trends, opportunities for growth and strengths, identify strategies to integrate into practice.
    - Program updates – Provide feedback and suggestions. What is working well and what needs to be modified.

- The Alternative Response Director's Steering Committee includes representatives from the Foster Care Review Office, Office of Inspector General, Region V Behavioral Health, Lancaster County Attorney's Office, Nebraska Children and Families Foundation, a Child Advocacy Center, Voices for Children and internal DCFS Administrators. This meeting is convened for:
    - Members to provide feedback and advice on the implementation and expansion of AR.
    - Review CQI data; obtain feedback and brainstorm opportunities for improvement.
- The Alternative Response Statewide Advisory Committee is comprised of the Director's Steering Committee members along with community and family partnering organizations. The purpose of this meeting is to:
    - Solicit input and feedback from stakeholders on the status of AR implementation.
    - Share updates on AR program.
    - Share evaluative data.
    - Review CQI data; discuss strengths, opportunities for improvement and brainstorm strategies

DCFS utilizes the expertise of the members within each workgroup to obtain feedback and generate ideas on Alternative Response. DCFS continues to meet regularly with each of these committees to share information on implementation, program strengths, challenges and modifications in order to continually improve how DCFS delivers AR.

Screening Criteria and Response Reassignment

The Alternative Response ineligibility criteria, known as the exclusionary criteria, were developed in collaboration with internal and external statewide stakeholders to ensure the families eligible for AR involved low-level reports of abuse and or neglect. There are 22 exclusionary criteria applied to intakes accepted at the hotline that are used to determine AR eligibility.

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:
    - Has an alcohol addiction; or

- Previously delivered a drug-exposed infant and did not successfully complete drug treatment; or
- Did not prepare for the newborn's birth; or
- Currently uses controlled substances as defined by Neb. Rev. Stat. § 28-401 or alcohol and breastfeeds or expresses intent to breastfeed; or
- 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:
    - The subject of an active Traditional Response; or
    - An individual or family that is receiving services through the DCFS Protection and Safety section; or
    - An individual or family involved in a 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 Child Abuse and Neglect 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.
22. A safety concern is otherwise identified which requires Department intervention within 24 hours.

The CCFL Interim Analyses conducted an exclusionary criteria analyses. In summary 14 percent of child abuse and neglect intakes are eligible for Alternative Response (Refer to attachment 2, pgs. 11-15). Of the intakes excluded from AR, the most frequently selected exclusionary criteria in the five pilot counties are:

- Prior substantiation - 27 percent;
- Use of Controlled Substance - 25 percent; and
- Domestic Violence - 22 percent.

In addition to the 22 exclusionary criteria, the intake screening process also includes a supplementary set of criteria that if alleged in the intake, will require a Review, Evaluate and Decide (RED) Team review. These criteria are not an automatic exclusion from Alternative Response, but trigger a secondary focused review by

the RED Team members. These reviews focus on the severity of the allegation, vulnerability of child(ren) involved, and family history to determine appropriate track assignment.

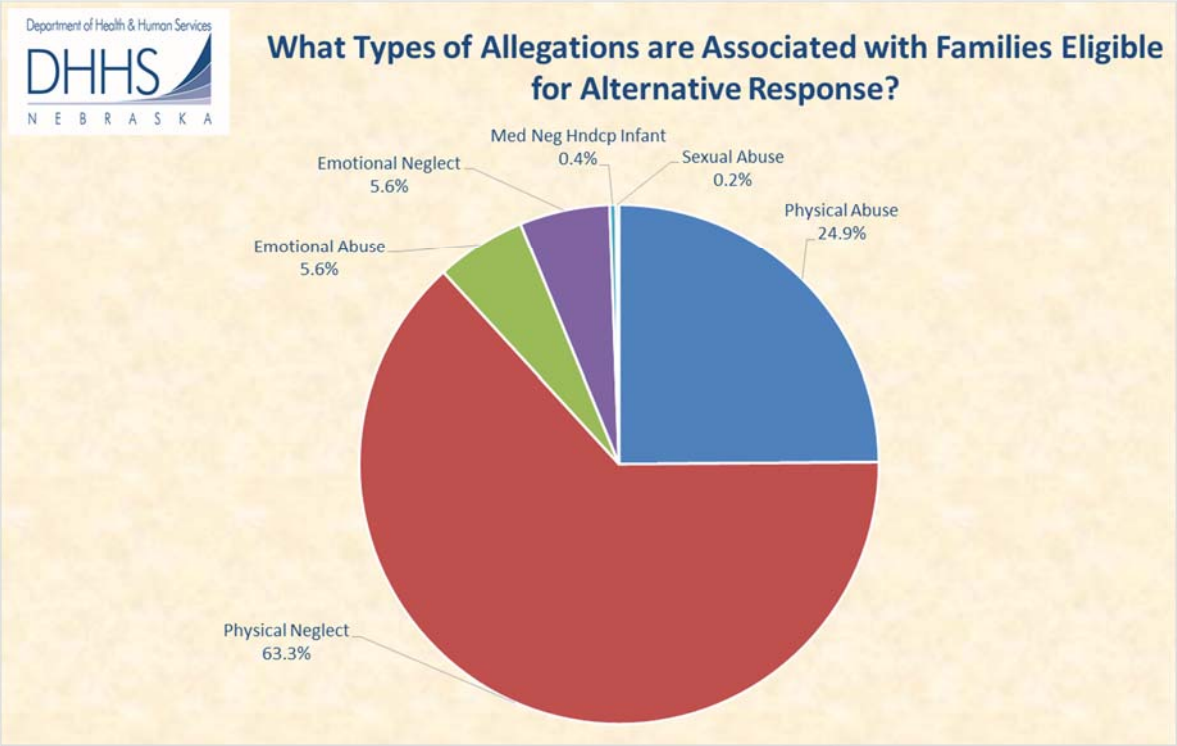
Review, Evaluate and Decide (RED) Team Criteria: Any Intake Accepted for Assessment that does not meet the exclusionary criteria described above, requires further review. The RED Team criteria are applied to intakes accepted at the hotline to determine eligibility for Alternative Response which includes 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 or 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 six months and there are two or more children under the age of 5 or one 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.
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.
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.

The CCFL Interim Analyses examined the use of RED team criteria within the five pilot counties. Overall, a RED Team criterion was applied to 3 percent of intakes and the most frequently used criterion was physical abuse allegation not rising to the level of physical abuse identified in the Exclusionary Criteria (Refer to attachment 2, pgs. 16-17).

A total of 306 RED Team staffings occurred from January 1, 2015 through June 30, 2016. Of these 306 staffings, 83 percent were determined eligible for AR while 17 percent of the decisions supported a traditional investigatory response.

Diagram 4



* Data Source, **Alternative Response IV-E Pilot Project Statistics from Oct. 2014-July 2016 (Data was taken 07.07.2016)**

Physical neglect is the most common allegation of an intake eligible for Alternative Response. This data is consistent with DCFS' goal to deliver AR to families with physical neglect allegations driven by stressors related to poverty and minimal supervision with low or moderate future risk of maltreatment.

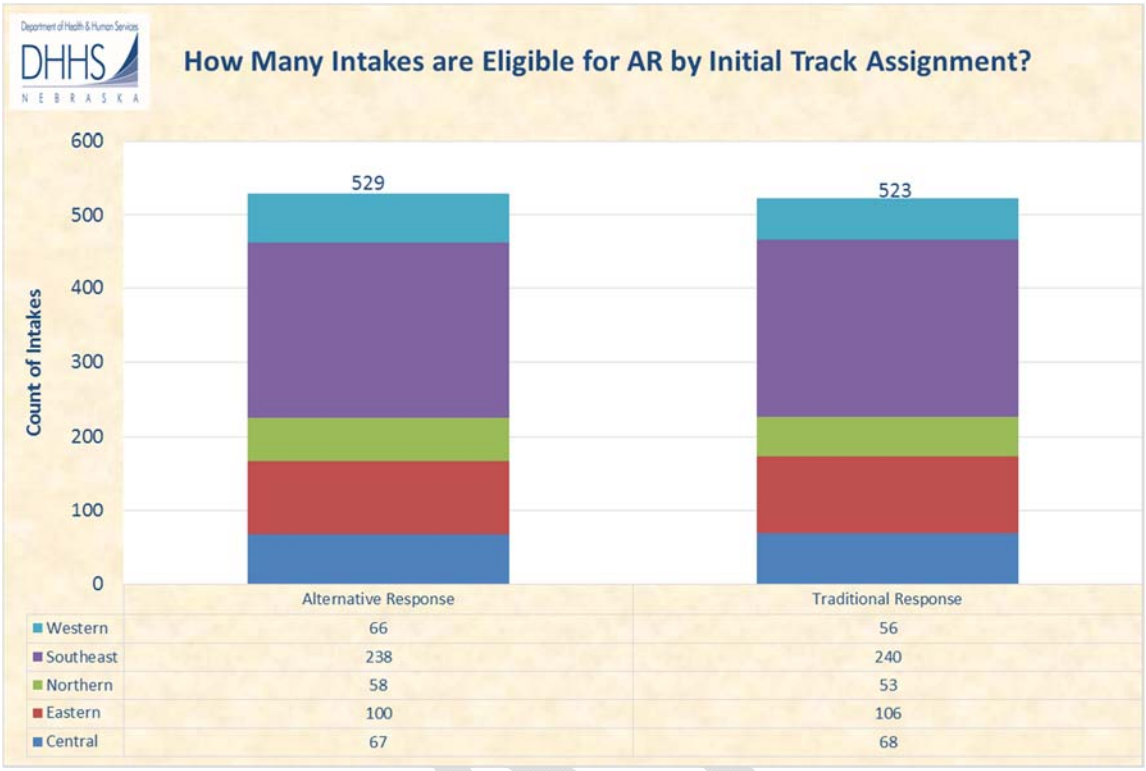
Table 1 illustrates the number of accepted child abuse and neglect intakes and the number and percent of intakes eligible for Alternative Response. From October 1, 2014 through June 30, 2016, 14.1 percent of child abuse and neglect intakes were eligible for Alternative Response. However, of the 14.1 percent of intakes eligible for AR, only 50 percent are randomized to AR by virtue of the random control trial evaluation design. This data suggests that NE is taking a very conservative approach with AR implementation.

Table 1: What Percent of Statewide Intakes are Eligible for Alternative Response?
(October 1, 2014 through June 30, 2016)

	AR County Intakes
Total Accepted Child Abuse and Neglect Intakes	7,447
AR Eligible Intakes	1,052
% AR Eligible Intakes	14.1%

* Data Source, **Alternative Response IV-E Pilot Project Statistics from Oct. 2014-July 2016 (Data was taken 07.07.2016)**

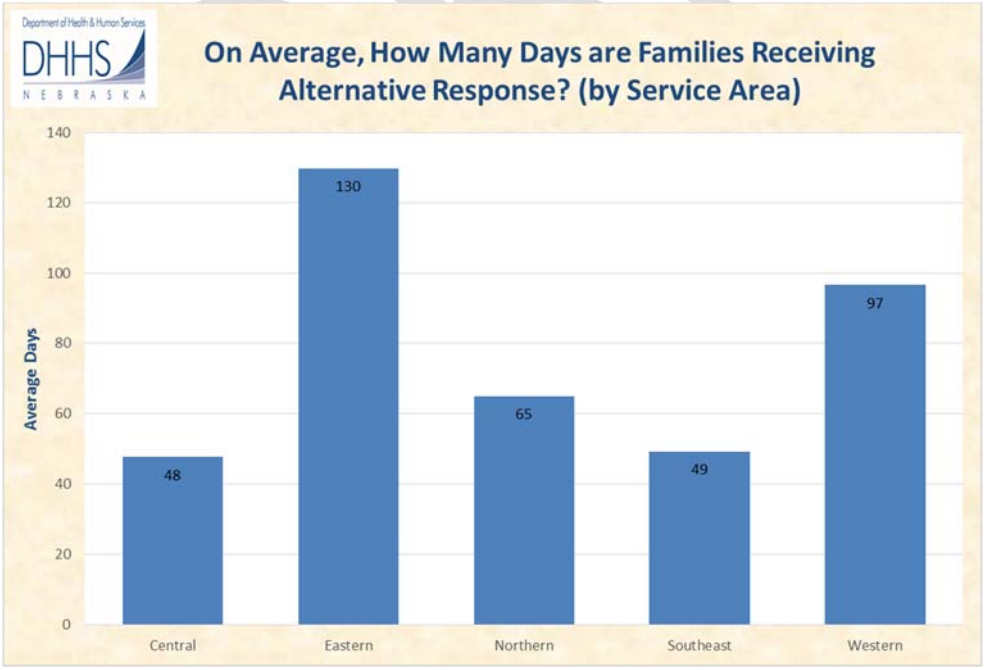
Diagram 5 depicts the randomization of accepted intakes to AR and TR.



* Data Source, **Alternative Response IV-E Pilot Project Statistics from Oct. 2014-July 2016 (Data was taken 07.07.2016)**

Of the 529 intakes randomized to AR, the average number of days a family is actively involved in AR varies by service area (Diagram 6).

Diagram 6



* Data Source, **Alternative Response IV-E Pilot Project Statistics from Oct. 2014-July 2016 (Data was taken 07.07.2016)**

III. Service Array

A family's ability to access timely services within their community is a vital component of AR. In an effort to expand service capacity, DCFS continues to collaborate with the Nebraska Children and Families Foundation (Nebraska Children) who leads local efforts aimed at minimizing poverty, homelessness, and child abuse/neglect within communities. Expanding the Community Response Initiative is one strategy specifically designed to achieve this goal. Community Response utilizes 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 Community Response 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 office to buy the concrete supports that are often needed by families. As of June 30, 2016, the most prevalent services utilized include housing related assistance (rent, cleaning, utilities, and deposits), transportation (motor vehicle repairs, gas, tires, and windshield), food and clothing. Purchase card expenditures as of June 30, 2016 total $19,623.67. Additionally, field staff report tremendous support from community agencies that have delivered supports and services at no cost.

In addition to connecting families with Community Response and the utilization of purchase cards, the AR workforce is able to refer families to services traditionally provided to families. Approximately $152,000 has been expended for families in Alternative Response to receive formal child welfare services such as family support; intensive family preservation, mediation and therapeutic services. These services coincide with the needs identified through the parental protective factors (Refer to pg. 9).

IV. Conclusion

Alternative Response has been implemented in Scotts Bluff, Hall, Lancaster, Dodge and Sarpy counties since October 1, 2014. Throughout 2016, additional jurisdictions were added to the pilot and currently AR is delivered in 57 counties. While statistically significant outcomes are premature, data reported through CQI, case reviews and the CCFL Interim Analyses indicate AR has the capacity to achieve the intended goals of enhancing child and family well-being, children can safely remain in their home and families have access to timely services. DCFS looks forward to sharing the CCFL Interim Evaluation in the spring of 2017.

Attachments

1. Alternative Response Expansion Plan, Division of Children and Family Services, 10.2016

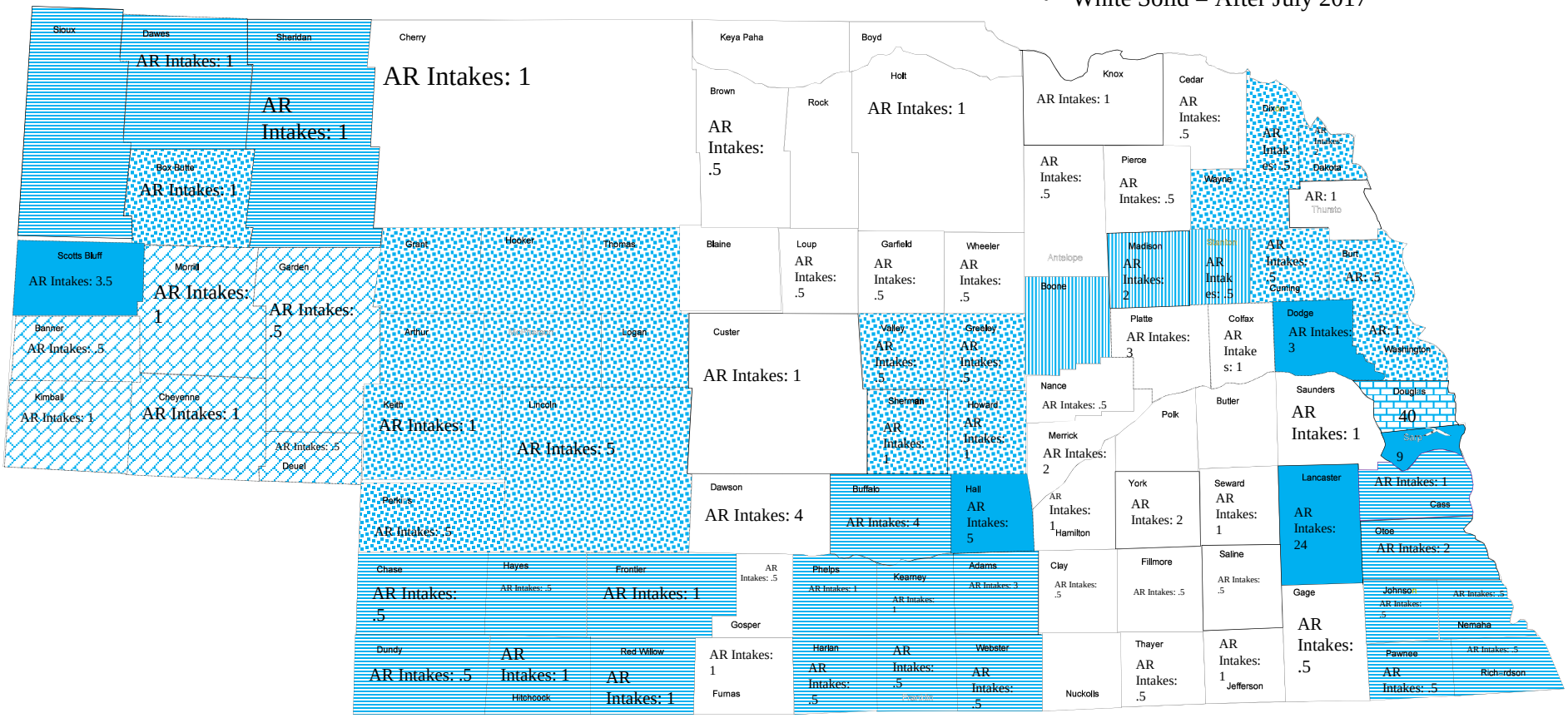
2. Interim Analyses of the Alternative Response Program for Nebraska Children's Commission, The University of Nebraska-Lincoln Center on Children, Families and the Law, 10.11.2016

AR Expansion Plan
(Attachement 1)

N.R.S. 68-1214 (LB 853) "*The department may continue using alternative response until July 1, 2017. Continued use of alternative response thereafter shall require approval of the Legislature.*"

AR Expansion Implementation Dates

- Blue Solid = October 1, 2014
- Blue Diagonal Bricks = January 2016
- Blue Vertical Lines = March 1, 2016
- Blue Dots = April 1, 2016
- Blue Horizontal Lines =July 1, 2016
- Blue Bricks = Douglas County – Zip codes 68107 and 68111 (8/9/16). Full implementation in Douglas County = January 15, 2017.
- White Solid = After July 2017



AR Intake = projected AR Eligible Intakes – post randomizer (based on intake data from Feb, Mar, Apr 2014)
* = Must have legislative approval to continue AR past July 2017

Revised:
11/7/2016

Interim Analyses of the Alternative Response Program for Nebraska Children's Commission

Submitted to
The Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68508

Submitted by
The University of Nebraska–Lincoln
Center on Children, Families, and the Law
206 S. 13th Street, Suite 1000
Lincoln, NE 68508

Submitted October 11, 2016

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

I.NEBRASKA TITLE IV-E WAIVER

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 (UNL-CCFL) to conduct the program evaluation.

