California Social Work Education Center

C A L S W E C

DIFFERENTIAL RESPONSE AND ALTERNATIVE RESPONSE IN DIVERSE COMMUNITIES

AN EMPIRICALLY BASED CURRICULUM

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CENTER FOR CHILD AND YOUTH POLICY

Established in 2000, the Center for Child and Youth Policy (CCYP) is an Organized Research Unit focused on interdisciplinary research and information dissemination on a variety of children's issues at the national, state, and local levels.

The Center brings together the talents of faculty from across the UC Berkeley campus who share an interest in children's issues and children's policy.

TABLE OF CONTENTS

[1] Portions of this chapter can also be found in: Conley, A. Differential response: A critical examination of a secondary prevention model published in *Children & Youth Services Review, 29,* 1454–1468.

Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., Geer, A., et al. (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum.* Berkeley: University of California at Berkeley, California Social Work Education Center.

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CALSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state coalition of social work educators and practitioners. It is a consortium of the state's 18 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and learn.

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To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum sections that employ varied research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum sections are made available through the CalSWEC Child Welfare Resource Library to all participating school and collaborating agencies.

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

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MODULE I

INTRODUCTION

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MODULE I
INTRODUCTION

INSTRUCTIONAL GUIDE

Purpose

- To provide an overview of the development of Differential Response (DR), highlighting its intent, its key components, and how its implementation marks a shift in the traditional culture of the Child Welfare System (CWS).

Learning Objectives

By the end of this chapter, students should be able to:

(1) Understand why and how DR was conceptualized,

(2) Describe the goals and main characteristics of AR/DR interventions,

(3) Understand how DR came about in California and describe the problems the intervention aims to address,

(4) Recognize how AR/DR represents a shift in the Child Welfare System's organizational culture and describe implementation tasks and challenges, and

(5) Describe the community's role in DR.

This chapter can be used to foster the following curriculum competencies:

2.1 Student demonstrates knowledge of legal, socioeconomic, and psychosocial issues facing immigrants, refugees, and minority groups and is able to devise culturally competent and effective interventions.

2.5 Student demonstrates ability to collaborate with individuals, groups, community-based organizations and government agencies to advocate for equitable access to culturally competent resources and services.

3.2 Student demonstrates ability to perform a preliminary safety assessment and to monitor the safety of the child through ongoing assessment of risk.

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3.9 Student demonstrates ability to engage and work with involuntary clients in a manner that includes the exercise of client self-determination.

3.11 Student recognizes the importance of working with biological families, foster families, and kin networks, as well as involving them in assessment and planning strategies.

3.12 Student understands the inherent power differential in working with clients and can effectively manage and balance that power.

3.18 Student understands the dual responsibility of the child welfare social worker to protect children and to provide services that support families as caregivers.

4.3 Student works collaboratively with biological families, foster families, and kin networks, involving them in assessment and planning and helping them access services and develop coping strategies.

QUESTIONS FOR DISCUSSION

1. Based on what you learned in this chapter, what would you say are the distinct attributes that make an intervention classifiable as DR or AR? [*Answer: (a) Screening based on risk level; (b) voluntary provision of case management and other services to lower-risk families; and (c) a less punitive and authoritative approach than traditional child protective services.*]

2. If you were redesigning the California Child Welfare System, which of the key components would you advocate for including? Are there any that you would leave out or any others that you think should be included?

3. Can services truly be considered voluntary if families know that CWS will be notified if they refuse services? What are the benefits and challenges of this approach?

PROBLEMS WITH THE TRADITIONAL CHILD WELFARE SCREENING/REFERRAL PROCESS

The differential response (DR) paradigm arose from a debate among child welfare professionals about how best to reform a child welfare system (CWS) facing

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great challenges. Some argue that too many families are brought into unnecessary contact with the CWS and advocate for narrowing child welfare's mandate. This argument points to the fact that an unwarranted investigation can have detrimental effects on a family, add to the fiscal strains of the CWS, and create a credibility gap between the community and the CWS (Child Welfare Services Stakeholders Group [CWSSG], 2002; Tumlin & Geen, 2000). Others contend that the current system intervenes only in desperate situations. They propose the broadening of child welfare services to minimize the possibility that a child may be left in an unsafe situation, which can lead to further harm or even death.