II.OBJECTIVE

The purpose of this report is to provide the Nebraska Children's Commission with a preliminary examination of the AR program. Therefore, this report will only focus on UNL-CCFL's evaluation of AR in an effort to aid in the pending legislative decision necessary for continuation past July 2017. Currently, the AR program has been implemented in Nebraska for nearly two years. At this point in the demonstration, analyses of some long-term outcome data (e.g., repeat allegations, subsequent substantiations, entries into out-of-home care) would be premature, as these outcomes tend to occur infrequently, especially within the AR target population, requiring more time for these data to accrue. However, processes related to the implementation of AR and intermediate outcome data have been examined; these are the focus of this report. The data summarized in this report cover the period of October 1, 2014 through June 30, 2016. The following processes and intermediate outcomes are summarized in this report:

- Summary of the AR program
- Summary of the AR evaluation
- AR eligibility processes
    - Exclusionary criteria analyses
    - RED team analyses
- Demographics
- Response reassignments
- Safety and Risk Assessment analyses
- Summary of family needs and services provided
- Summary of family engagement, protective factors, and well-being

III. INTRODUCTION

Summary of AR Program

DCFS began implementation of AR on October 1, 2014. As stated in the DCFS AR Program Manual (dated July 2016), the AR program was "designed to partner with families to increase safety and lower the likelihood of future abuse or neglect to children while helping families and communities connect." In a traditional response (TR), allegations of child abuse or neglect are formally investigated, a finding is determined, a victim and perpetrator are identified, and, if the allegation is substantiated, the parties' names will be entered on the central registry of child protection cases. By contrast, "in AR there is not a formal investigation or finding as to whether child abuse or neglect has occurred, no labels, no parties will have their names entered on the central registry of child protection cases (Neb. Rev. Stat. § 28-710, 28-712.01 and 28-718), and most importantly, services and supports are voluntary once the Department has established safety and the comprehensive assessment is complete" (AR Program Manual, July 2016). The goal of DCFS is to work with families through AR to enhance families' protective factors, connect families with local community resources, and enable families to find sustainable solutions whenever future needs or crises arise.

Summary of AR Evaluation

In accordance with Nebraska's Waiver Terms & Conditions, AR is being evaluated through a randomized controlled trial. Meaning, after initial eligibility is determined, cases are randomly assigned to either AR or TR and all AR-eligible families are included in the evaluation. AR-eligible cases assigned to TR constitute the control group, allowing UNL-CCFL to draw conclusions about the effect of AR on key child and family outcomes when compared to traditional case practice. To assess the processes, outcomes, and costs associated with AR, UNL-CCFL has compiled and examined a variety of data sources. Refer to Appendix A, *Summary of Evaluation Data Sources,* for detailed information about these data sources.

IV. ELIGIBILITY

The AR evaluation includes any family that does not meet one or more of the exclusionary criteria outlined by DCFS. Additionally, some families may be eligible for AR based on the decision of a Review, Evaluation, and Decide (RED) team. Staff of the centralized hotline unit use the exclusionary criteria to determine whether a case is eligible for AR or in need of further review by a RED team. Any intake accepted for assessment that alleges one (or more) of the 22 exclusionary criteria will be automatically assigned to TR and will be excluded from the AR evaluation. Any intake accepted for assessment that alleges one (or more) of the 8 RED team criteria will be flagged for further review. Any intake that does not allege any of the exclusionary or RED team criteria will be automatically designated as AR eligible and will be included in the evaluation.

After AR eligibility is determined, intakes are randomly assigned to either AR or TR at a 1:1 ratio. This process is automated through the state's administrative data system (N-FOCUS). Random assignment is commonly considered the gold standard of evaluation. One main benefit of this research method is that it removes a primary source of bias regarding the response assignment process. This increases the

likelihood that families assigned to either AR or TR are similar and should allow for any observed differences between the two groups to be more confidently attributed to effects of AR. A flowchart on the following page details the AR case assignment process.

Exclusionary Criteria Analyses

To examine the use of AR exclusionary criteria over time, all intakes for the initial 5 pilot counties (Dodge, Hall, Lancaster, Sarpy, and Scotts Bluff) were examined. The most frequently selected exclusionary criteria were those related to domestic violence, use of controlled substances, and prior substantiations. An exclusionary criterion in at least one of these categories was selected in nearly three quarters of the intakes. Overall, 86% of intakes were excluded, meaning only 14% of intakes were eligible for AR. Refer to Appendix B, *Exclusionary Criteria Analyses*, for detailed frequencies of the overall and individual exclusionary criterion applied over time.

RED Team Analyses

RED Team Criteria Analyses

To examine the use of RED team criteria over time, all intakes for the initial 5 pilot counties (Dodge, Hall, Lancaster, Sarpy, and Scotts Bluff) were examined. Overall, only 3% of intakes had a RED team criterion applied. The most frequently selected RED team criterion was related to physical abuse that did not rise to the level of the exclusionary criterion. Refer to Appendix C, *RED Team Analyses*, for detailed frequencies of the overall and individual RED team criterion applied over time.

RED Team Process Analyses

According to RED team documentation provided by DCFS, the RED team reviewed an average of 15 intakes per month since the beginning of implementation. On average, 2 intakes were reviewed per meeting (ranging from 1 to 5). Additionally, meetings included 4 individuals and lasted approximately 6.5 minutes per intake, on average. Refer to Appendix C, *RED Team Analyses*, for more information.

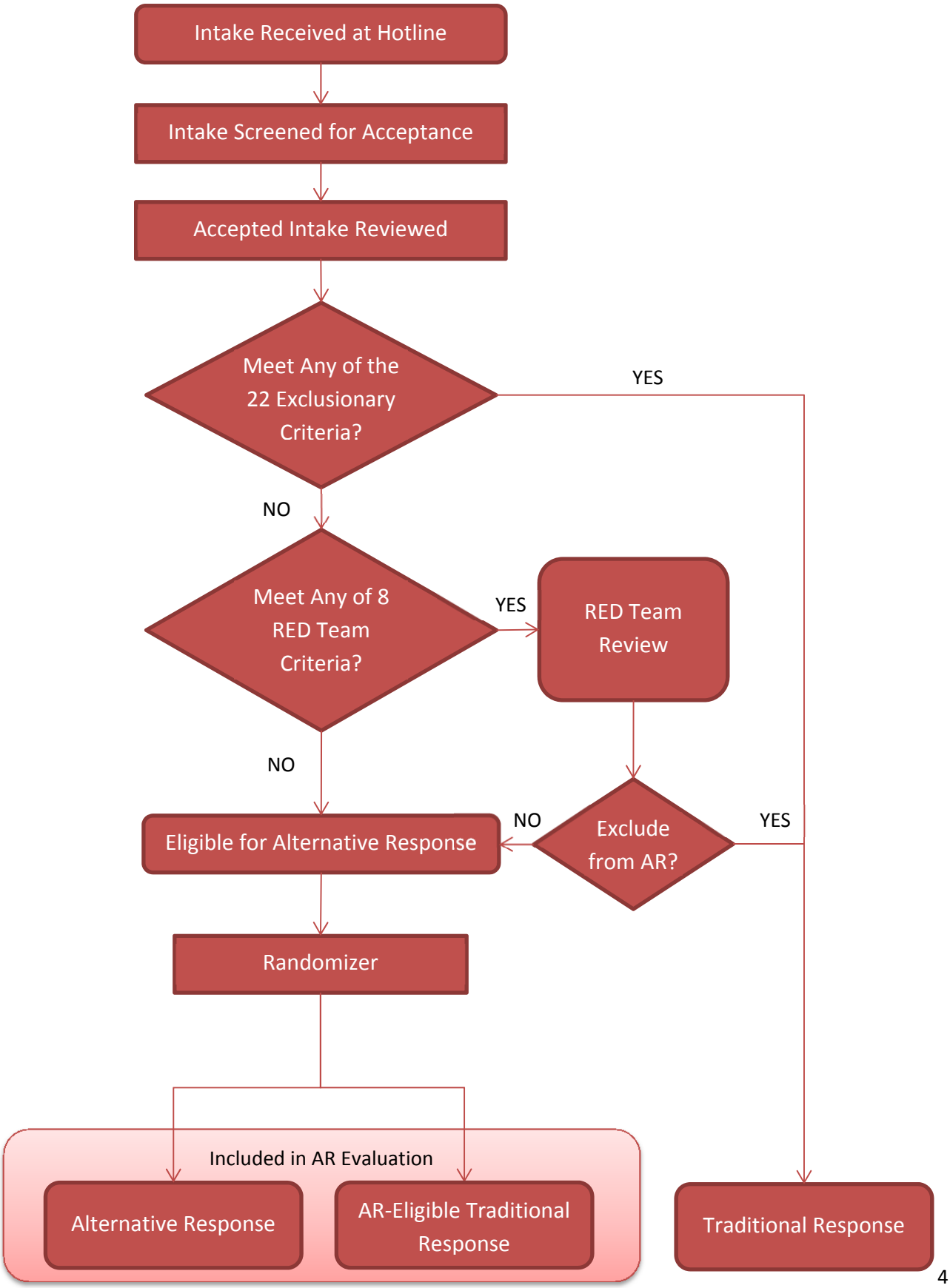
V. DEMOGRAPHICS OF AR-ELIGIBLE FAMILIES

Demographics were assessed to gain a better understanding of the types of families that are being deemed eligible for AR. The demographic variables assessed include gender, age, race, and allegation type. Overall, AR-eligible children appear equally distributed between males and females and fairly well spread between age groups, with the largest percentage of children aged between 4 and 7 years old. Additionally, most AR-eligible children are White (74%) and are brought to the attention of DCFS for allegations of physical neglect (73%). Refer to Appendix D, *Demographic Variables Analyses*, for more information.

VI. RESPONSE REASSIGNMENT

If circumstances change or information is learned about the family after the initial intake that warrants heightened concerns, the family may be reassigned from AR to TR. DCFS has outlined 5 specific circumstances which require a response reassignment. Additionally, some families may switch tracks

Alternative Response Case Assignment Process



based on the decision of a RED team. If a family is reassigned from AR to TR, the reason is documented on N-FOCUS. To examine the reasons for response reassignments over time, all AR cases for the initial 5 pilot counties (Dodge, Hall, Lancaster, Sarpy, and Scotts Bluff) were examined. Overall, approximately 12% of AR cases were reassigned to TR. The most frequent reason was that new information was learned about the family after the initial intake that would have otherwise excluded them from participating in AR. Refer to Appendix E, *Frequency of Response Reassignment Reasons,* for detailed frequencies of the overall and individual response reassignment reasons selected over time.

VII. SAFETY AND RISK

All AR-eligible families are assessed for safety and risk level. The overwhelming majority of AR-eligible families (97% of AR and 95% of TR) were found to be safe, compared to conditionally safe or unsafe. No significant differences were observed between AR and TR families in terms of the safety decision, meaning that AR children were found to be as safe as TR children. However, different risk level patterns emerged between AR and TR families; this difference was statistically significant. AR families appeared to be more equally distributed between risk levels (low, moderate, high, and very high), whereas TR families tended to be more frequently rated as moderate. Refer to Appendix F, *Safety and Risk Analyses*, for more in-depth information about the analyses performed.

VIII. NEEDS AND SERVICES

In order to get a complete picture of family needs and the services being used to address these needs, data were examined from a number of sources, including administrative data from N-FOCUS, SharePoint data, Worker Survey data, and Family Survey data (for more information on these data sources, see Appendix A, *Summary of Evaluation Data Sources*).

Family Needs

Based on random assignment, AR and TR families should present with similar types of needs at case opening. To examine this, workers are asked to provide information about the needs of the AR-eligible families (assigned to either AR or TR) that they serve. Over a quarter of families were identified as having none of the needs listed in the Worker Survey. However, for families that presented with needs, the most common needs were related to parenting skills, child's emotional/behavioral adjustment, and the mental health of a child. Looking at the differences between AR and TR families, TR families were more likely to be identified as having needs related to parenting skills and developmental delays/disabilities of an adult compared to AR families. AR families were more likely to be identified as having needs related to the mental health of a child compared to TR families. Both AR and TR workers indicated that they were able to address family needs through their work with the family. Furthermore, both AR and TR workers indicated that they were able to improve the families' needs at least somewhat. Refer to Appendix G, *Needs and Services Analyses*, for more in-depth information about family needs.

Services Provided

DCFS has specified that through AR, workers will have the flexibility to tailor services to meet family needs. To assess this, data about services were examined from a number of sources. Overall, it appears that AR families were more likely to receive services than TR families. AR families also received a greater variety of services than TR families. However, the most common types of services provided were largely the same for AR and TR. For contracted services documented in N-FOCUS, AR and TR families received an average of 2 types of services, with AR families' service costs totaling $4,343 per family and TR families' service costs totaling $3,105 per family (this difference is not statistically significant). Additional service information was provided by AR workers for AR families (similar information is not provided for TR cases). This information revealed an average cost of $658 per family for AR families not receiving other services through a DCFS contract. However, most of these services are still being paid for by DCFS, with the majority of services being used to address concrete supports for parents. According to the worker survey, the most commonly provided services for AR and TR families were related to mental health, social support services, and services to address material needs. Overall, the most common categories of service providers were mental health providers, schools, and neighbors/friends/extended family for both AR and TR families. Refer to Appendix G, *Needs and Services Analyses*, for more in-depth information about services provided.

Timeliness of Services

DCFS has hypothesized that through AR, families will receive services and supports to address their specific needs sooner. To test the hypothesis regarding timeliness of services (the match between services and needs is addressed in the section below), UNL-CCFL examined administrative data and collected survey data from AR-eligible families and the workers that they worked with. Based on these collective data, AR families appear to receive services sooner than TR families. In order to assess the timeliness of services using N-FOCUS, the amount of time from the initial report to the receipt of a service was calculated. According to these data, AR families received services approximately one week sooner than TR families (although this difference was not statistically significant). According to the worker survey, AR families were significantly more likely to receive services sooner than TR families, with more AR families receiving services within 2 weeks of the initial report. If TR families received support or services, it was significantly more likely to have already been in place prior to DCFS involvement (compared to AR families). Additionally, TR families were significantly more likely to only have been provided information about a support or service compared to AR families. From the family's perspective, most families (both AR and TR) indicated that they received support or services when they needed it; however, AR families reported this significantly more often than TR families. Refer to Appendix G, *Needs and Services Analyses*, for more in-depth information service timeliness.

Match Between Services and Family Needs

DCFS has hypothesized that through AR, families will receive services and supports to address their specific needs sooner. To test the hypothesis regarding the match between services and needs, UNL-CCFL collected survey data from AR-eligible families and the workers that they worked with. Most workers reported that they were able to match services to the needs of the family; however, AR workers reported a significantly greater degree of match compared to TR families. Additionally, the majority of

families indicated that they received the help that they needed. AR families reported this more frequently than TR families, but the difference was not statistically significant. AR families also more frequently reported the support and services they received as both the kind of help they needed and enough to really help them; although again, these differences were not statistically significant. Refer to Appendix G, *Needs and Services Analyses*, for more in-depth information about the match between services and family needs.

Barriers to Providing Services

UNL-CCFL also examined potential barriers workers may have experienced in their provision of services for families. Across all AR-eligible families assigned to either AR or TR, nearly half of workers indicated no barriers were experienced. However, for those workers that experienced barriers to providing services, the most common barriers were worker caseload, followed by limited staff time to work with families, and other pressing cases on their caseload. Furthermore, AR workers reported barriers related to caseload and limited time to work with families significantly more than TR workers. Refer to Appendix G, *Needs and Services Analyses*, for more in-depth information about barriers to providing services.

IX. FAMILY ENGAGEMENT, PROTECTIVE FACTORS, AND WELL-BEING

Family Engagement

DCFS has hypothesized that through AR, families will feel respected and engage with their worker. To test this hypothesis, UNL-CCFL has collected survey data from AR-eligible families and the workers that they worked with. Both the worker and the family surveys include an adapted version of Yatchmenoff's Client Engagement Scale, which includes 4 subscales to measure 1) receptivity, 2) buy-in, 3) working relationship, and 4) mistrust. Ultimately, these 4 subscales are summed into a total score of Engagement. AR families were higher in Buy-In and overall Engagement than TR families from both the family's and the worker's perspectives. These differences were statistically significant according to worker survey data, but not according to family survey data. Additionally, TR families' scores indicated higher levels of Mistrust than AR families. Again, these results were statistically significant according to worker survey data, but not according to family survey data. Working Relationship was more positive for AR families than TR families from the family perspective, although not statistically significant; however, Working Relationship was reported at similar levels by AR and TR workers. Finally, levels of Receptivity were higher for AR families than TR families from the worker's perspective, although not statistically significant; however, similar levels of Receptivity were reported by AR and TR families. Refer to Appendix H, *Family Engagement, Protective Factors, and Well-Being Analyses* for more in-depth information about the family engagement analyses performed.

Protective Factors

DCFS has hypothesized that protective factors will be enhanced through AR. To test this hypothesis, UNL-CCFL has collected family-level survey data related to family protective factors for all AR-eligible families. These data are collected through the family survey, which is completed at the end of the case for all AR-eligible families. Because families are randomly assigned to AR or TR, it would be expected that protective factors should, on average, present at the same level at the beginning of the case for

both AR and TR families. Therefore, any difference at the end of the case should be due to the type of response that family received. According to families' responses, no significant differences were observed between AR and TR families on any of the protective factors after their involvement with DCFS. Refer to Appendix H, *Family Engagement, Protective Factors, and Well-Being Analyses* for more in-depth information about the protective factor analyses performed.

Well-Being

DCFS has hypothesized that child well-being will be enhanced through AR. To test this hypothesis, UNL-CCFL has collected child-level survey data related to well-being for all AR-eligible families. These data are collected through the worker survey, which is completed at the end of the case for all AR-eligible families. Similar to protective factors, because families are randomly assigned to AR or TR, it would be expected that well-being should, on average, present at the same level at the beginning of the case for both AR and TR families. Therefore, any difference at the end of the case should be due to the type of response that family received. According to workers' responses, AR children were perceived to have significantly lower hyperactivity (e.g., restless, overactive, cannot stay still for long; easily distracted, concentration wanders) and peer relationship problems (e.g., solitary, prefers to play alone; picked on or bullied by other children) at case closure, compared to TR children. Additionally, AR children were perceived to have significantly higher prosocial behavior (e.g., offers help to others; kind to younger children) at case closure, compared to TR children. All of these significant differences were in the hypothesized direction. Refer to Appendix H, *Family Engagement, Protective Factors, and Well-Being Analyses* for more in-depth information about the well-being analyses performed.

Appendix A

Summary of Evaluation Data Sources

Administrative Data

Information that is regularly collected on all families involved with the Department of Children and Family Services (DCFS) is documented on the Nebraska Family Online Client User System, commonly referred to as N-FOCUS. N-FOCUS is the computer system created by the Department of Health and Human Services to document economic assistance programs, including children and family services. N-FOCUS is a part of the Nebraska Child Welfare Information System (CWIS), which is part of a federally mandated program for State Automated Child Welfare Information Systems (SACWIS). All family case information is to be documented on N-FOCUS. For the purposes of the evaluation, the evaluators at University of Nebraska-Lincoln Center on Children, Families, and the Law (UNL-CCFL) receive regularly scheduled downloads of this information.

Family Survey

The *Family Experience Survey* (family survey) was designed to assess families' satisfaction and relationship with their assigned worker, engagement, protective factors, and overall perceptions of outcomes as a result of involvement with the child welfare system. The family survey was adapted and extended from the family survey originally used by the QIC-DR. Primary caregivers are asked to complete this survey at the end of every AR-eligible case, assigned to either AR or Traditional Response (TR). This survey is administered in English and Spanish. Initially, the family survey was sent via U.S. mail, along with a postage-paid envelope for the survey's return. As an incentive, each family received a $10 Walmart gift card upon receipt of their completed survey. However, due to low response rates, UNL-CCFL modified the protocol to increase the survey's access and incentives. Beginning in July 2015, families with provided email addresses were asked to complete the survey online. If online responses were not received, then a paper survey was mailed to the family. Then, beginning at the end of October 2015, an anonymous link was added to the informed consent letter mailed out with the paper surveys, allowing for families to complete the survey online, if they preferred. Additionally, the incentive was increased from a $10 Walmart gift card to a $20 Walmart gift card and respondents have a chance to win a $100 Walmart gift card, which is raffled off every 6 months. The overall response rate for the family survey is 20%.

Protective Factors and Well-Being Questionnaire

At the request of DCFS, UNL-CCFL assisted the Alternative Response (AR) leadership with the development of an adapted version of the FRIENDS National Center's Protective Factors Survey, entitled the *Nebraska DCFS Protective Factors Questionnaire*. This survey was designed to assess families' protective factors and includes the following domains: social connections, concrete supports for parents, parental resilience, knowledge of parenting and child development, nurturing and attachment, and the social and emotional competence of the children. This original version of the Protective Factors Questionnaire (PFQ) was in practice from October 2014 through June 2015. New AR guidelines were released in the AR Program Manual in July 2015. At this same time, an updated version of the PFQ, now

titled the *Nebraska DCFS Protective Factors and Well-Being Questionnaire*, was introduced. The Protective Factors and Well-Being Questionnaire (PFWBQ) expanded upon the PFQ to include the measurement of well-being. The additional well-being items were taken or adapted from the *Child Protection Best Practices Well-Being Checklist* developed by the New Mexico Court Improvement Project and the *Strength and Difficulties Questionnaire*. This form is to be completed with AR families at the beginning of their case, and should be re-administered every 90 days throughout an AR case. Overall, 57% of AR cases have completed PFQ/PFWBQ data.

SharePoint Database

AR workers are asked to document additional service information in a SharePoint database housed on the DCFS intranet. This spreadsheet includes information about the types of services being provided, service providers, support categories (e.g., transportation, food, housing), service costs, funding sources, and protective factors. For this reporting period, AR workers were expected to document this information for all services provided to AR families, including information about services provided by DCFS and services donated from the community. These data are not collected for AR-eligible TR cases.

Worker Survey

The *Worker End-of-Case Survey* (worker survey) was designed to assess workers' perceptions of their relationship with the family, the needs of the family, services provided, changes in protective factors, and estimates of time spent on the case. The original version of the worker survey was in practice from December 2014 through June 2015. When the updated PFWBQ was implemented in July 2015, the same well-being items were added to and implemented with the worker survey. The worker survey was adapted and extended from the worker survey originally used by the QIC-DR and the well-being items were taken or adapted from the *Child Protection Best Practices Well-Being Checklist* developed by the New Mexico Court Improvement Project and the *Strengths and Difficulties Questionnaire*. Workers are asked to complete this survey at the end of every AR-eligible case, assigned to either AR or TR, and are encouraged to consult N-FOCUS to refresh their memory about the specific case, if needed. A survey link is emailed to the worker after case closure. Two follow-up reminder emails are sent for missing or incomplete responses. DCFS leadership encourages staff to complete these surveys. The overall response rate for the worker survey is 73%.

Appendix B

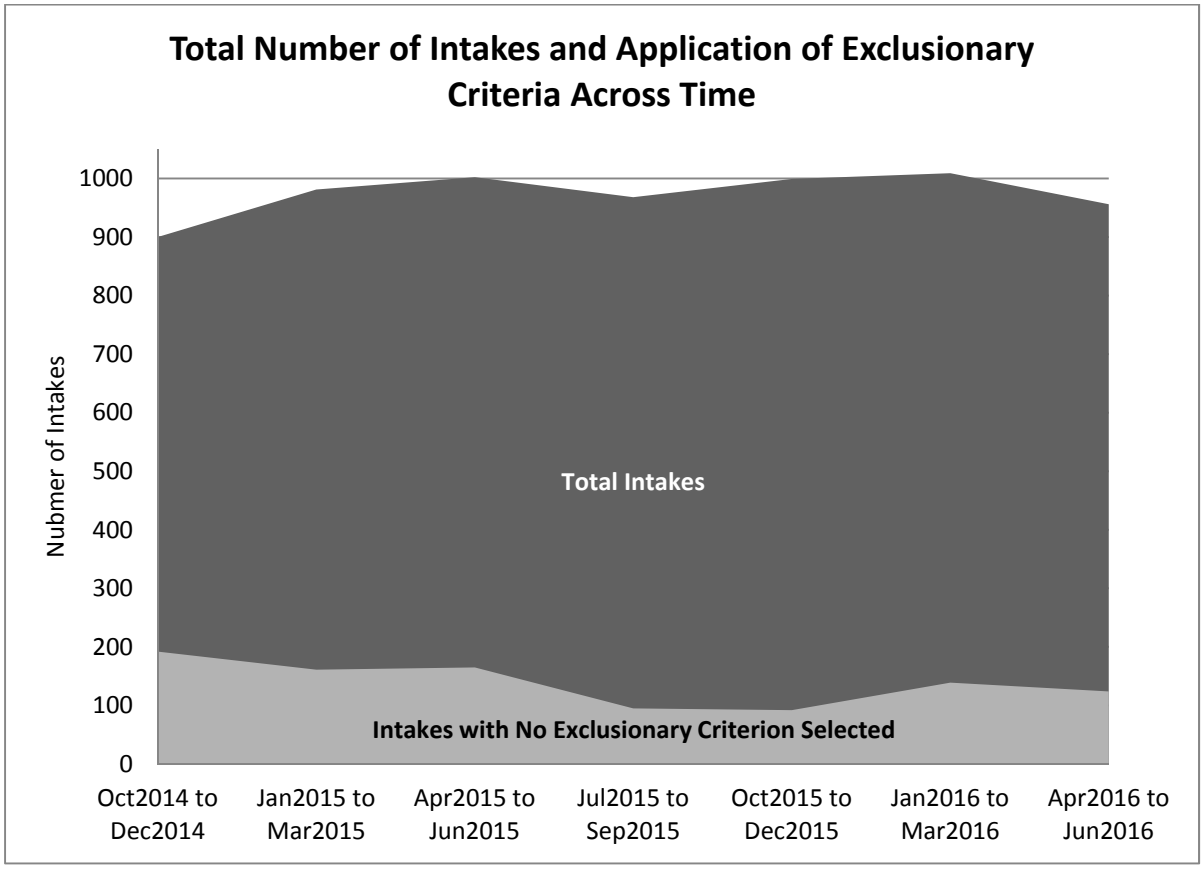
Exclusionary Criteria Analyses

In order to assess the application of the exclusionary criteria over time, only data from the original 5 pilot counties (Dodge, Hall, Lancaster, Sarpy, and Scotts Bluff) were included. These data were obtained from DCFS administrative data on all intakes accepted for assessment (for more information on this data source, see Appendix A, *Summary of Evaluation Data Sources*).

The following table summarizes 1) the number and percentage of intakes with no exclusionary criterion selected, 2) the number and percentage of intakes with one or more exclusionary criterion selected, and 3) the total number of intakes received and accepted for each quarter and overall for the original 5 pilot counties.

	Oct2014 to Dec2014	Jan2015 to Mar2015	Apr2015 to Jun2015	Jul2015 to Sep2015	Oct2015 to Dec2015	Jan2016 to Mar2016	Apr2016 to Jun2016	Total
No Exclusionary Criterion Selected	192 (21%)	161 (16%)	165 (17%)	95 (10%)	92 (9%)	139 (14%)	124 (13%)	968 (14%)
At Least 1 Exclusionary Criterion Selected	708 (79%)	820 (84%)	837 (83%)	873 (90%)	907 (91%)	870 (86%)	832 (87%)	5847 (86%)
Total	900	981	1002	968	999	1009	956	6815

The following graph displays the number of intakes received and accepted along with the number of intakes with no exclusionary criterion selected for the original 5 pilot counties.



The following table details the frequencies of specific exclusionary criterion selected, including 1) the total number of intakes received and accepted (N) and 2) the number and percentage of intakes for each criterion selected for each quarter and overall. Additionally, similar exclusionary criteria were categorized by topic (far left) and the overall number and percentage of intakes for that category are presented in the final column (far right). Percentages indicate the percent of total intakes that had that exclusionary criterion selected. Please note that each intake could have multiple exclusionary criteria apply, therefore the sum of percentages may total over 100%.

	Exclusionary Criterion	Oct2014 to Dec2014 N=900	Jan2015 to Mar2015 N=981	Apr2015 to Jun2015 N=1002	Jul2015 to Sep2015 N=968	Oct2015 to Dec2015 N=999	Jan2016 to Mar2016 N=1009	Apr2016 to Jun2016 N=956	Total by Criterion N = 6815	Total by Category N = 6815
Physical Abuse	1.i. Physical abuse of a child under the age of six involving an injury to the head or torso	36 (4%)	32 (3%)	31 (3%)	23 (2%)	27 (3%)	22 (2%)	14 (2%)	185 (3%)	6%
	1.ii. Physical abuse of a child with a disability	8 (1%)	3 --	5 (1%)	8 (1%)	14 (1%)	13 (1%)	10 (1%)	61 (1%)	
	1.iii. Physical abuse of a child which resulted in serious bodily injury to a child as defined in Neb. Rev. Stat. § 28-109(20)	23 (3%)	20 (2%)	15 (2%)	11 (1%)	20 (2%)	27 (3%)	19 (2%)	135 (2%)	
	1.iv. Physical abuse of a child is likely to cause death or severe injury to a child	5 1%	6 (1%)	7 (1%)	4 --	2 --	4 --	4 --	32 --	
DV	2. Domestic violence involving a caretaker and the alleged perpetrator has access to the child or caretaker	173 (19%)	206 (21%)	199 (20%)	237 (25%)	282 (28%)	212 (21%)	190 (20%)	1499 (22%)	22%
Sexual Abuse	3. Sexual assault of a child as defined in Neb. Rev. Stat. §§ 28-319.01, 28-320.01	39 (4%)	52 (5%)	57 (6%)	61 (6%)	48 (5%)	41 (4%)	51 (5%)	349 (5%)	6%
	4. Sex trafficking of a minor as defined in Neb. Rev, Stat. §§ 28-830(14), 28-831(3)						2 --	1 --	3 --	
	5. Sexual exploitation of a child as defined in Neb. Rev. Stat. §28-707(d)	3 --	4 --	1 --	1 --	4 --	8 (1%)	5 (1%)	26 --	
Serious Neglect	6. Neglect of a child resulting in serious bodily injury as defined in Neb. Rev. Stat. § 28-109(20)	4 --	4 --	6 (1%)	7 (1%)	2 --	3 --	5 (1%)	31 --	0%

	Exclusionary Criterion	Oct2014 to Dec2014 N=900	Jan2015 to Mar2015 N=981	Apr2015 to Jun2015 N=1002	Jul2015 to Sep2015 N=968	Oct2015 to Dec2015 N=999	Jan2016 to Mar2016 N=1009	Apr2016 to Jun2016 N=956	Total by Criterion N = 6815	Total by Category N = 6815
Requires coordination	7. Requires Child Advocacy Center, Law Enforcement, and Department coordination (Neb. Rev. Stat. § 28-728(3)(d)(iii))	59 (7%)	64 (7%)	58 (6%)	55 (6%)	68 (7%)	69 (7%)	79 (8%)	452 (7%)	7%
Child death	8. A household member allegedly caused the death of a child	3 --	0 --	0 --	0 --	0 --	0 --	0 --	3 --	0%
Drug Positive Newborn	9.i. Newborn whose urine or meconium has tested positive for alcohol AND whose caretaker has an alcohol addiction	5 (1%)	5 (1%)	4 --	3 --	7 (1%)	0 --	0 --	24 --	1%
	9.ii. Newborn whose urine or meconium has tested positive for alcohol AND whose caretaker previously delivered a drug-exposed infant and did not successfully complete drug treatment	3 --	0 --	1 --	2 --	0 --	1 --	0 --	7 --	
	9.iii. Newborn whose urine or meconium has tested positive for alcohol AND whose caretaker did not prepare for the newborn's birth	0 --	1 --	2 --	0 --	1 --	0 --	0 --	4 --	
	9.iv. Newborn whose urine or meconium has tested positive for alcohol AND whose caretaker currently uses controlled substances as defined by Neb. Rev. Stat. § 28-401 or alcohol AND breastfeeds or expresses intent to breastfeed	1 --	2 --	2 --	5 (1%)	2 --	12 (1%)	10 (1%)	34 --	
	9.v. Newborn whose urine or meconium has tested positive for alcohol AND whose caretaker has no in-home support system or alternative primary care arrangements	0 --	1 --	1 --	0 --	0 --	0 --	0 --	2 --	

	Exclusionary Criterion	Oct2014 to Dec2014 N=900	Jan2015 to Mar2015 N=981	Apr2015 to Jun2015 N=1002	Jul2015 to Sep2015 N=968	Oct2015 to Dec2015 N=999	Jan2016 to Mar2016 N=1009	Apr2016 to Jun2016 N=956	Total by Criterion N = 6815	Total by Category N = 6815
Use of controlled substance	10. Household member uses or manufactures methamphetamine or other controlled substances as defined in Neb. Rev. Stat. §§ 28-401, 28-405	165 (18%)	206 (21%)	183 (18%)	241 (25%)	259 (26%)	241 (24%)	215 (23%)	1510 (22%)	25%
	11. Pregnant woman who has tested positive for methamphetamine or other controlled substance as defined in Neb. Rev. Stat. §§ 28-401, 28-405	17 (2%)	15 (2%)	22 (2%)	22 (2%)	15 (2%)	13 (1%)	4 --	108 (2%)	
	12. Child who has had contact with methamphetamine or other controlled substance as defined by Neb. Rev. Stat. §§ 28-401, 28-405, including a positive meconium or hair follicle screen or test	20 (2%)	16 (2%)	11 (1%)	25 (3%)	16 (2%)	17 (2%)	12 (1%)	117 (2%)	
Previous TPR/Relinq	13. Child who resides with a household member whose parental rights have been terminated or relinquished during a court-involved case	9 (1%)	6 (1%)	6 (1%)	8 (1%)	7 (1%)	11 (1%)	6 (1%)	53 (1%)	1%
Current System Involvement	14.i. Abuse or neglect of a child who resides with the subject of an active traditional response investigation	30 (3%)	59 (6%)	61 (6%)	55 (6%)	67 (7%)	49 (5%)	58 (6%)	379 (6%)	11%
	14.ii. Abuse or neglect of a child who resides with an individual or family that is receiving services through the DCFS Protection and Safety	51 (6%)	53 (6%)	40 (4%)	53 (6%)	42 (4%)	32 (3%)	26 (3%)	297 (4%)	
	14.iii. Abuse or neglect of a child who resides with an individual or family who is involved in a juvenile court petition pursuant to Neb. Rev. Stat. § 43-247(3)(a)	N/A	N/A	N/A	N/A	3 --	23 (2%)	32 (3%)	58 (1%)	
Out of Home	15. Abuse or neglect has occurred in an out-of-home setting	33 (4%)	27 (3%)	26 (3%)	34 (4%)	28 (3%)	15 (2%)	26 (3%)	189 (3%)	3%

	Exclusionary Criterion	Oct2014 to Dec2014 N=900	Jan2015 to Mar2015 N=981	Apr2015 to Jun2015 N=1002	Jul2015 to Sep2015 N=968	Oct2015 to Dec2015 N=999	Jan2016 to Mar2016 N=1009	Apr2016 to Jun2016 N=956	Total by Criterion N = 6815	Total by Category N = 6815
Prior Substantiation	16. Household member has a prior court substantiated report of child abuse or neglect OR is a sex offender	103 (11%)	128 (13%)	127 (13%)	144 (15%)	139 (14%)	129 (13%)	101 (11%)	871 (13%)	27%
	17. Household member appears on the central registry of child protection cases under Neb. Rev. Stat. § 28-720	128 (14%)	152 (16%)	150 (15%)	141 (15%)	146 (15%)	128 (13%)	115 (12%)	960 (14%)	
Young Child(ren) w/ Repeat Allegation	18. 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	6 (1%)	4 --	4 --	5 (1%)	1 --	15 (2%)	8 (1%)	43 (1%)	1%
Unknown Info	19. Child whose caretaker's identity or whereabouts are unknown	16 (2%)	6 (1%)	12 (1%)	22 (2%)	17 (2%)	15 (2%)	12 (1%)	100 (1%)	1%
Law Enforcement Involvement	20. Law enforcement has cited a caretaker for the child abuse or neglect alleged in the intake accepted for assessment	73 (8%)	89 (9%)	76 (8%)	94 (10%)	74 (7%)	91 (9%)	80 (8%)	577 (8%)	14%
	21. Department is made aware by law enforcement of an ongoing law enforcement investigation involving a household member	33 (4%)	48 (5%)	61 (6%)	61 (6%)	72 (7%)	54 (5%)	45 (5%)	374 (5%)	
24-Hour Response	22. A safety concern is otherwise identified which requires Department intervention within 24 hours	1 --	2 --	4 --	1 --	9 (1%)	51 (5%)	66 (7%)	134 (2%)	2%

Appendix C

RED Team Analyses

In order to assess the application of the RED team criteria over time, only data from the original 5 pilot counties (Dodge, Hall, Lancaster, Sarpy, and Scotts Bluff) were included. These data were obtained from DCFS administrative data on all intakes accepted for assessment (for more information on this data source, see Appendix A, *Summary of Evaluation Data Sources*).