With limited resources, CWS administrators and workers have traditionally targeted services to those families at greatest risk. A call to the child abuse and neglect hotline is generally the entryway into the system. Thus the screening of calls and the decisions based upon that process have important consequences for families and for the CWS as a whole. In the traditional system, hotline workers screen calls to determine whether or not there is sufficient evidence to begin a child welfare investigation. If the call does not meet the criteria for opening a case, no further action is taken and families who may be in need of help—with their basic needs or parenting skills—are not offered services that may improve their circumstances (Schene, 2001a).

There is growing consensus among practitioners and researchers that services are needed for families whose allegations of maltreatment do not meet the definition of child abuse or neglect or for which there is insufficient proof of harm. Mounting evidence indicates that a large proportion of children initially screened out by the child welfare

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hotline, or who do not meet the criteria for keeping a case open after investigation, eventually come back into contact with the child welfare system (Drake, Jonson-Reid, Way, & Chung, 2003; Inkelas & Halfon, 1997; Way, Chung, Jonson-Reid, & Drake, 2001; Wolock, Sherman, Feldman, & Metzger, 2001;). Because desperate families do not just go away, and endemic problems do not resolve themselves easily, the questions of "when to intervene" and "what type of help to offer" are now common discussion topics in the child welfare field. In order to address this issue, researchers and practitioners in child welfare recently have begun to promote the incremental development of a new system—differential response (DR)—to reform the safety and crisis orientation of traditional child welfare services by screening families based on risk and offering them voluntary services and support.

The DR approach—also known as alternative response (AR), multi-track response, and dual-track response—is catching the attention of policy makers and child welfare administrators throughout the country. According to the *National Study of Child Protective Services and Reform Efforts*, as of April 2003, approximately 20 states had begun incorporating DR into their child welfare systems, with 10 implementing it statewide (U.S. Department of Health and Human Services, 2003). Program examples and research findings from five states that have experience with the implementation of AR/DR are included in Module II.

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CALIFORNIA'S RESPONSE: DEVELOPMENT OF DIFFERENTIAL RESPONSE AND CHILD WELFARE SERVICES REDESIGN

The California Child Welfare Services (CWS) Redesign Plan—the result of a 3-year effort—is a long-term implementation plan to improve the child welfare system in the state. In 2000, the 60-member Child Welfare Services Stakeholders Group (CWSSG) was appointed by Governor Davis and the California State Legislature to examine the current system of child welfare, build on existing effective child welfare services within California and elsewhere in the United States (U.S.), and recommend system changes and a strategic plan to improve child welfare outcomes for children and families (CWSSG, 2003).

The CWS Redesign: The Future of California's Child Welfare Services—Final Report (CWSSG, 2003) emphasized the CWSSG's vision for the future of the child welfare system: "Every child in California will live in a safe, stable, permanent home, nurtured by healthy families and strong communities" (CWSSG, p. 14). In order to achieve this goal, the Redesign sought to incorporate intervention strategies that prevent child abuse and neglect, preserve and strengthen families, restore the capacity of families to care for children, rebuild alternative families for children when necessary, and prepare youth successfully for the transition into adulthood.

As part of the Redesign planning process, *The Early Intervention and Differential Response Strategies Workgroup* outlined the rationale for a switch from the traditional child welfare intake system. These justifications included that:

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(a) families often do not get the help they need early enough and are often re-referred for child neglect or abuse; (b) 40% of children referred have at least one subsequent referral within 24 months; (c) responses are allegation driven, incident focused, and largely adversarial; (d) by the time CWS is able to intervene, problems have escalated, making problem resolution more challenging and costly; (e) CWS is perceived as solely responsible for child protection; and (f) CWS funding and policies do not support serving more families earlier (CWSSG, 2002, p. 50).