RED Team Criteria Analyses

The following table summarizes 1) the number and percentage of intakes with no RED team criterion selected, 2) the number and percentage of intakes with one or more RED team criterion selected, and 3) the total number of intakes received and accepted for each quarter and overall for the original 5 pilot counties.

	Oct2014 to Dec2014	Jan2015 to Mar2015	Apr2015 to Jun2015	Jul2015 to Sep2015	Oct2015 to Dec2015	Jan2016 to Mar2016	Apr2016 to Jun2016	Total
No RED Team Criterion Selected	883 (98%)	962 (98%)	979 (98%)	939 (97%)	958 (96%)	967 (96%)	904 (95%)	6592 (97%)
At Least 1 RED Team Criterion Selected	17 (2%)	19 (2%)	23 (2%)	29 (3%)	41 (4%)	42 (4%)	52 (5%)	223 (3%)
Total Intakes	900	981	1002	968	999	1009	956	6815

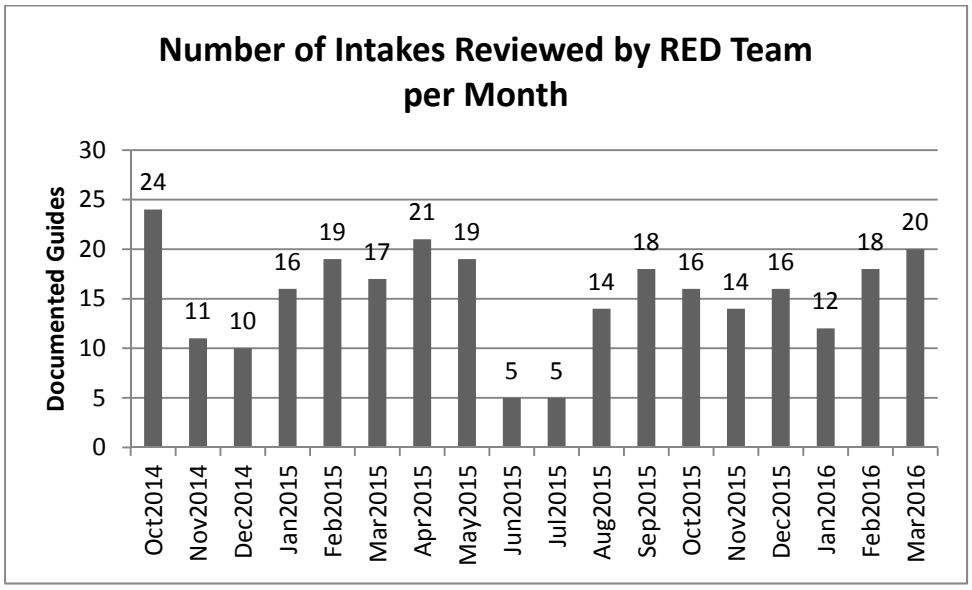
The following table details the RED team criteria selected, including 1) the total number of intakes received and accepted (N) and 2) the number and percentage of intakes for each criterion selected for each quarter and overall. Percentages indicate the percent of total intakes that had that RED team criterion selected. Please note that each intake could have multiple RED team criteria apply.

RED Team Criteria	Oct2014 to Dec2014 N=900	Jan2015 to Mar2015 N=981	Apr2015 to Jun2015 N=1002	Jul2015 to Sep2015 N=968	Oct2015 to Dec2015 N=999	Jan2016 to Mar2016 N=1009	Apr2016 to Jun2016 N=956	Total by Criterion N = 6815
1. Caretaker has a significant mental health diagnosis AND the reporting party is a physician, mental health, or other health care provider	1 --	2 --	1 --	1 --	1 --	0 --	4 --	10 --
2. Caretaker exhibits symptoms related to significant mental illness, including but not limited to, psychotic behaviors, delusional behaviors, and danger to self or others	3 --	3 --	5 (1%)	4 --	1 --	7 (1%)	7 (1%)	30 --

RED Team Criteria	Oct2014 to Dec2014 N=900	Jan2015 to Mar2015 N=981	Apr2015 to Jun2015 N=1002	Jul2015 to Sep2015 N=968	Oct2015 to Dec2015 N=999	Jan2016 to Mar2016 N=1009	Apr2016 to Jun2016 N=956	Total by Criterion N = 6815
3. Caretaker is identified as a current or former state ward	10 (1%)	6 (1%)	6 (1%)	5 (1%)	3 --	5 (1%)	11 (1%)	46 (1%)
4. The family has had another intake accepted for assessment within the past six months AND includes two or more children under the age of five or one child under the age of two	3 --	2 --	1 --	1 --	0 --	2 --	2 --	11 --
5. The family currently receives an alternative response	0 --	3 --	0 --	0 --	0 --	1 --	0 --	4 --
6. Abuse or neglect AND alcohol or other mood altering substance use by a household member AND there are two or more children under the age of five or one child under the age of two	2 --	3 --	1 --	4 --	3 --	2 --	4 --	19 --
7. Physical abuse that does not rise to the level of physical abuse identified in the exclusionary criteria	N/A	N/A	11 (1%)	18 (2%)	35 (4%)	23 (2%)	27 (3%)	114 (2%)
8. Household member or alternative 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	N/A	N/A	N/A	N/A	1 --	7 (1%)	6 (1%)	14 --

RED Team Process Analyses

In order to assess the RED team process, UNL-CCFL reviewed RED team documentation provided by DCFS from October 1, 2014 through March 30, 2016. During this time, an average of 15 intakes were reviewed by the RED team each month. On average, 2 intakes were reviewed per meeting; this ranged from 1 to 5 intakes per meeting. Additionally, meetings included 4 individuals and lasted approximately 6.5 minutes per intake, on average. The total number of intakes reviewed each month is summarized in the graph below.

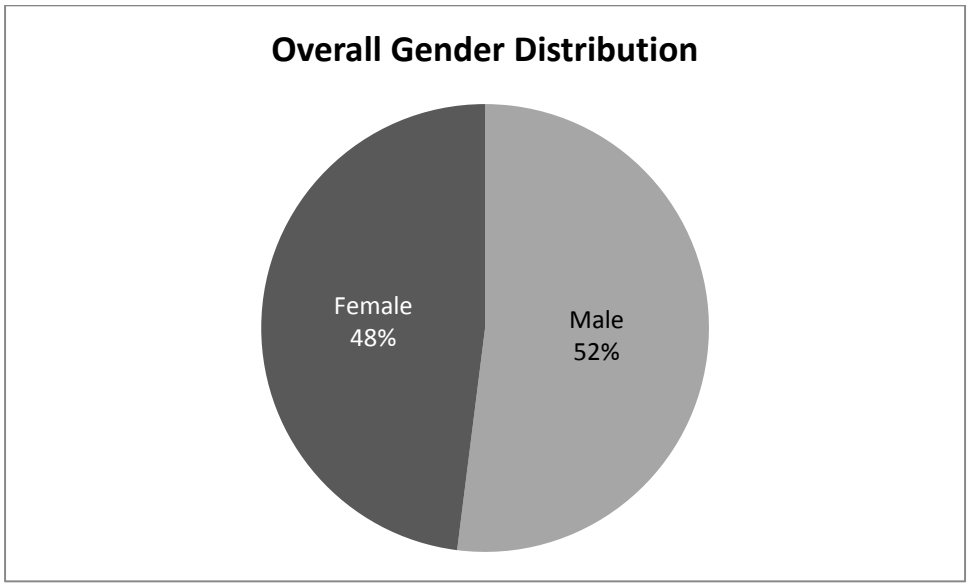


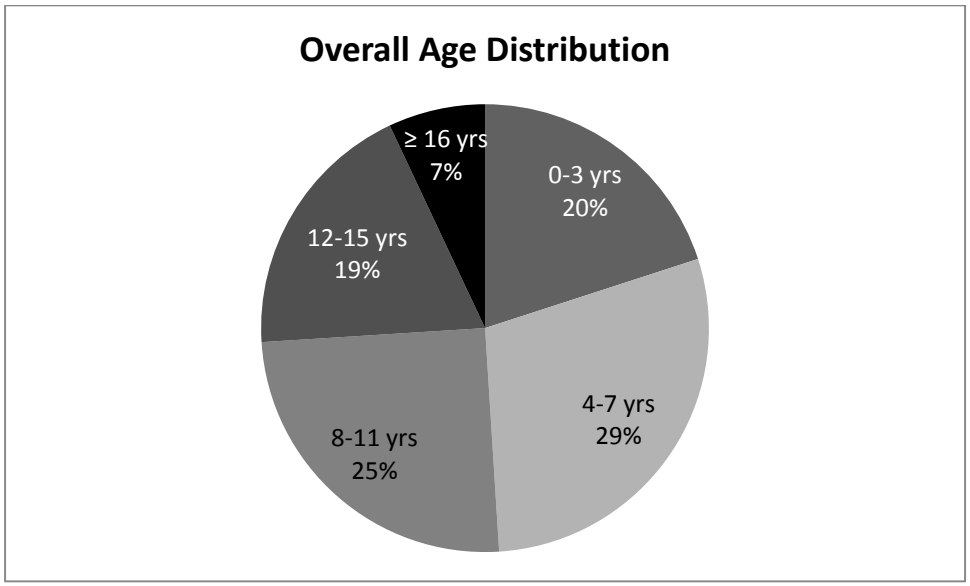
Appendix D

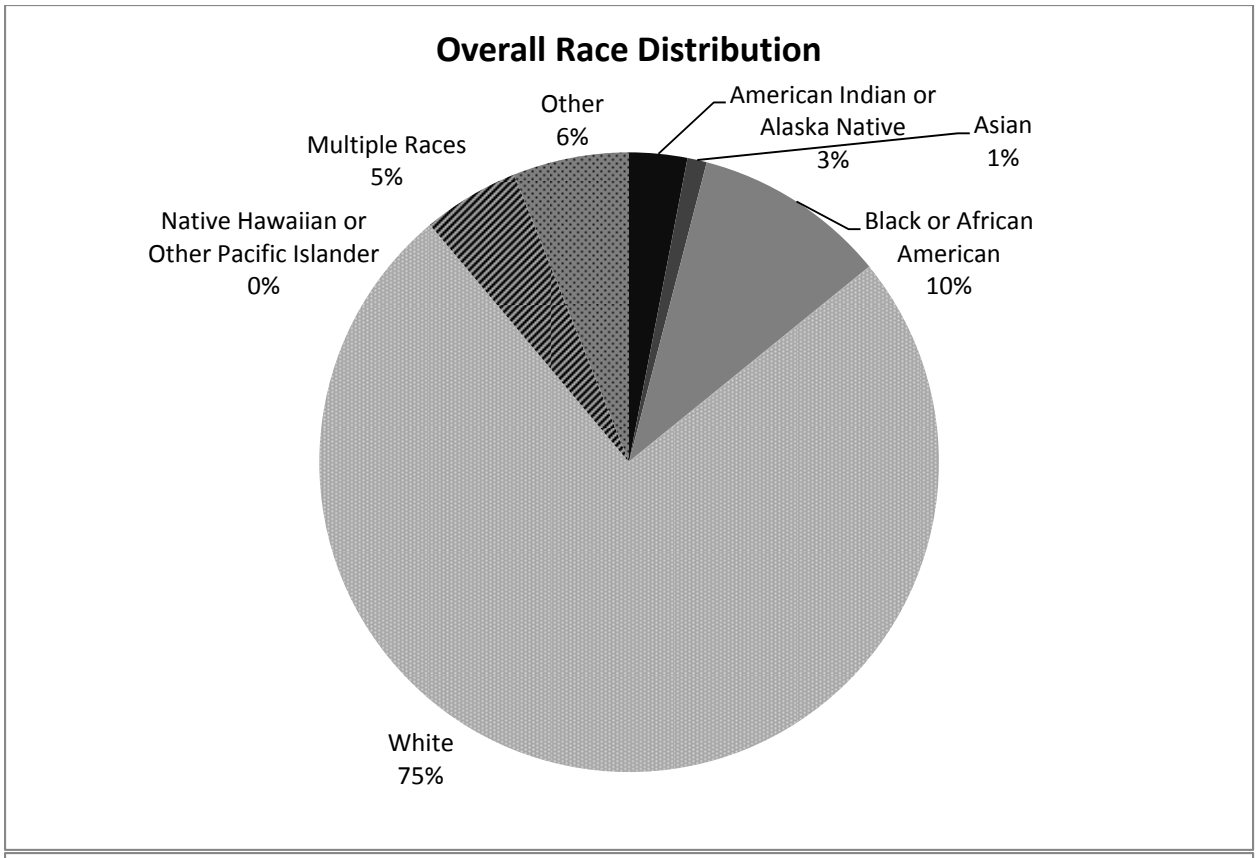
Demographic Variables Analyses

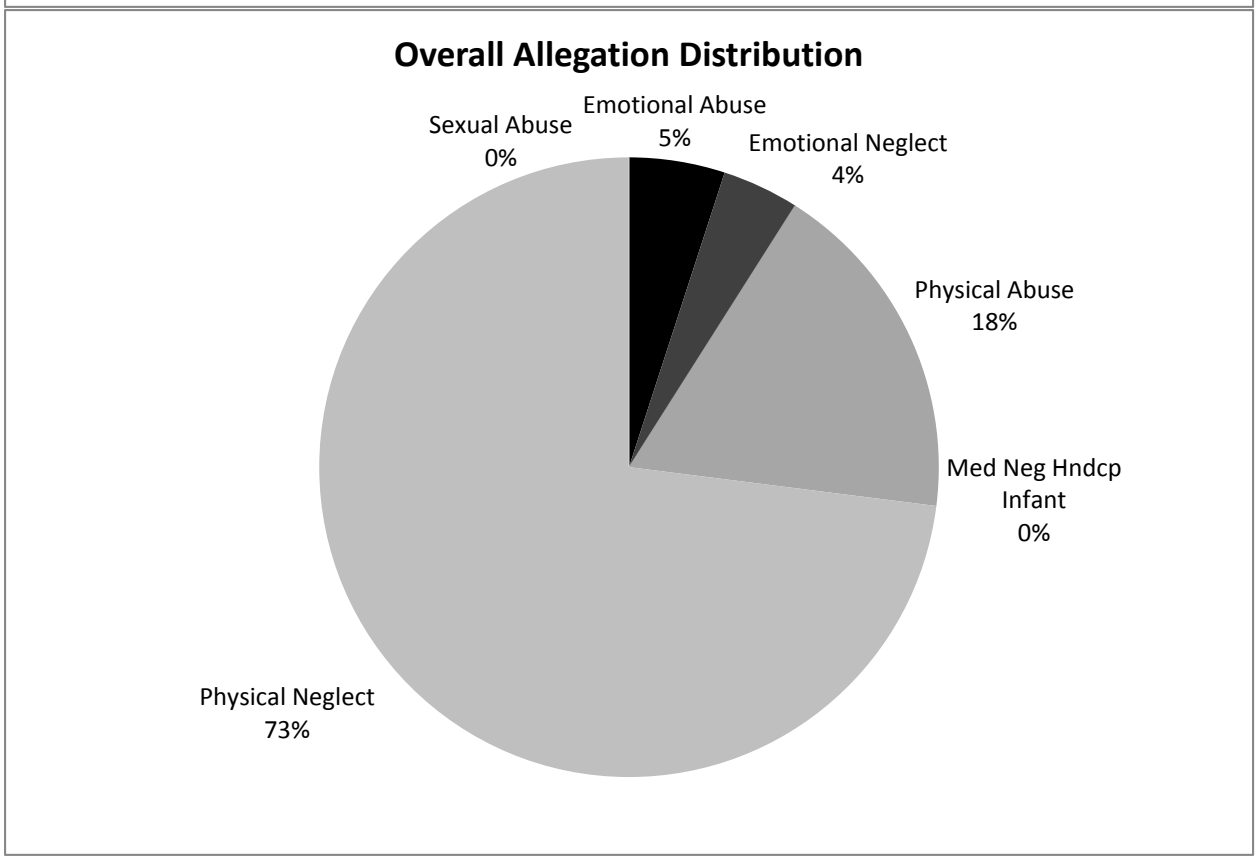
In order to assess demographics, administrative data were examined (for more information on this data source, see Appendix A, *Summary of Evaluation Data Sources*). The demographic variables assessed included gender, age, race, and allegation type.

Overall, AR-eligible children appear equally distributed between males and females and fairly well spread between age groups, with the largest percentage of children aged between 4 and 7 years old. Additionally, most AR-eligible children are White (74%) and are brought to the attention of DCFS for allegations of physical neglect (73%). The following charts display the distributions for gender, age, race, and allegation type for AR-eligible children.