To address these concerns, the CWSSG ultimately recommended a shift to DR and described it as a "fundamental component" of the California Redesign. In contrast to the traditional CWS intake system, the redesigned system relies on community partnerships, incorporates prevention strategies, engages families and children, and tailors its response to each family (CWSSG, 2003). Also, instead of being simply screened in or screened out with no further services, families are referred to one of three differential response pathways—Community Response, Child Welfare Services and Community Response, or traditional Child Welfare Service Response.

Importantly, California's version of Differential Response differs markedly from that offered in most other states. While the California model is targeted toward those families who are initially screened out at the child abuse hotline and who are then assessed as low- to moderate-risk, the national model of Differential Response is targeted to families *screened in* for services*,* but whose level of risk is characterized as low to moderate. In California, families who would have received no services are

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instead offered a community-based, strengths-focused, voluntary program (Kaplan & Merkel-Holgúin, 2008). In the national model, however, the approach is to offer community-based, strengths-focused, voluntary services to a population who would have otherwise received a mandatory, sometimes intrusive, and too often punitive response. Both the national and the California models share the goal of preventing future involvement with the child welfare system. A secondary goal of the national model, however, is to ensure that child safety is not compromised (that is, children are no worse off) by an approach that could be considered "softer" in tone and content.

OVERVIEW OF DIFFERENTIAL RESPONSE IN CONTRA COSTA COUNTY

The California Department of Social Services (CADSS), in collaboration with a foundation consortium, selected 11 counties[3] to become "early implementers" of Redesign efforts during the 2004-2005 fiscal year. The intent was for these counties to pilot key elements of the Redesign (including DR), evaluate their efforts, and share lessons learned with other counties. Contra Costa County (CCC) was one of the selected counties.

In order to target their efforts and maximize their impact, CCC chose to focus their resources on children under the age of 5 living in the North Richmond and the Iron Triangle area of Richmond, the Monument Corridor area of Concord, Pittsburg, and old Antioch. These communities are largely low income and African American and were

[3] Contra Costa, Glenn, Humboldt, Los Angeles, Placer, Sacramento, San Luis Obispo, San Mateo, Stanislaus, Tehama, and Trinity.

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selected, in part, to address racial CWS disproportionality concerns. Differential response in CCC is marked by three distinct pathways to which reports of child abuse and neglect are assigned based on the assessed level of risk. The model also relies heavily on partnerships with a wide, diverse group of community-based organizations (CBOs) that provide intensive, home-based case management services. (See Module III for more detailed information about CCC's model.)

OVERVIEW OF ALTERNATIVE RESPONSE IN ALAMEDA COUNTY

Pre-dating the California CWS reform movement, Alameda County has provided a two-track differential response approach since 2002. Track 1, known as the Another Road to Safety (ARS) program, serves cases screened out of the public CWS and diverted for community services, while Track 2 serves cases which indicate the need for court-mandated services. ARS offers voluntary services to those families who meet the following criteria: (a) screened out of traditional investigation; (b) child age 0-5 or a pregnant mother in the home; and (c) residence in designated neighborhoods (South Hayward and East Oakland) where a high proportion of child maltreatment referrals originate. The program was expanded in 2005 to a third neighborhood (West Oakland), where families with children ages 0-18 are served. ARS clients receive intensive home visiting, with a host of concrete services, support and mentoring, and referrals to other formal service providers. See Module IV for more detailed information about AC's model.

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KEY COMPONENTS OF DIFFERENTIAL RESPONSE/ALTERNATIVE RESPONSE

While Contra Costa and Alameda Counties represent two distinct models of differential or alternative response programs, numerous other iterations of AR/DR have been implemented throughout the state and country. Regardless of the specific approach, however, AR/DR is characterized by the following general components: screening based on risk, voluntary provision of services, respectful engagement of families, community involvement, and a focus on prevention. Each of these key components is reviewed in greater detail below.

Screening Based on Risk

Through a deliberate screening process, DR is designed to sort families by risk levels and offers services to those deemed at low to moderate levels of risk, who under traditional child welfare services would receive nothing. In this system, child welfare retains the authoritative protective role over families that present as high risk, and allocates to CBOs the role of providing preventative and supportive services to families who present as lower risk (Waldfogel, 1998a).

There are two predominant models for risk assessment in child welfare. Consensus-based models are a list of family characteristics believed by experts to be associated with risk of child maltreatment. Child welfare workers, guided by consideration of these characteristics, use their own clinical judgment to determine whether families meet the threshold of risk (Baird, Wagner, Healy, & Johnson, 1999). Actuarial models are constructed with factors and combinations of factors determined through statistical procedures to have a high association with a particular outcome—in

this case, the outcome of maltreatment. Based on the presence of these factors, child welfare workers score the family at a particular level of risk for future maltreatment (Rycus & Hughes, 2003). Actuarial-based systems have been found to have greater reliability than consensus-based systems in predicting subsequent investigations, substantiations, and placements for cases assessed at different risk levels (Baird & Wagner, 2000).

Voluntary Provision of Services

Although the child welfare system has historically had a mechanism for families to voluntarily seek services, families typically become involved in the system as a result of a court order. Moreover, parents who may perceive concerns in their parenting are more likely to hide from a system that bestows labels of abuse and neglect rather than voluntarily seek out involvement (Pelton, 1998). Thus, in Pelton's words, the CWS has a "dual role structure"; that is, agencies hold the responsibility of investigating maltreatment allegations and removing children who they consider unsafe, while simultaneously promoting family preservation and offering family support.

In a differential response system, the alternative services offered are, by definition, voluntary; clients may choose to accept or refuse services. It is presumed that, because the services are offered through CBOs rather than through the CWS, families will be more likely to accept them. However, in some counties, families are informed that in cases of refusal, CWS will be notified and may choose to take action. Even when this isn't the case, families may perceive it to be so. This raises the question of whether participation in AR/DR can truly be considered *voluntary.* Whereas services

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are provided by CBOs rather than CWS workers, the specter of formal CPS involvement may still remain since the contact initiated as a result of a CWS referral.

Few studies have examined the veracity of the *voluntary* claim in child welfare services; the studies that do exist hint that some level of coercion may still be involved. In an examination of voluntary and court-mandated foster care services in Arizona, Mississippi, Oregon, and Tennessee, Yoshikama and Emlen (1983) found that parents who voluntarily placed their children in foster care tended to do so for reasons of family conflict or parental incapacitation because of issues like illness and financial difficulties. The majority reported strong influence or coercion by child welfare workers or family members in making their decision.

What are the benefits and drawbacks of offering child welfare services on a nominally voluntary rather than mandatory basis? Provision of voluntary services is viewed by the field as holding promise for greater levels of client motivation (Thomas, Berrick, & Koren, n.d.), leading to higher rates of engagement and retention in services. The field of child welfare is just beginning to examine the concept of engagement as it relates to non-voluntary clients. A qualitative study by Yatchmenoff (2002) found an association between client expressions of investment in the change process and engagement in services. Fear and mistrust of the caseworker and the CWS were found to negatively influence client receptivity (Yatchmenoff). It follows that CBOs offering voluntary services to families at-risk of CWS involvement can target those clients who are ready to change and do not need coercion to participate in services. Further, since

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CBOs do not have the power to remove children, the interference of fear and mistrust in the helping process is likely minimized.

Family Engagement

Differential response has made family engagement an integral part of its overall approach. As part of DR, families are seen as experts in identifying, assessing, and solving their own problems. However, since DR is voluntary, some families inevitably choose not to engage or participate in the program.