Overall Race Distribution
Other
6%
American Indian or
Alaska Native
3%
Asian
1%
Multiple Races
5%
Native Hawaiian or
Other Pacific Islander
0%
Black or African
American
10%
White
75%


Overall Allegation Distribution
Sexual Abuse
0%
Emotional Abuse
5%
Emotional Neglect
4%
Physical Abuse
18%
Med Neg Hndcp
Infant
0%
Physical Neglect
73%

Appendix E

Frequency of Response Reassignment Reasons

In order to assess the frequencies of the response reassignment reasons selected over time, only data from the original 5 pilot counties (Dodge, Hall, Lancaster, Sarpy, and Scotts Bluff) were included. These data were obtained from DCFS administrative data on all intakes accepted for assessment (for more information on this data source, see Appendix A, *Summary of Evaluation Data Sources*).

The following table details the response reassignment reasons selected, including 1) the total number of AR cases that could have had a response reassignment (N) and 2) the number and percentage of AR cases for each response reassignment reason selected and the total for each quarter and overall. Additionally, response reassignment reasons are categorized by mandatory response reassignments, cases that required a RED team review prior to response reassignment, and other. Percentages indicate the percent of total AR cases that had that response reassignment reason selected.

Response Reassignment Reason	Oct2014 to Dec2014 N=92	Jan2015 to Mar2015 N=79	Apr2015 to Jun2015 N=91	Jul2015 to Sep2015 N=43	Oct2015 to Dec2015 N=39	Jan2016 to Mar2016 N=66	Apr2016 to Jun2016 N=57	Total by Category N=467
Mandatory Response Reassignment								
1. A safety threat is present that cannot be managed through an in-home safety plan	1 1%	1 1%	3 3%	2 5%	1 3%	1 2%	0 --	9 2%
2. DCFS cannot assess child safety	0 --	0 --	1 1%	0 --	0 --	0 --	0 --	1 --
3. Law Enforcement notifies the Department that they will continue investigating the child abuse or neglect intake	2 2%	1 1%	2 3%	0 --	2 5%	0 --	1 2%	8 2%
4. Parent(s) request the case be managed using the Traditional Response track	0 --	1 1%	0 --	0 --	0 --	0 --	0 --	1 --
5. The Department learns a household member allegedly caused the death of a child	0 --	0 --	0 --	0 --	0 --	0 --	0 --	--

Response Reassignment Reason	Oct2014 to Dec2014 N=92	Jan2015 to Mar2015 N=79	Apr2015 to Jun2015 N=91	Jul2015 to Sep2015 N=43	Oct2015 to Dec2015 N=39	Jan2016 to Mar2016 N=66	Apr2016 to Jun2016 N=57	Total by Category N=467
RED Team Review								
6. New information is learned about a family that meets one or more exclusionary criteria	5 5%	8 10%	3 3%	1 2%	0 --	0 --	0 --	17 4%
7. A new intake for the family was accepted and assigned to TR	0 --	0 --	0 --	0 --	0 --	0 --	1 2%	1 --
8. The RED team reviewed the case and made a decision to change to TR (because a new intake was received, but didn't have exclusionary criteria)	0 --	0 --	0 --	1 2%	3 8%	0 --	1 2%	5 1%
Other								
9. Correction or update to intake screening decision, response priority, or AR eligibility criteria	0 --	0 --	1 1%	1 2%	0 --	2 3%	0 --	4 1%
10. No reason selected	8 9%	0 --	0 --	0 --	1 3%	1 2%	0 --	10 2%
Total AR Cases with a Response Reassignment Reason Selected	16 17%	11 14%	10 11%	5 12%	7 18%	4 6%	3 5%	56 12%

Appendix F

Safety and Risk Analyses

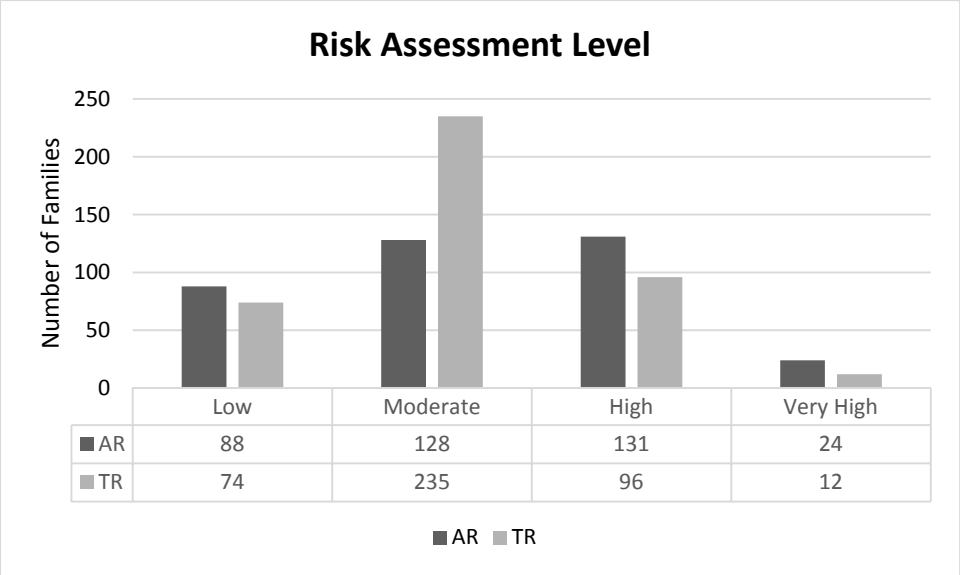
In order to examine the safety and risk determinations, administrative data on AR-eligible intakes were examined. For more information on this data source, see Appendix A, *Summary of Evaluation Data Sources*.

Safety Assessment Decision

Safety assessments were completed for 946 AR-eligible families (496 AR, 450 TR) between October 1, 2014 and June 30, 2016. The overwhelming majority of AR-eligible families (481 AR families, 97% and 426 TR families, 95%) were assessed as safe. No significant differences were observed between AR and TR families in terms of the safety decision. The graph and table below show the distribution of safety assessment decisions for AR and TR families.

Risk Assessment Decision

Risk assessments were completed for 788 AR-eligible families (317 AR, 417 TR). Different risk level patterns emerged between AR and TR cases. AR families appeared to have more equally distributed risk levels than TR families, which appear to have a moderate risk level most frequently. The relationship between risk level and track assignment was significant, χ^2 (3, N = 788) = 39.60, p = 0.00, meaning that difference in outcomes may be due to influences other than track assignment alone. The graph and table below show the distribution of risk assessment levels for AR and TR families.


Risk Assessment Level
Number of Families
250
200
150
100
50
0
Low
Moderate
High
Very High
AR
88
128
131
24
TR
74
235
96
12
AR
TR

Appendix G

Needs and Services Analyses

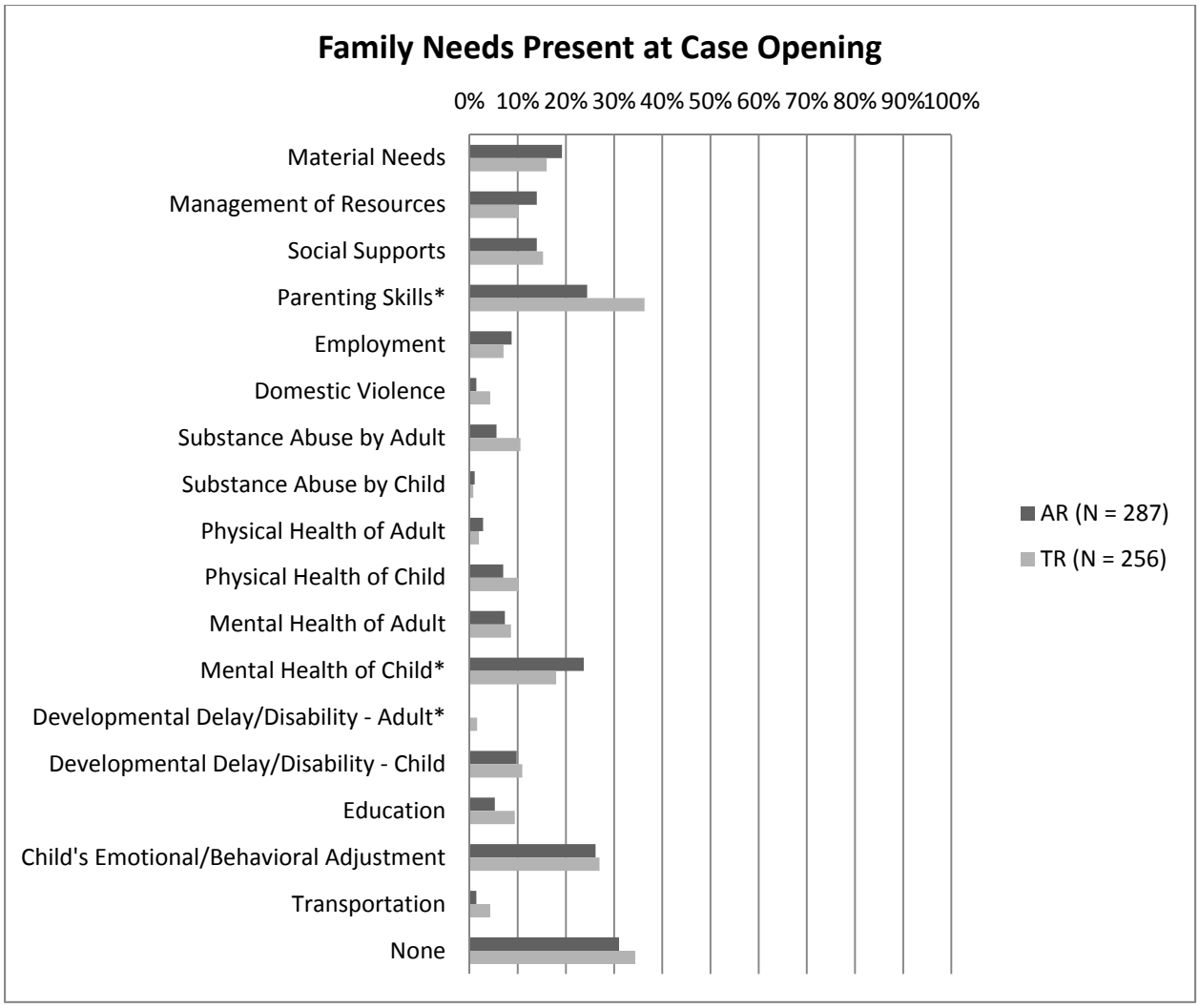
In order to get a complete picture of family needs and the services being used to address these needs, data were examined from a number of sources, including administrative data from N-FOCUS, SharePoint data, Worker Survey data, and Family Survey data (for more information on these data sources, see Appendix A, *Summary of Evaluation Data Sources*).

Family Needs

Worker Survey

In the Worker Survey, workers are asked to provide case-specific information about the types of needs the family presented with at the beginning of the case. A total of 646 (329 AR cases, 317 TR cases) worker surveys were completed between October 1, 2014 and June 30, 2016. The most common needs were in the areas of parenting skills (25%), child's emotional/behavioral adjustment (22%), and mental health of a child (18%). Additionally, over a quarter (27%) of families were identified as having none of the listed needs.

Due to random assignment we would expect the characteristics of AR and TR families to be similar, including the types of needs that families present. However, some significant differences were observed between AR and TR families. TR families were significantly more likely to present with needs related to parenting skills, χ^2 (1, N = 646) = 5.56, p= 0.02. There was no significant difference between AR and TR families regarding child's emotional/behavioral adjustment, χ^2 (1, N = 646) = 0.10, p= 0.75. However, AR families were significantly more likely to present with needs related to the mental health of a child, χ^2 (1, N = 646) = 4.21, p= 0.04. Additionally, TR families were significantly more likely to present with needs associated with developmental delays/disabilities of an adult, χ^2 (1, N = 646) = 4.18, p= 0.04. The following graph displays the distribution of family needs present at case opening for AR and TR families.



**These differences are statistically significant*

If a family was identified as presenting with a need, workers were then asked to indicate whether or not they were able to address that need with the family while the case was open. Overall, workers indicated that they were usually able to address the identified needs with the family while the case was open, regardless of track assignment. There were no significant differences between AR and TR. The following graph displays the distribution of needs that were addressed with AR and TR families.

If workers indicated that they were able to address a need during their work with the family, then they were asked to rate the extent to which the family improved on each of the identified needs. Each need was rated on a 4-point scale of improvement (1 = None, 2 = A little, 3 = Some, 4 = A lot). Overall, workers indicated that families improved at least some during their involvement with DCFS. There were no significant differences between AR and TR. The following graph shows the average improvement rating of each need for AR and TR families.

Services Provided

Administrative Data

According to N-FOCUS data, a total of 758 AR-eligible cases opened and closed between October 1, 2014 and June 30, 2016. Most of these families (666 families, 88%) did not receive a service; although these data only include services paid for through a DCFS contract. In total, 92 cases (12%) received one or more types of services. Of those families that received a service, 65 (71%) were AR and 27 (29%) were TR. This indicates that AR families were more than twice as likely to receive a contracted service compared to TR families.

Looking at the specific service types, the majority of services being provided to families were the same between AR and TR; with the exception that AR families were more likely to receive Intensive Family Preservation and TR families were more likely to be drug tested. However, AR families received a greater variety of service types compared to TR families; AR families received a total of 39 different types of services and TR families received a total of 20 different types of services. On average, both AR and TR received 2 types of services per family, with AR ranging from 1-8 service types per family and TR ranging

from 1-9 service types per family. In total, AR families' service costs were $4,343 per family and TR families' service costs were $3,105 per family. Although this may seem like a meaningful difference, because of the small sample size and relatively large standard deviations, the average case cost is not statistically significant, t (90) = 0.57, p = 0.57. The following table lists the 5 most frequently provided service types and the number and percentage of AR and TR families receiving that type of service.

AR Families		TR Families	
Service Type	# (%)	Service Type	# (%)
1. Family Support Services	20 (31%)	1. Family Support Services	11 (40%)
2. Intensive Family Preservation	17 (26%)	2. Travel Time and Distance	9 (33%)
3. Travel Time and Distance	14 (22%)	3. Drug Test Lab Confirmation	5 (19%)
4. Interpreter	6 (9%)	4. Motor Vehicle Gas	5 (19%)
5. Motor Vehicle Gas	6 (9%)	5. Interpreter	4 (15%)

SharePoint Database

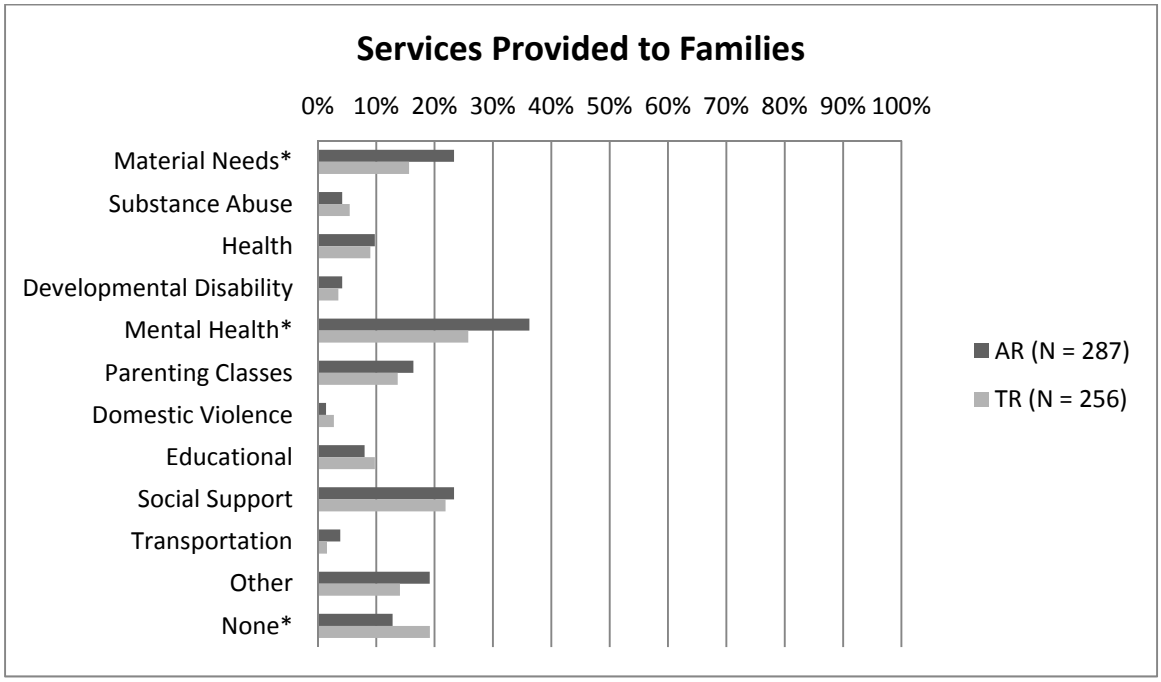
In addition to the regular reports generated from N-FOCUS, AR workers are asked to document service information in a SharePoint database. Although these data are not provided for AR-eligible cases assigned to TR, these data allow for a more complete examination of the services and service costs specific to AR families. In total, the SharePoint database included 49 closed cases between October 1, 2014 and June 30, 2016. These data provided unique information for 43 cases, including 20 cases that weren't provided a service through N-FOCUS and additional information for 23 cases that were already included in N-FOCUS. For the 20 families that were only documented on SharePoint, the average cost per family was $658. For the 23 families that were documented in both SharePoint and N-FOCUS, the average cost per family was $3,694. According to the SharePoint data, it appears that the majority (80%) of services were paid for by DCFS and the remaining 20% were paid for by an alternative source (e.g., donations, community response). Additionally, it appears that the majority of services (62%) are being used to address concrete supports for parents.

Worker Survey Data

Workers are asked to give case-specific information about the types of services provided to families, the categories of service providers, and indicate the families' level of participation in those services. Workers for most families (543 families, 84%) indicated that they had either directly provided families with services or given them information about services. However, TR families were significantly more likely to receive no services compared to AR families, χ^2 (1, N = 646) = 5.05, p= 0.03.