Research into voluntary family support interventions has identified a host of factors at the parent, home visitor, and community levels, which influence engagement and retention of clients. Daro, McCurdy, and Nelson (2005) found that initial enrollment in home visiting programs is most significantly predicted by intent to enroll, which in turn is influenced by the client's readiness to change, attitude towards seeking help, and prior service experiences. At the point of service engagement, perceived risk to the child is the most important factor. Over time, other factors assume greater importance, including the subjective experience of receiving services, the objective value of services received, characteristics of the provider and program, and characteristics of the community.

Similarly, Wagner, Spiker, Linn, Gerlach-Downie, and Hernandez's (2003) findings, based on interviews and focus groups from a multisite home visiting program using the *Parents as Teachers* model, indicate that client engagement can occur at different levels. Researchers constructed a five-dimensional model of engagement levels, ranging from *say yes*, for parents who agreed to participation, to *look for more,*

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for those parents who sought out additional information and support for parenting. This model suggests that the concept of parent engagement is more complex than merely participation or attrition.

With regard to the community, Daro et al. (2005) found that families living in more chaotic communities were less likely to make use of voluntary family support for extended periods of time. This finding was also found in a study by McGuigan, Katzev, and Pratt (2003), which found that retention for 1 year in a voluntary child abuse prevention program was negatively associated with community violence.

Community Involvement

Differential response recognizes that community involvement and partnerships are a necessary component in ensuring the safety and protection of all children. As a result, DR has helped to foster partnerships between the CWS and CBOs that allow them to work together to provide families with the support and resources they need to prevent future child maltreatment. This is especially important because families raise children within specific communities. Hence, the resources, strengths, and weaknesses of communities ultimately impact the well-being of families and children. With this in mind, it is clear that partnerships between CWS and community agencies are a unique and integral part of efforts that aim to prevent child abuse and neglect.

A Preventative Approach

Although traditional child welfare services do not provide services or support to families who are reported to the system but whose cases are not substantiated, a percentage of these cases are subsequently re-referred into the system at a later date

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with allegations of child abuse and neglect that are more severe and likely to be substantiated at that point. In order to prevent this scenario, a major goal of the differential response system is to provide support, services, and opportunities to families before unsubstantiated cases rise to a higher level of severity that requires traditional CPS intervention. Using this approach, DR attempts to act early in order to preserve and strengthen families before their problems turn into crises. Information from the National Child Abuse and Neglect Data System (NCANDS) reveals that alternative response systems—such as differential response—serve children and families that don't qualify for traditional CWS intervention, but can still benefit from services and resources that help to prevent future abuse or neglect (Shusterman, Hollinshead, Fluke, & Yuan, 2005).

SUMMARY

Traditionally, the child welfare system (CWS) has targeted families at greatest risk for child abuse or neglect, while taking no further action on cases deemed to be at low to moderate risk. However, practitioners and researchers agree that families whose mistreatment does not meet criteria for abuse still need services. Differential Response (DR) is an effort to reform this system by offering voluntary services to these families who would not qualify for services under the traditional CWS. While the specific implementation of DR varies by locality, all DR models share five general components: screening based on risk, voluntary provision of services, respectful engagement of families, community involvement, and a focus on prevention. There is some controversy over classifying these services as *voluntary.* Sometimes CWS is notified if families

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refuse services or families may perceive this to be the case. Whether or not the services are truly voluntary may impact client motivation to participate in services. Nevertheless, all DR approaches see the families as experts in identifying, assessing, and solving their own problems, and establish partnerships between CWS and community-based organizations to serve at-risk families in the community.

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MODULE II

DIFFERENTIAL RESPONSE:
A REVIEW OF THE LITERATURE

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MODULE II
DIFFERENTIAL RESPONSE:
A REVIEW OF THE LITERATURE

INSTRUCTIONAL GUIDE

Purpose

- To illustrate models and findings from Differential Response programs as they have been implemented in five states.

Learning Objectives

By the end of this chapter, students should be able to:

(1) Identify key practices and outcomes from DR models in other states.

(2) Understand the challenge of evaluating AR/DR programs given the variability of implementation models across the country.

(3) Begin to identify and evaluate different types, or levels, of success within AR/DR interventions.

(4) Consider implications for practice based on current findings from AR/DR evaluations.

This chapter can be used to foster the following curriculum competencies:

1.1 Student demonstrates respect, fairness, and cultural competence in assessing, working with, and making service decisions regarding clients of diverse backgrounds.

3.8 Student demonstrates ability to respectfully relate to, engage, and assess family members from a strengths-based *person-in-environment* perspective, and to develop and implement a case plan based on this assessment.

3.18 Student understands the dual responsibility of the child welfare social worker to protect children and to provide services that support families as caregivers.

7.8 Student understands the purpose of outcome measurement and is able to seek client, organization, and community feedback for purposes of monitoring practice, service refinement, and outcome evaluation.

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QUESTIONS FOR DISCUSSION

1. When the state of Missouri evaluated outcomes from their DR program, they found that rates of child removal and placement were higher among families who participated in the intervention than for families not in the program. To what might we attribute this finding? How do you think this finding should be interpreted? How can it inform future practice?

2. An evaluation of Washington State's Community Based Alternative Response System (CBARS) concluded that the intervention appeared to have an *inhibitory,* or short-term impact on families' likelihood to reabuse. Why might this be the case? What measures can be taken to sustain longer-term reduction in risk of reabuse?

3. Outcomes from various DR/AR programs across the country are inconclusive with respect to their ability to prevent maltreatment. What are some of the positive effects of DR/AR interventions? Are there ways to maximize these effects and make the preventive qualities of the DR/AR intervention more sustainable?

DIFFERENTIAL RESPONSE: A REVIEW OF THE LITERATURE

Evaluations of DR and AR models have been conducted in Missouri (Loman & Siegel, 2004b), Minnesota (Loman & Siegel 2004a), Virginia (Virginia Department of Social Services, 2003), North Carolina (Center for Child and Family Policy, 2004), and Washington State (English, Wingard, Marshall, Orme, & Orme, 2000). In general, findings from these state-level evaluations were mixed. Child safety (as measured by subsequent maltreatment reports) was not compromised, nor was it improved in North Carolina, or Washington; in Minnesota and Missouri, DR families were less likely to be re-reported. And families who received differential response were more likely to have their children removed in Missouri (Loman & Siegel, 2004b), less likely in Minnesota

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(Loman & Siegel, 2004a), and there was no difference in Washington (English et al.); this outcome was not measured in North Carolina.

States have taken varied approaches for organizing and delivering DR and AR services. Case management may be provided to lower-risk families through public child welfare agencies (Missouri, Virginia, North Carolina, Florida), or through community-based agencies contracted by child welfare (Washington, Michigan, South Carolina), or they may be mixed in the state and vary by county (Minnesota, Louisiana; Schene, 2001c. One worker may stay with a case from the assessment through service delivery, or a case may be reassigned after assessment. The varied nature of program models must be kept in mind when interpreting the research findings from the state-level evaluations described below.

EXAMPLES OF DIFFERENTIAL RESPONSE AND ALTERNATIVE RESPONSE PROGRAMS AND RESEARCH FINDINGS

Missouri

In 1994 Missouri passed legislation to pilot a new, more flexible approach to working with families reported for child abuse or neglect. The new system had two tracks: *Investigation* and *Family Assessment.* The investigation track was utilized when severe cases of maltreatment were suspected. State law requires that such cases be investigated and substantiated if sufficient evidence is found, with the perpetrator's name entered into a registry and services offered to the family if warranted. The family assessment track is a less accusatory and more supportive response, in which

providers assess both child safety (creating a plan if problems are detected) and the need for services (connecting families to community providers if there is a need).

An initial evaluation was conducted of the 14-county demonstration from July 1993 through November 1997. Each county was paired with a comparison county and multiple forms of data were collected. Major findings for the demonstration counties included: (a) child safety was not compromised and in some cases improved; (b) recurrence of maltreatment reports decreased; (c) needed services were delivered more quickly and with greater utilization of community resources; (d) families' experiences of cooperation and satisfaction improved; and (e) the family assessment approach was preferred by CPS workers and community providers. Based on these positive findings, the DR system was extended statewide in 1998 (Loman & Siegel, 2004b).