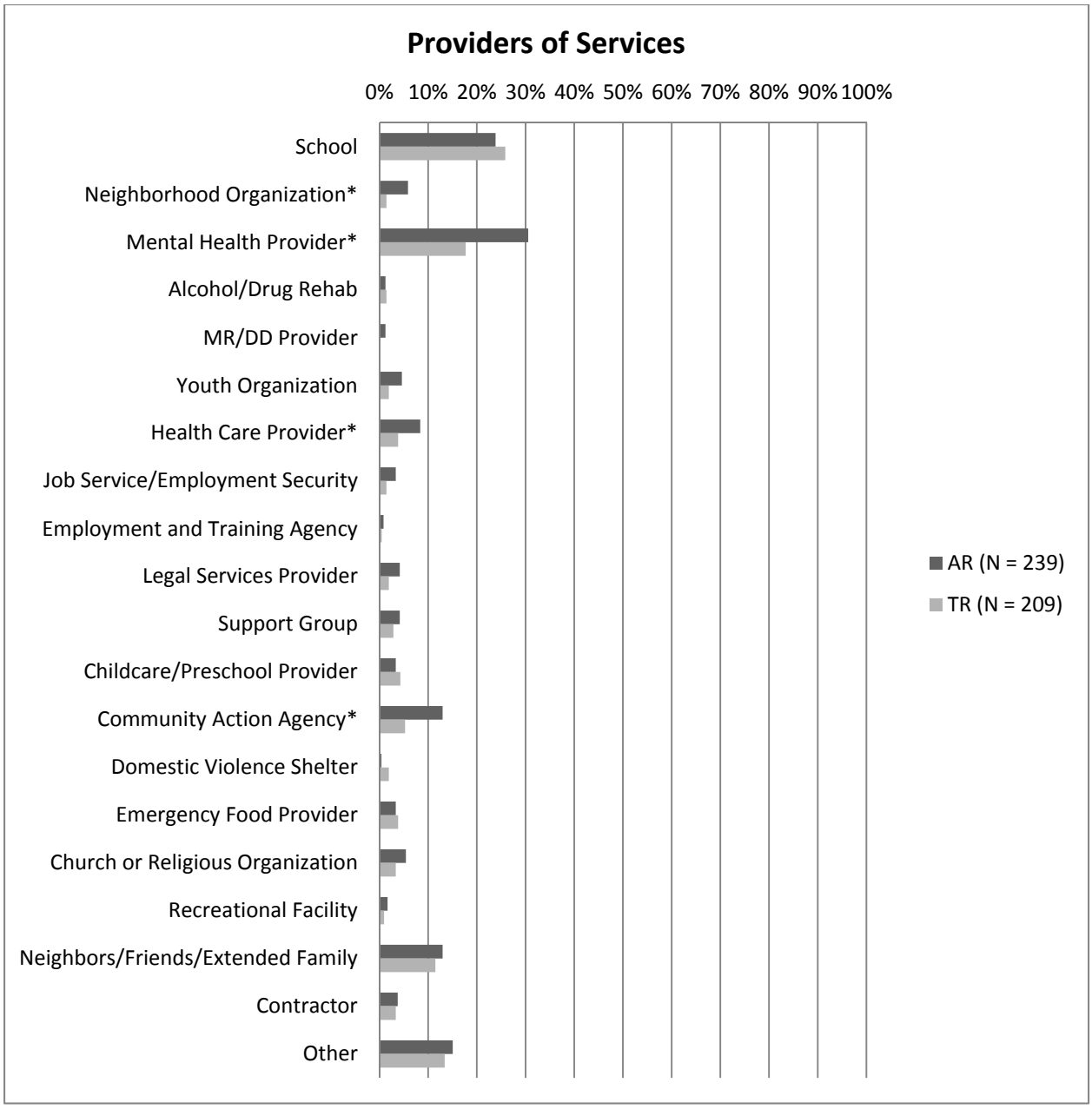
The most commonly provided services were related to mental health, social support services, and services to address material needs. Furthermore, AR families were significantly more likely to receive mental health services, χ^2 (1, N = 646) = 9.70 p= 0.002, with 36% of AR families and 26% of TR families receiving this service. There was not a significant difference between AR (23%) and TR (22%) families in the receipt of social support services, χ^2 (1, N = 646) = 0.76, p= 0.38. However, AR families were also significantly more likely to receive services to address material needs, χ^2 (1, N = 646) = 7.01, p= 0.001, with 23% of AR families and 16% of TR families receiving this service. If other services were provided that were not listed on the survey, workers were asked to fill in this information. Other common

services listed include day care, Intensive Family Preservation, and Legal Aid. Additionally, workers indicated that both AR and TR families were given DHHS Resource Guides, which detail where and how families can attain services to cover basic needs as well as information about child and family programs. The following graph displays the distribution of service types provided to AR and TR families.



**These differences are statistically significant*

Workers were also asked to give information about the categories of service providers that were involved with these families. Overall, the most common categories of service providers were mental health providers, schools, and neighbors/friends/extended family. AR families were significantly more likely to receive services from mental health providers, χ^2 (1, N = 646) = 12.64, p= 0.00, with 31% of AR families and 18% of TR families working with these providers. However, there were no significant differences between AR and TR families receiving services from schools (AR, 17%; TR, 17%) or neighbors/friends/extended family (AR, 9%; TR, 8%); χ^2 (1, N = 646) = 0.01, p= 0.92 and χ^2 (1, N = 646) = 0.71, p= 0.40, respectively. Still, AR families were significantly more likely than TR to receive service from a neighborhood organization, health care provider, and a community action agency; χ^2 (1, N = 646) = 6.90, p= 0.01; χ^2 (1, N = 646) = 4.92, p= 0.03; and χ^2 (1, N = 646) = 9.41, p= 0.002, respectively. The following graph shows the distribution of service providers involved with AR and TR families.



**These differences are statistically significant*

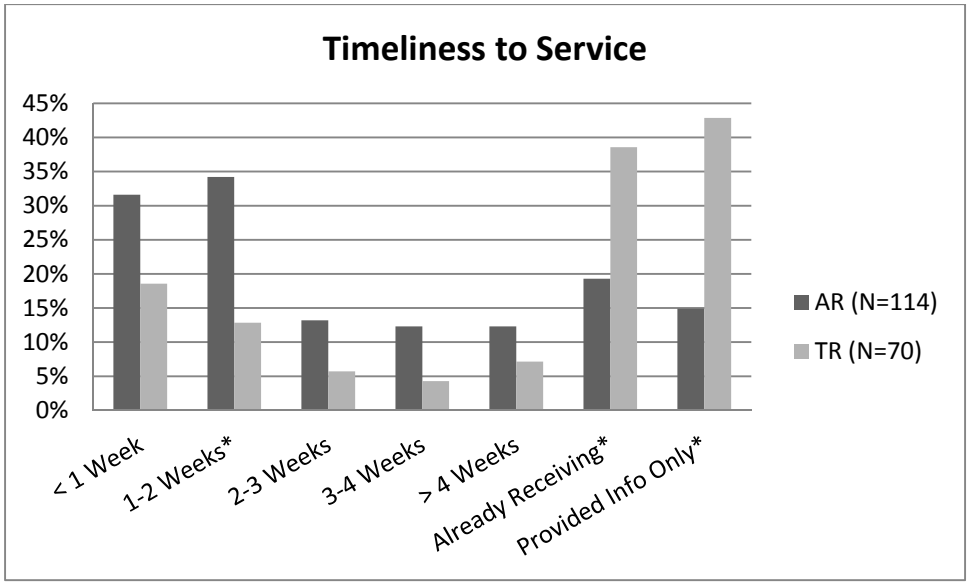
Timeliness of Services

Administrative Data

In order to assess the timeliness to service delivery, the number of days to service was calculated using the date the first service was provided minus the date the initial intake was received. On average, AR families received a service after 38 days and TR families received a service after 45 days. AR families appear to be receiving services about a week sooner than TR families; however, this difference is not statistically significant, $t(90) = 1.44$, $p = 0.15$.

Worker Survey

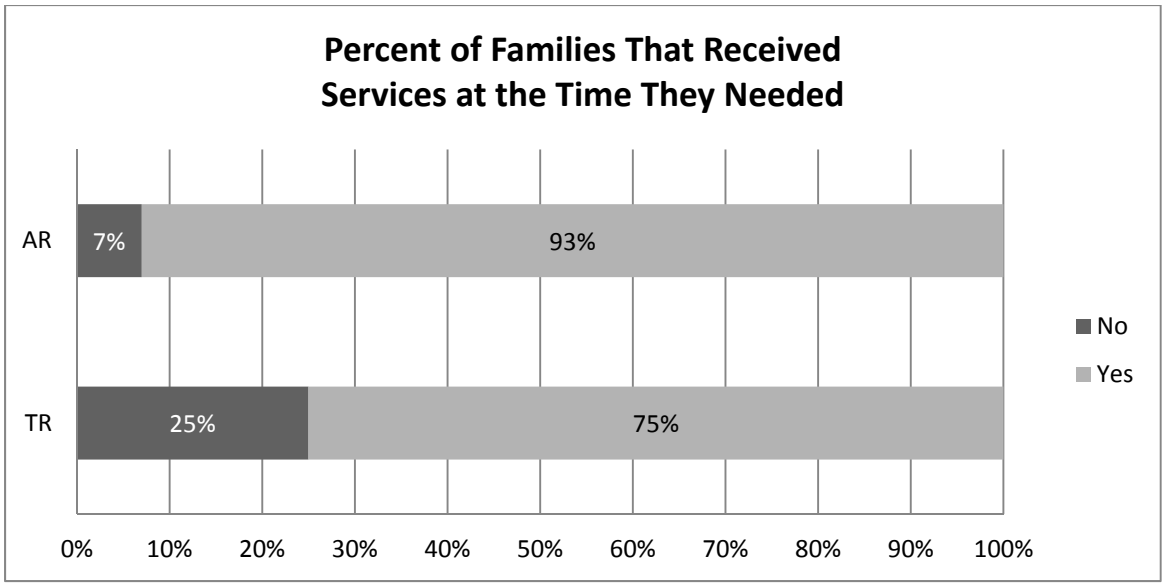
If a service was provided to a family, workers were asked to indicate how soon that service was provided. According to these data, it appears that AR families receive services significantly sooner than TR families, with AR workers most commonly reporting providing services within 2 weeks (< 1 week, U = 3471, p = 0.05; 1-2 weeks, U = 3138, p = 0.001). Additionally, if a TR family received a service, it was most likely to have already been in place before DCFS involvement (U = 3221, p = 0.004) or for the family to only be provided with information about the service (U = 2875, p = 0.00). The following graph shows the distribution of service timeliness for AR and TR families.



**These differences are statistically significant*

Family Survey

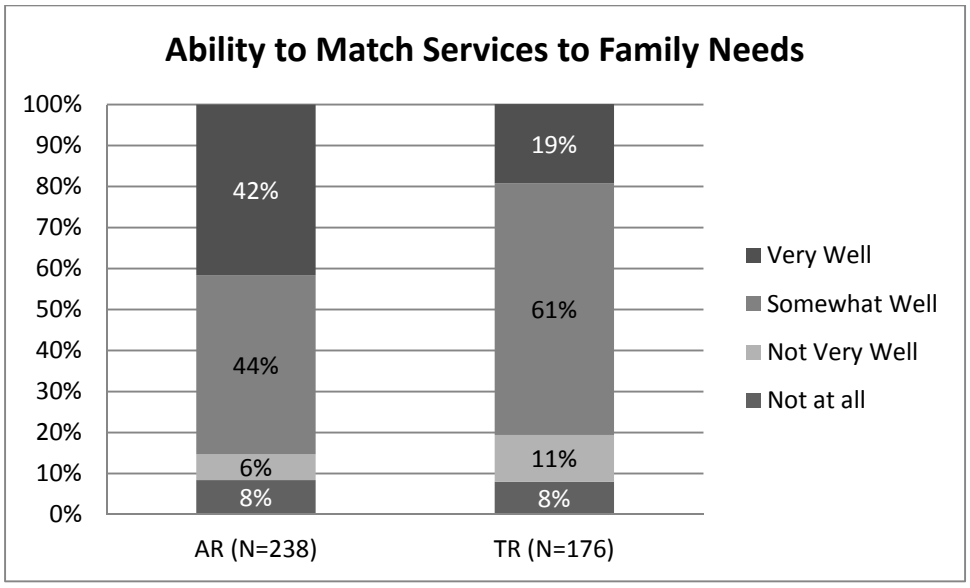
Families are asked to indicate whether or not they received support or services at the time they needed it. Overall, most families indicated that they received support or services when they needed it; however, AR families reported this significantly more (40 families, 93%) than TR families (27 families, 75%), χ^2 (1, N = 79) = 4.94, p= 0.03. The following graph shows the distribution of responses for AR and TR families.



Match Between Services and Family Needs

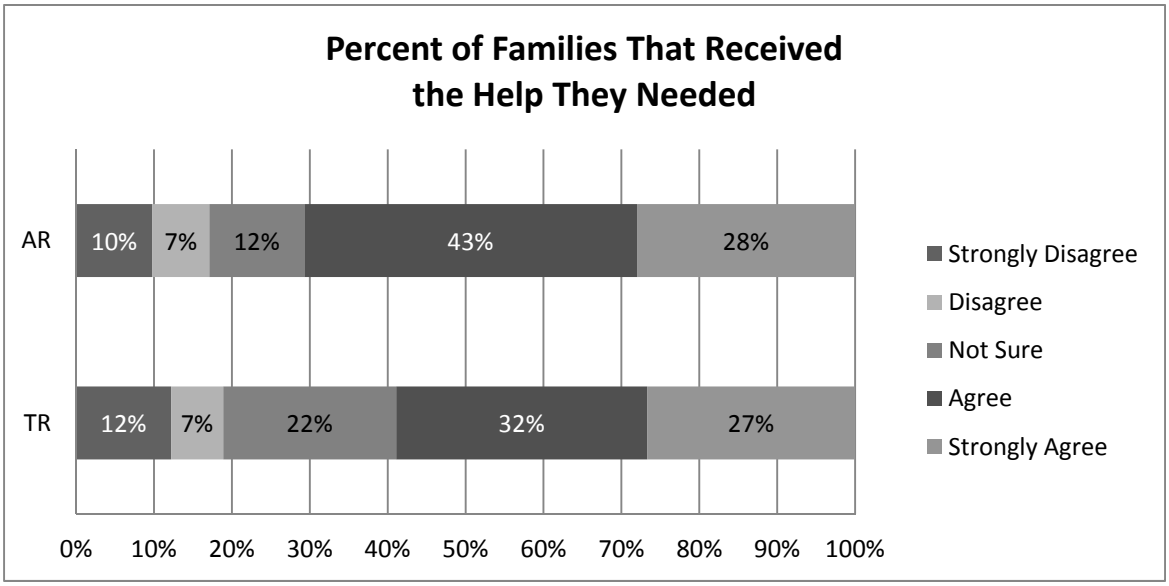
Worker Survey

If a worker indicated that a service was provided to a family, they were then asked to indicate the degree to which they believed they were able to match that service to the family's needs. Most workers (83%) reported that they were able to match services to the needs of the family. However, workers for AR families reported a significantly greater degree of match compared to TR families, t (398) = 3.20 p = 0.001, with workers reporting that they matched services to AR family needs "very well" twice as often. The following graph shows the distribution of response for AR and TR families.

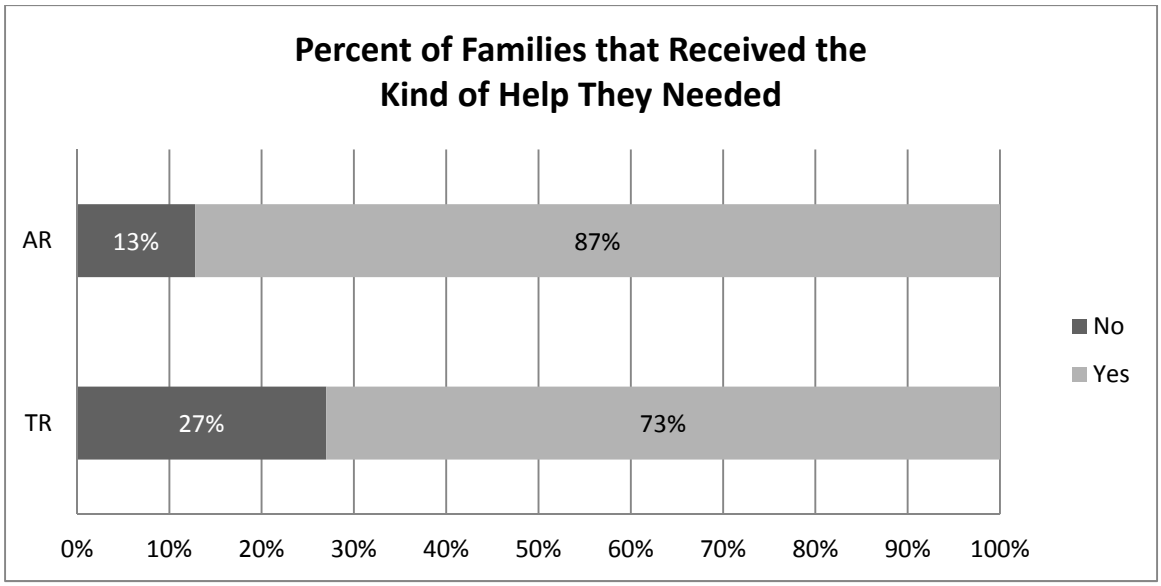


Family Survey

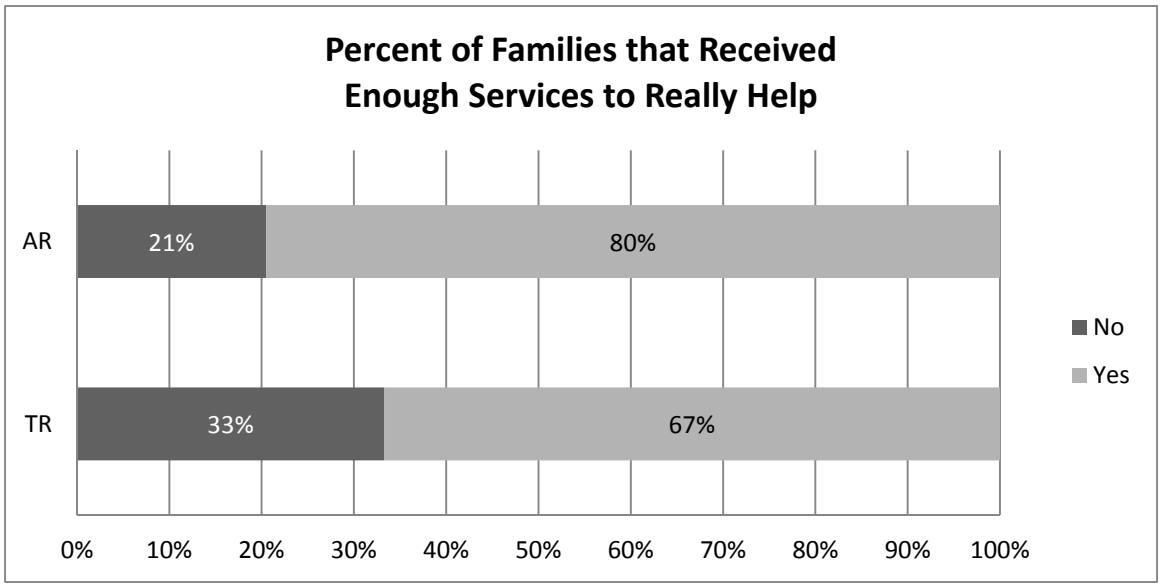
The Family Survey asks families to report their level of agreement with the statement, "My family got the help we really need from my worker." Overall, the majority of families (111 families, 62%) agreed or strongly agreed with this statement. Additionally, when examining these responses by response assignment, AR families reported agreement at a higher rate (58 families, 71%) than TR families (53 families, 59%); however this difference was not statistically significant, $\chi 2$ (5, N = 173) = 0.51, p> .05. The following graph displays the distribution of responses between AR and TR families.