Follow-up research was conducted using cases from the original study and updated files through November 2002. Analyses revealed that families' risk of future re-report to the CPS system was significantly lower among demonstration families in the assessment track. For both groups, the re-referral rate was related to initial risk level. Rates of child removal and placement were found to be higher among demonstration families than comparison families at every risk level—the first strike against this model found by researchers. Finally, follow-up research revealed that those families deemed as having "chronic child abuse and neglect" (defined as multiple contacts with CPS over a period of several years) did not experience significantly different outcomes by track assignment (Loman & Siegel, 2004b).

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Minnesota

Minnesota first implemented AR/DR in 20 pilot counties in the latter half of 2001; based on preliminary evaluation findings, the intervention was rolled out statewide beginning in 2003. Child welfare hotline screeners in Minnesota determine whether referrals meet a legal threshold of maltreatment required for intervention and, if so, whether the *Alternative Response* or *Traditional Response* track is most appropriate (Institute of Applied Research, 2004; Loman & Siegel, 2004a).

Evaluation of the AR program in the initial 20 pilot counties included an impact and outcome study, a process analysis of the project's implementation, and interview data from families and service providers. In the impact study, 5,049 families from 14 of the pilot counties were screened as low- to moderate-risk and were therefore deemed appropriate for AR. They were randomly assigned either to an experimental AR treatment group or a traditional CWS control group (Institute of Applied Research, 2004; Loman & Siegel, 2004a).

Overall, findings revealed that families and workers were more satisfied with AR services as compared with controls that were part of the traditional response track. When asked in an interview why they were satisfied or dissatisfied with services, families receiving AR were more likely to make comments that emphasized the interpersonal skills of the child welfare worker and their willingness to help and to listen than families receiving traditional services. Negative experiences with child welfare workers, such being treated disrespectfully or rudely, were more common among families receiving traditional services. Families receiving AR were more likely to receive

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services other than case management, and they also benefited from more services (1.6 as compared to 0.9). Child safety was maintained at similar levels for families receiving AR and traditional services.

Post-intervention, families in the AR track had better outcomes than the control group. Analyses indicated that they were less likely to be re-reported to CPS. Families who had received AR were also less likely to report drug abuse or domestic violence during the 1-year follow-up, more likely to report that they were better off because of the intervention at the 2-year follow-up, and less likely to report stress during the first, second, and third year follow-ups (Institute of Applied Research, 2004; Loman & Siegel, 2004a).

Virginia

In May 2002 Virginia began implementing a Differential Response System that, like Missouri, has two response tracks: the traditional *Investigation* and the *Family Assessment*. In the Investigation track, cases are considered *founded* if abuse or neglect is determined to have occurred. In such cases, the name of the caretaker responsible for the abuse is entered into a state registry and services may be offered if deemed warranted. In the Family Assessment track, valid CPS reports without immediate child safety concerns are assessed for family needs and strengths and community services are offered to decrease the risk of future maltreatment.

An evaluation of this system was conducted using administrative data on track assignment and service usage from January to December 2004 (Virginia Department of Social Services, 2005) as well as on-line surveys of juvenile court and domestic

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relations judges and CPS workers. No comparison group was included in this study. Of the 28,697 valid and accepted referrals made from January to December 2004, 66% were assigned to the Family Assessment response track, an increase from the 55% of valid cases assigned to this track in 2002 and the 61% assigned in 2003. Among the families assigned to this track, 36% were found by CPS workers to have service needs to treat or prevent child abuse, with the most frequently needed services cited as counseling, parent education, and substance abuse evaluation or treatment (Virginia Department of Social Services, 2005). According to 40% of directors, service needs resulted in higher costs to agencies. However, 78% of CPS directors, 84% of CPS supervisors, and 57% of CPS line staff workers preferred DR to the previous system (Virginia Department of Social Services, 2003). Evaluators conclude that the administrative and other data reviewed do not suggest that child safety has been compromised by reductions in the number of investigations (Virginia Department of Social Services, 2003), but this claim is difficult to verify in the absence of an experimental or quasi-experimental research design.