If families received support or services, they were asked to indicate if it was "the kind of help you needed?" Again, AR families (41 families, 87%) more frequently reported that they received the kind of help they needed compared to TR (27 families, 73%); however this difference was not statistically significant, $\chi 2$ (1, N = 84) = 2.73, p= 0.09. The following graph displays the distribution of responses between AR and TR families.



Additionally, families were asked if the support or services they received was "enough to really help?" AR families (35 families, 80%) more frequently reported receiving enough support or services to help compared to TR families (24 families, 67%); although this was not statistically significant, $\chi 2$ (1, N = 80) = 0.19, p= 0.21. The following graph displays the distribution of responses between AR and TR families.

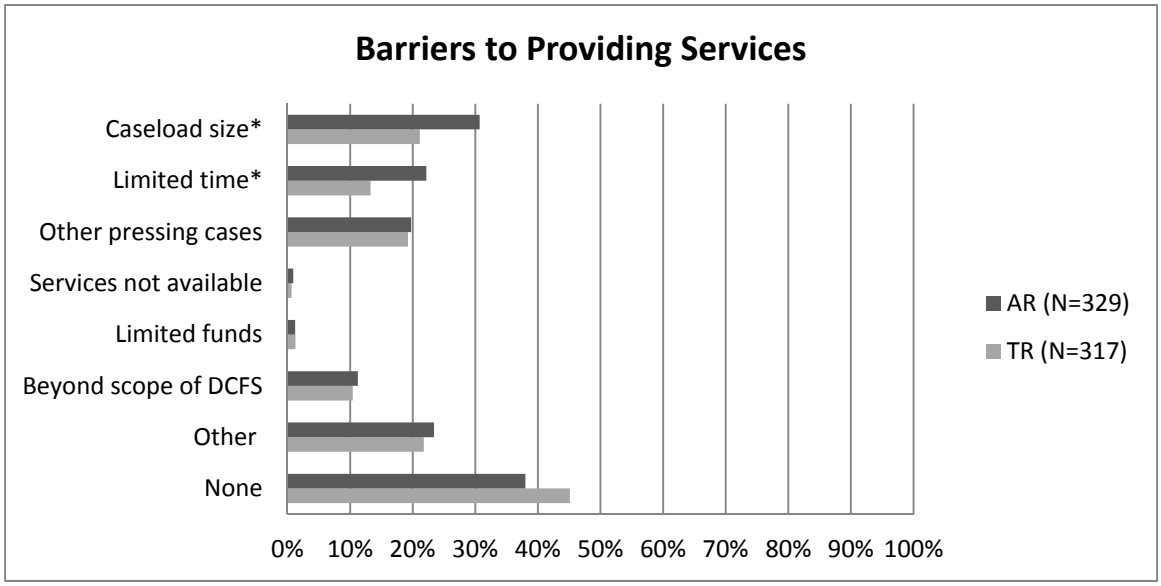


Barriers to Providing Services

Worker Survey

Workers were asked to provide information about any barriers they experienced in providing services to families. Overall, 41% of workers indicated no barriers were experienced. However, for those workers that experienced barriers to providing services, the most common barriers were worker caseload, followed by limited staff time to work with families, and other pressing cases on their caseload. AR workers reported barriers due to caseload significantly more often than TR workers, $\chi 2$ (1, N = 646) =

7.67, p= 0.001. AR workers also reported barriers due to limited time significantly more often than TR workers, $\chi 2$ (1, N = 646) = 8.82, p= 0.003. There was no significant difference between AR and TR workers regarding other pressing cases on their caseload, $\chi 2$ (1, N = 646) = 0.03, p= 0.87. If other barriers were experienced that were not listed on the survey, workers were asked to fill in this information. 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. The following graph displays the distribution of barriers experienced by AR and TR workers.



**These differences are statistically significant*

Appendix H

Family Engagement, Protective Factors, and Well-Being Analyses

In order to get a complete picture of family engagement, protective factors, and well-being, data were examined from a number of sources, including data from the worker survey, family survey, and the Nebraska Protective Factors and Well-Being Questionnaire (for more information on these data sources, see Appendix A, *Summary of Evaluation Data Sources*).

Family Engagement

DCFS has hypothesized that through AR families will feel respected and engage with their worker. To test this hypothesis, UNL-CCFL has collected survey data from AR-eligible families and the workers that served them.

Yatchmenoff's Client Engagement Scale

Both the worker and the family surveys include an adapted version of Yatchmenoff's Client Engagement Scale (YCES; 2005). This measure has been used successfully by the Quality Improvement Center on Differential Response (QIC-DR) to measure client engagement in previous evaluations of Differential Response programs. This scale was tailored to Nebraska's program goals, which eliminated three of the original scale items due to poor alignment. The remaining 16 items were slighted adapted in wording to reflect the perspective of either the worker or family. In both surveys, respondents are asked to indicate their level of agreement on a 5-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree). In total, 4 subscales are created to measure 1) receptivity, 2) buy-in, 3) working relationship, and 4) mistrust. *Receptivity* is defined as an "openness to receiving help, characterized by recognition of problems or circumstances that resulted in agency intervention and by a perceived need for help." *Buy-In* is defined as a "perception of benefit; sense of being helped or expectation of receiving help through the agency's involvement; a feeling that things will change for the better; commitment to the helping process, characterized by active participation in planning or services." *Working Relationship* is defined as a "interpersonal relationship with worker characterized by sense of reciprocity or mutuality and good communication." Finally, *Mistrust* is defined as "the belief that the agency or worker is manipulative, malicious, or capricious, with intent to harm the client." Ultimately, these 4 subscales are summed into a total score of Engagement.

Family Survey

In total, 162-170 families (depending on the item) were included in the analyses (78-82 AR families, 84-90 TR families). While no significant differences were observed between AR and TR families, all were in the hypothesized direction. AR families reported higher Buy-In, Working Relationship, and overall Engagement; whereas TR families were higher in Mistrust. AR and TR families displayed no difference in Receptivity. The following table summarizes the average scale scores, number of respondents, and results of an independent t-test of each subscale and overall engagement for AR and TR families.

Scale Name (Total Possible Score)	AR Families		TR Families		t-test results
	Avg Scale Score	N	Avg Scale Score	N	
Receptivity (20)	10.80	80	10.07	90	t (168) = 1.13, p = 0.26
Buy-In (30)	20.57	79	18.69	89	t (166) = 1.90, p = 0.06
Working Relationship (20)	16.64	81	15.47	87	t (166) = 1.94, p = 0.06
Mistrust (10)	3.39	82	3.96	88	t (158) = -1.87, p = 0.06
Overall Engagement (80)	51.45	78	48.36	84	t (160) = 1.83, p = 0.07

Worker Survey

In total, 558-610 workers responses (depending on the item) were included in the analyses (297-312 AR families, 266-298 TR families). Workers perceived significantly higher Buy-In and overall Engagement for AR families and significantly higher Mistrust for TR families. There were no statistically significant differences between Receptivity and Worker Relationship for AR and TR families as perceived by their workers. The following table summarizes the average scale scores, number of respondents, and results of an independent t-test of each subscale and overall engagement for AR and TR families.

Scale Name (Total Possible Score)	AR Families		TR Families		t-test results
	Avg Scale Score	N	Avg Scale Score	N	
Receptivity (20)	11.17	306	10.66	283	t (587) = 1.81, p = 0.07
Buy-In* (30)	19.51	297	18.25	271	t (566) = 3.34, p = 0.001
Working Relationship (20)	15.99	312	15.81	293	t (546) = 0.83, p = 0.41
Mistrust* (10)	4.22	312	4.49	298	t (556) = -2.08, p = 0.04
Overall Engagement* (80)	50.86	292	49.25	266	t (556) = 2.42, p = 0.02

Protective Factors

DCFS has hypothesized that protective factors will be enhanced through AR. To test this hypothesis, UNL-CCFL has collected family-level survey data related to family protective factors for all AR-eligible families. For families receiving AR, protective factor data are collected at the beginning (pre) and throughout the case on the Protective Factor and Well-Being Questionnaire (PFWBQ); finally, protective factor data are collected at the end (post) of the case through the family survey. For AR-eligible families receiving TR, protective factor data are collected at the end (post) of the case only, through the family survey. This report focuses on comparisons between the AR and TR end (post) of case measures; however, future reports may examine differences in protective factors throughout AR cases.

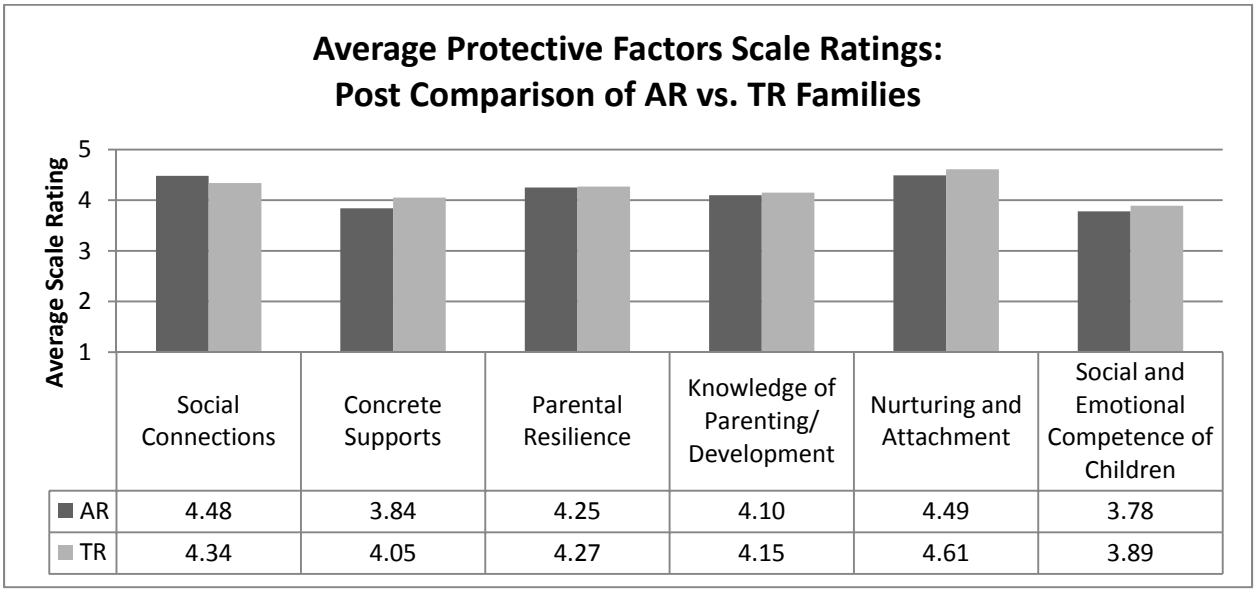
Protective Factor Scale

Both the PFWBQ and the family survey include an adapted version of the FRIENDS National Center's Protective Factor Survey. This survey was tailored to Nebraska's program goals and has resulted in a total of 25 items across 6 subscales, 1) Social Connections, 2) Concrete Supports for Parents, 3) Parental Resilience, 4) Knowledge of Parenting and Child and Youth Development, 5) Nurturing and Attachment, and 6) Social and Emotional Competence of Children. In both surveys, respondents are asked to rate each item on a 5-point Likert scale of agreement (1 = Strongly Disagree, 5 = Strongly Agree) or frequency (1 = Never, 5 = Always). Detailed rating averages for each item are included in Appendix H.1, *Average Protective Factor Rating by Item*.

Note that the PFWBQ allows for the measurement of protective factors throughout an AR case, but these data are not collected for AR-eligible TR families. Therefore, comparisons between AR and TR families can only be performed on family survey data, which are completed at the end of the case for all AR-eligible families.

Family Survey

In total, 160-163 families (depending on the item) were included in the analyses (78-80 AR families, 80-83 TR families). Because families are randomly assigned to AR or TR, it would be expected that protective factors should, on average, present at the same level at the beginning of the case for both AR and TR families. Therefore, any difference at the end of the case should be due to the type of response that family received. According to families' responses, no significant differences were observed between AR and TR families on any of the protective factors after their involvement with DCFS. The following graph and table present the average rating of each protective factor for AR and TR families.



	Social Connections	Concrete Supports	Parental Resilience	Knowledge of Parenting/ Development	Nurturing and Attachment	Social and Emotional Competence of Children
AR	4.48	3.84	4.25	4.10	4.49	3.78
TR	4.34	4.05	4.27	4.15	4.61	3.89

Well-Being

DCFS has hypothesized that well-being will be enhanced through AR. To test this hypothesis, UNL-CCFL has collected child-level survey data related to well-being for all AR-eligible families. For families

receiving AR, child-level well-being data are collected at the beginning (pre) and throughout the case on the PFWBQ; finally, well-being data are collected at the end (post) of the case through the worker survey. For AR-eligible families receiving TR, well-being data are collected at the end (post) of the case only, through the worker survey. This report focuses on comparisons between the AR and TR end (post) of case measures; however, future reports may examine differences in protective factors throughout AR cases.

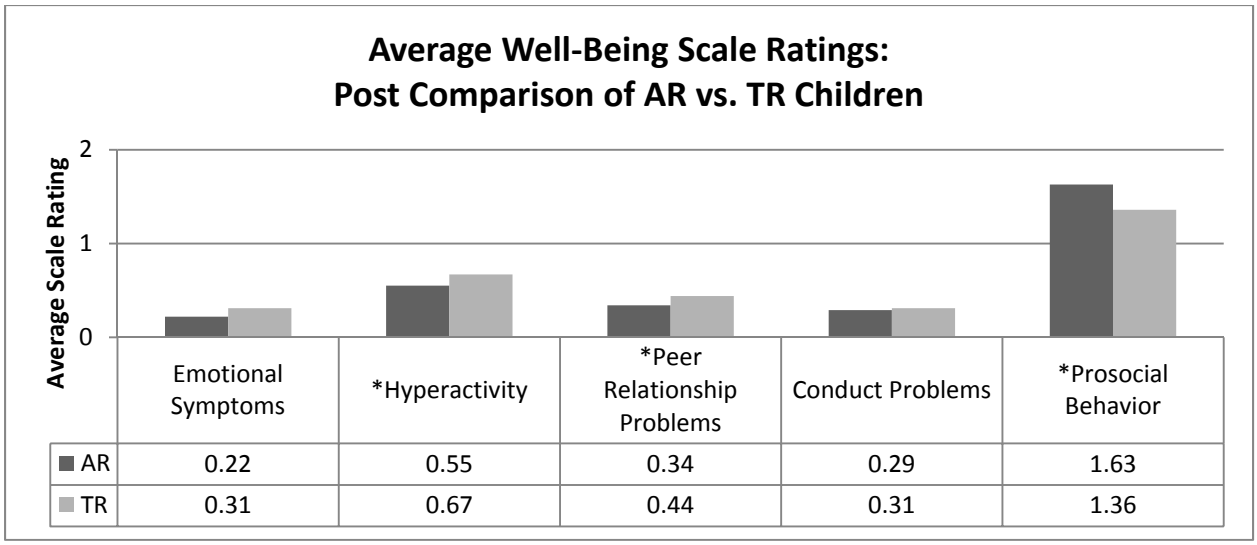
Well-Being Measure

Both the PFWBQ and the worker survey include adapted items from the New Mexico Court Improvement Project's Child Protection Best Practices Well-Being Checklists and the complete set of items contained on the Strengths and Difficulties Questionnaire (SDQ). The resulting measure has a total of 39 items that aim to assess four child well-being outcome domains 1) physical health/development, 2) cognitive functioning, 3) emotional/behavioral functioning, and 4) social functioning. The domains of physical health/development and cognitive functioning are assessed with yes/no items and are labeled as health and education respectively. The domains of emotional/behavioral and social functioning are rated on a 3-point scale (0 = Not True, 1 = Somewhat True, 2 = Certainly True) and are comprised of subscales. Emotional/behavioral functioning has two subscales from the SDQ: emotional symptoms and hyperactivity. Social functioning has three subscales from the SDQ: peer relationship problems, conduct problems, and prosocial behavior. These items were implemented in July 2015, so data for these analyses include AR-eligible families from July 2015 through June 2016. Detailed rating averages for each item are included in Appendix H.2, *Average Well-Being Rating by Item*.

Note that the PFWBQ allows for the measurement of well-being throughout an AR case, but these data are not collected for AR-eligible TR families. Therefore, comparisons between AR and TR families can only be performed on worker survey data, which is completed at the end of the case for all AR-eligible families.

Worker Survey

A total of 443-488 children, within 213-234 families (depending on the dimension), were included in these analyses; this included 291-306 AR children (within 132-138 families) and 144-182 TR children (within 81-96 families). Health and Education domains were not tested for significant differences, but item-level statistics are presented in Appendix H.2, *Average Well-Being Rating by Item*. Overall, ratings indicate that children are in good health and educational needs are not a concern for AR or TR families. According to workers, AR children were perceived to have significantly lower hyperactivity (e.g., restless, overactive, cannot stay still for long; easily distracted, concentration wanders) than TR children at the end of their involvement with DCFS, $t(466) = -2.51$, $p = 0.01$. AR children were also reported to have significantly lower peer relationship problems (e.g., solitary, prefers to play alone; picked on or bullied by other children), $t(270) = -2.38$, $p = 0.02$., and significantly higher prosocial behavior (e.g., offers help to others; kind to younger children), $t(265) = 5.07$, $p = 0.00$. All of these significant differences were in the hypothesized direction. There were no significant differences between AR and TR children in Emotional Symptoms or Conduct Problems. The following graph and table summarize the average well-being ratings for AR and TR children.


Average Well-Being Scale Ratings:
Post Comparison of AR vs. TR Children
Average Scale Rating
2
1
0
Emotional Symptoms
*Hyperactivity
*Peer Relationship Problems
Conduct Problems
*Prosocial Behavior
AR 0.22 0.55 0.34 0.29 1.63
TR 0.31 0.67 0.44 0.31 1.36

Appendix H1

Average Protective Factor Rating by Item

The following tables detail 1) the number and percentage of responses for each response option, 2) the overall average rating, and 3) the total number of responses for each item. SD = strongly disagree (1), D = disagree (2), N = not sure (3), A = agree (4), SA = strongly agree (5). Nv = Never (1), R = Rarely (2), S = Sometimes (3), F = Frequently (4), Al = Always (5). The sum of percentages may not total 100% due to rounding.

End-of-case (post) measure of Protective Factors for AR families

The following set of responses represents the final (post) measure of protective factors, through the family survey, for families that received AR.

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Social Connections							
1. I have others who will listen when I need to talk about my problems.	0 --	2 3%	4 5%	30 38%	44 55%	4.45	80
2. I have others who I can talk to when I'm lonely.	0 --	3 4%	2 3%	26 33%	47 60%	4.50	78
3. I have others who I can talk to if there is a crisis.	0 --	4 5%	4 5%	21 26%	51 64%	4.49	80
Concrete Supports for Parents							
4. I would know where to go for help if my family needed food or housing.	2 3%	5 6%	1 1%	28 35%	44 55%	4.34	80
5. I would know where to go for help if I had trouble making ends meet.	11 14%	12 15%	4 5%	24 30%	29 36%	3.60	80
6. I would know where to go for help if I needed help finding a job.	11 14%	10 13%	8 10%	23 29%	28 35%	3.59	80
Knowledge of Parenting/Development							
7. I know how to help my child learn.	0 --	0 --	4 5%	37 47%	38 48%	4.43	79
8. I think my child misbehaves just to upset me.*	22 28%	28 36%	19 24%	9 11%	1 1%	2.23	79
Survey Item	***Nv***	***R***	***S***	***F***	***Al***	**Average**	**Responses**
Parental Resilience							
9. In my family we talk about problems.	0 --	1 1%	18 23%	26 33%	34 43%	4.18	79
10. In my family we listen to both sides of the story when we argue.	0 --	1 1%	14 18%	29 36%	36 45%	4.25	80
11. In my family we take time to listen to each other.	0 --	2 3%	14 18%	24 30%	40 50%	4.28	80
12. In my family we pull together when things are stressful.	1 1%	1 1%	13 16%	22 28%	43 54%	4.31	80

Survey Item	*Nv*	*R*	*S*	*F*	*Al*	Average	Responses
13. In my family we manage to solve our problems.	0 --	1 1%	15 19%	30 38%	34 43%	4.21	80
Nurturing and Attachment							
14. I praise this child for good behavior.	0 --	0 --	2 3%	31 39%	47 59%	4.56	80
15. I discipline this child without losing control.	1 1%	0 --	5 6%	32 40%	42 53%	4.43	80
16. I am able to soothe this child when he/she is upset.	0 --	0 --	13 16%	21 26%	46 58%	4.41	80
17. I spend time with this child doing things that he/she likes to do.	0 --	0 --	10 13%	33 41%	37 46%	4.34	80
18. I feel close to this child.	0 --	3 4%	8 10%	14 18%	55 69%	4.51	80
19. I enjoy being with this child.	0 --	0 --	6 8%	12 15%	62 78%	4.70	80
Social and Emotional Competence of Children							
20. This child gets along well with family members.	0 --	2 3%	14 18%	22 28%	42 53%	4.30	80
21. This child gets along well with others his/her age.	0 --	4 5%	16 20%	24 30%	36 45%	4.15	80
22. This child shows concern for others' feelings.	2 3%	1 1%	17 21%	23 29%	37 46%	4.15	80
23. This child "loses it" when he/she is upset.*	8 10%	24 30%	34 43%	10 13%	4 5%	2.73	80
24. This child has trouble talking about his/her feelings.*	14 18%	16 20%	35 44%	11 14%	4 5%	2.69	80
25. This child misbehaves or gets in trouble.*	12 15%	25 31%	34 43%	7 9%	2 3%	2.53	80

**These items were reverse coded when creating the subscale average.*

End-of-case (post) measure of Protective Factors for TR families

The following set of responses represents the (post) measure of protective factors, through the family survey, for families that received TR.

Survey Item	*SD*	*D*	*N*	*A*	*SA*	Average	Responses
Social Connections							
1. I have others who will listen when I need to talk about my problems.	2 2%	2 2%	1 1%	29 35%	48 59%	4.45	82
2. I have others who I can talk to when I'm lonely.	3 4%	4 5%	2 2%	28 34%	46 55%	4.33	83
3. I have others who I can talk to if there is a crisis.	3 4%	4 5%	2 2%	28 34%	46 55%	4.33	83

Survey Item	SD	D	N	A	SA	Average	Responses
Concrete Supports for Parents							
4. I would know where to go for help if my family needed food or housing.	2 2%	2 2%	4 5%	28 34%	47 57%	4.40	83
5. I would know where to go for help if I had trouble making ends meet.	7 9%	9 11%	7 9%	20 25%	38 47%	3.90	81
6. I would know where to go for help if I needed help finding a job.	9 11%	5 6%	11 13%	22 27%	35 43%	3.84	82
Knowledge of Parenting/Development							
7. I know how to help my child learn.	1 1%	0 --	9 11%	37 46%	34 42%	4.27	81
8. I think my child misbehaves just to upset me.*	30 37%	32 40%	11 14%	8 10%	0 --	1.96	81
Survey Item	**Nv**	**R**	**S**	**F**	**Al**	**Average**	**Responses**
Parental Resilience							
9. In my family we talk about problems.	0 --	3 4%	15 18%	28 34%	37 45%	4.19	83
10. In my family we listen to both sides of the story when we argue.	0 --	4 5%	18 22%	24 29%	37 45%	4.13	83
11. In my family we take time to listen to each other.	0 --	3 4%	11 13%	29 35%	40 48%	4.28	83
12. In my family we pull together when things are stressful.	1 1%	3 3%	8 10%	19 23%	51 62%	4.41	82
13. In my family we manage to solve our problems.	0 --	2 2%	13 16%	20 24%	47 57%	4.37	82
Nurturing and Attachment							
14. I praise this child for good behavior.	0 --	0 --	2 2%	23 28%	57 70%	4.67	82
15. I discipline this child without losing control.	2 2%	2 2%	4 5%	22 27%	52 63%	4.46	82
16. I am able to soothe this child when he/she is upset.	0 --	1 1%	6 7%	25 31%	50 61%	4.51	82
17. I spend time with this child doing things that he/she likes to do.	0 --	2 2%	3 4%	27 33%	50 61%	4.52	82
18. I feel close to this child.	0 --	0 --	4 5%	16 20%	62 76%	4.71	82
19. I enjoy being with this child.	0 --	0 --	2 3%	11 14%	68 84%	4.81	81
Social and Emotional Competence of Children							
20. This child gets along well with family members.	0 --	0 --	10 12%	23 28%	49 60%	4.48	82
21. This child gets along well with others his/her age.	0 --	0 --	10 13%	30 38%	40 50%	4.38	80
22. This child shows concern for others' feelings.	0 --	1 1%	12 15%	21 26%	47 58%	4.41	81

Survey Item	*Nv*	*R*	*S*	*F*	*Al*	Average	Responses
23. This child "loses it" when he/she is upset.*	8 10%	30 37%	31 38%	10 12%	2 3%	2.60	81
24. This child has trouble talking about his/her feelings.*	11 14%	26 32%	26 32%	11 14%	7 9%	2.72	81
25. This child misbehaves or gets in trouble.*	12 15%	23 28%	38 46%	7 9%	2 2%	2.56	82

**These items were reverse coded when creating the subscale average.*

Appendix H2

Average Well-Being Rating by Item

The following tables detail 1) the number and percentage of responses for each response option, 2) the overall average rating, and 3) the total number of responses for each item. *Y* = Yes (1), *N* = No (0), *DK* = Don't Know, *NA* = Not Applicable. *NT* = Not True (0), *ST* = Somewhat True (1), *CT* = Certainly True (2). The sum of percentages may not total 100% due to rounding.

End-of-case (post) measure of well-being for AR children

The following set of responses represents the final (post) measure of well-being, through the worker survey, for each child that received AR.

Survey Item	*Y*	*N*	*DK*	*NA*	Average	Responses
Health						
1. This child is up to date on all immunizations.	308 85%	12 3%	31 9%	12 3%	.96	363
2. This child has a primary care physician.	325 89%	11 3%	16 4%	11 3%	.97	363
3. This child is in good physical health.	344 95%	3 1%	6 2%	10 3%	.99	363
4. This child shows age-appropriate physical and cognitive development.	325 89%	22 6%	6 2%	10 3%	.94	363
5. This child receives regular medical treatment, when needed.	324 89%	2 1%	24 7%	13 4%	.99	363
6. This child receives regular dental care.	268 74%	18 5%	48 13%	29 8%	.94	363
7. This child receives mental health treatment, if needed.	248 68%	9 3%	36 10%	70 19%	.96	363
Education						
8. This child is enrolled in an early education program.	30 8%	134 37%	21 6%	178 49%	.18	363
9. This child is working at his/her grade level in school.	218 60%	46 13%	19 5%	80 22%	.83	363
10. This child participates in an Individualized Education Program (IEP), if eligible.	54 15%	120 33%	22 6%	167 46%	.31	363
11. This child has both parents participating in his/her IEP, if eligible.	34 9%	32 9%	27 7%	270 74%	.52	363
12. This child receives special education or other education supports (tutoring, after school program, speech or occupational therapy, etc.), if needed.	52 14%	46 13%	24 7%	241 66%	.53	363

Survey Item	*NT*	*ST*	*CT*	*DK*	Average	Responses
Behavioral/Emotional Functioning						
Emotional Symptoms						
13. This child often complains of headaches, stomach-aches or sickness.	255 78%	20 6%	5 2%	49 15%	.11	329
14. This child has many worries or often seems worried.	203 62%	70 21%	10 3%	46 14%	.32	329
15. This child is often unhappy, depressed or tearful	236 72%	43 13%	5 2%	45 14%	.19	329
16. Nervous or clingy in new situations, easily loses confidence	200 61%	66 20%	10 3%	53 16%	.31	329
17. Many fears, easily scared	239 73%	31 9%	4 1%	55 17%	.14	329
Hyperactivity						
18. This child is restless, overactive, cannot stay still for long.	163 50%	94 29%	35 11%	37 11%	.56	329
19. This child is constantly fidgeting or squirming	208 63%	68 21%	13 4%	40 12%	.33	329
20. Easily distracted, concentration wanders	167 51%	93 28%	23 7%	46 14%	.49	329
21. Can stop and think things out before acting *	36 11%	123 37%	114 35%	56 17%	1.29	329
22. Good attention span, sees work through to the end *	27 8%	126 38%	121 37%	55 17%	1.34	329
Social Functioning						
Peer Relationship Problems						
23. This child is rather solitary, prefers to play alone.	167 51%	90 27%	15 5%	57 17%	.44	329
24. This child has at least one good friend *	17 5%	33 10%	208 63%	71 22%	1.74	329
25. Generally liked by other children *	5 2%	64 19%	194 59%	66 20%	1.72	329
26. Picked on or bullied by other children or youth	222 67%	33 10%	8 2%	66 20%	.19	329
27. Gets along better with adults than with other children or youth	163 50%	81 25%	11 3%	74 22%	.40	329
Conduct Problems						
28. This child often loses his/her temper.	184 56%	86 26%	21 6%	38 12%	.44	329
29. This child is generally well behaved, usually does what adults request *	13 4%	101 31%	181 55%	34 10%	1.57	329
30. This child often fights with other children or bullies them	241 73%	22 7%	8 2%	58 18%	.14	329

Survey Item	*NT*	*ST*	*CT*	*DK*	Average	Responses
31. Often argumentative with adults**	35 70%	6 12%	0 --	9 18%	.20	50
32. Can be spiteful to others**	40 75%	4 8%	0 --	9 17%	.09	53
33. Often lies or cheats***	198 72%	46 17%	7 3%	25 9%	.24	276
34. Steals from home, school or elsewhere***	226 82%	15 5%	5 2%	30 11%	.10	276
Prosocial Behavior						
35. This child is considerate of other people's feelings.	4 1%	87 26%	196 60%	42 13%	1.67	329
36. This child shares readily with other children (e.g., toys, treats, pencils).	11 3%	100 30%	166 50%	52 16%	1.56	329
37. This child is helpful if someone is hurt, upset or feeling ill.	7 2%	54 16%	196 60%	72 22%	1.74	329
38. Kind to younger children	0 --	51 16%	220 67%	58 18%	1.81	329
39. Often offers to help others (parents, teachers, other children)	5 2%	103 31%	552 47%	66 20%	1.57	329

**These items were reverse coded when creating the subscale average.*

***These items are only answered for children 2-4 years old.*

****These items are only answered for children 5 and older.*

End-of-case (post) measure of well-being for TR children

The following set of responses represents the (post) measure of well-being, through the worker survey, for each child that received TR.

Survey Item	*Y*	*N*	*DK*	*NA*	Average	Responses
Health						
1. This child is up to date on all immunizations.	226 80%	1 0%	46 16%	10 4%	1.00	283
2. This child has a primary care physician.	231 82%	5 2%	37 13%	10 4%	.98	283
3. This child is in good physical health.	248 88%	4 1%	27 10%	4 1%	.98	283
4. This child shows age-appropriate physical and cognitive development.	228 81%	25 9%	26 9%	4 1%	.90	283
5. This child receives regular medical treatment, when needed.	230 81%	2 1%	41 14%	10 4%	.99	283
6. This child receives regular dental care.	198 70%	3 1%	63 23%	19 7%	.99	283
7. This child receives mental health treatment, if needed.	166 59%	14 5%	48 17%	55 19%	.92	283

Survey Item	*Y*	*N*	*DK*	*NA*	Average	Responses
Education						
8. This child is enrolled in an early education program.	47 17%	85 30%	44 16%	107 38%	.36	283
9. This child is working at his/her grade level in school.	162 57%	31 11%	42 15%	47 17%	.84	282
10. This child participates in an Individualized Education Program (IEP), if eligible.	55 19%	79 28%	41 14%	108 38%	.41	283
11. This child has both parents participating in his/her IEP, if eligible.	37 13%	30 11%	45 16%	171 60%	.55	283
12. This child receives special education or other education supports (tutoring, after school program, speech or occupational therapy, etc.), if needed.	56 20%	50 18%	42 15%	135 48%	.53	283
Survey Item	***NT***	***ST***	***CT***	***DK***	**Average**	**Responses**
Behavioral/Emotional Functioning						
Emotional Symptoms						
13. This child often complains of headaches, stomach-aches or sickness.	95 39%	6 2%	5 2%	137 56%	.15	243
14. This child has many worries or often seems worried.	73 30%	32 13%	10 4%	127 52%	.45	242
15. This child is often unhappy, depressed or tearful	106 44%	13 5%	9 4%	114 47%	.24	242
16. Nervous or clingy in new situations, easily loses confidence	87 36%	23 10%	6 2%	126 48%	.30	242
17. Many fears, easily scared	88 36%	12 5%	3 1%	139 57%	.17	242
Hyperactivity						
18. This child is restless, overactive, cannot stay still for long.	75 31%	54 22%	17 7%	97 40%	.60	243
19. This child is constantly fidgeting or squirming	88 37%	37 15%	8 3%	107 45%	.40	240
20. Easily distracted, concentration wanders	74 31%	38 16%	19 8%	111 46%	.58	242
21. Can stop and think things out before acting *	21 9%	61 25%	41 17%	119 49%	1.16	242
22. Good attention span, sees work through to the end *	27 11%	50 21%	54 22%	111 46%	1.21	242
Social Functioning						
Peer Relationship Problems						
23. This child is rather solitary, prefers to play alone.	81 33%	29 12%	8 3%	124 51%	.38	242

Survey Item	*NT*	*ST*	*CT*	*DK*	Average	Responses
24. This child has at least one good friend *	6 2%	37 15%	96 40%	103 43%	1.65	242
25. Generally liked by other children *	13 5%	35 14%	78 32%	116 48%	1.52	242
26. Picked on or bullied by other children or youth	82 34%	20 8%	7 3%	133 55%	.31	242
27. Gets along better with adults than with other children or youth	42 17%	28 12%	10 4%	161 67%	.60	241
Conduct Problems						
28. This child often loses his/her temper.	84 35%	29 12%	13 5%	116 48%	.44	242
29. This child is generally well behaved, usually does what adults request *	12 5%	59 24%	89 37%	82 34%	1.48	242
30. This child often fights with other children or bullies them	107 44%	10 4%	4 2%	121 50%	.15	242
31. Often argumentative with adults**	25 51%	2 4%	0 --	22 45%	.07	49
32. Can be spiteful to others**	24 49%	1 2%	0 --	24 49%	.04	49
33. Often lies or cheats***	100 52%	19 10%	4 2%	70 36%	.22	193
34. Steals from home, school or elsewhere***	112 58%	6 3%	3 2%	72 37%	.10	193
Prosocial Behavior						
35. This child is considerate of other people's feelings.	8 3%	63 26%	74 30%	98 40%	1.46	243
36. This child shares readily with other children (e.g., toys, treats, pencils).	8 3%	56 23%	51 21%	128 53%	1.37	243
37. This child is helpful if someone is hurt, upset or feeling ill.	10 4%	32 13%	51 21%	149 62%	1.44	242
38. Kind to younger children	4 2%	32 13%	73 30%	133 55%	1.63	242
39. Often offers to help others (parents, teachers, other children)	14 6%	46 39%	50 21%	132 55%	1.33	242

**These items were reverse coded when creating the subscale average.*

***These items are only answered for children 2-4 years old.*

****These items are only answered for children 5 and older*.