North Carolina

Ten counties in North Carolina piloted the *Multiple Response System* (MRS), their version of DR. Referrals are assigned to *Investigation Assessment* or *Family Assessment.* Investigation Assessment follows the traditional child welfare model, with investigation to establish whether child maltreatment can be substantiated. Family Assessment, on the other hand, has a wider focus on child well-being as well as safety. Family needs are assessed and one of the following determinations are made: (a)

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services needed, for cases in which service participation is mandated; (b) services recommended, for cases in which services are voluntary; and (c) services not recommended, for cases in which service needs have not been identified.

An evaluation assessed outcomes in four areas: child safety, timeliness of response, timeliness of service, and coordination of local human services. Nine of the 10 pilot counties were matched to a county that had not yet implemented MRS and also compared to the county's own previous historic data, while the 10th county was compared to its previous historic data alone. Data were collected from administrative databases as well as surveys and focus groups (Center for Child and Family Policy, 2004).

To determine the impact of MRS services on child safety, researchers checked rates of investigations and substantiations in the treatment counties for the first year of MRS implementation and compared these rates to the comparison counties and previous historic rates. There was no significant difference in these rates between treatment and comparison counties, or between the 1st year of MRS implementation and the 5 previous years' rates for each treatment county, leading researchers to conclude that child safety was neither improved nor compromised due to the implementation of MRS services. With regard to other measures, timeliness of response and length from report to initiation of services did not significantly differ between the control and treatment groups. The majority of families, CPS line staff, and CPS supervisors reported satisfaction with MRS services. Workers appreciated the increased ability to coordinate services (Center for Child and Family Policy, 2004).

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Washington

Efforts to reassign low- to moderate-risk child maltreatment referrals to CBOs began in the 1980s in Washington. In 1997, the *Community Based Alternative Response System* (CBARS) was funded by the legislature and mandated for implementation. Services provided by CBARS agencies include case assessment and management, referrals, and ancillary services.

The Washington State Office of Children's Administrative Research conducted a study to evaluate the outcomes of 1,263 *low* risk cases diverted to CBARS between 1992 and 1995. At the conclusion of services, outcomes were compared for families treated with the CBARS approach versus a group of *low* risk families in another community who received traditional CPS services. Re-referral rates were similar for families who did and did not receive assessment services at 18 months, and were highest for cases where domestic violence was present (English et al., 2000). There was a lower rate of re-referral at 6 months for CBARS families, indicating a possible *inhibitory* effect that suggests that services had a short-term impact on families' likelihood of reabuse (English et al.).

The U.S. Department of Health and Human Services (2005) conducted a study on case-level data reported to the federal government (through the National Archive of Child Abuse and Neglect Data System) for six states (Kentucky, Minnesota, Missouri, New Jersey, Oklahoma, and Wyoming) that offer both differential response and traditional investigation. Six months subsequent to the initial report, re-report rates appeared to be similar between those cases assigned to traditional investigation or

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differential response, with the exception of Oklahoma, where rates of subsequent reporting were lower.

SUMMARY

Evaluations of the effectiveness of Differential Response (DR) and Alternative Response (AR) models in various states have resulted in mixed findings, perhaps due to the variation seen in the organization and delivery of systems across the nation. In general, families and staff have very positive regard for the approach. Findings on the outcomes of DR, however, are more equivocal. Given the variation in service delivery, research methods and outcomes of these evaluations, the current literature offers little conclusive evidence regarding the effectiveness of AR/DR systems. Further experimental research is needed to determine the impact AR/DR has on child and family outcomes.

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MODULE III

A DETAILED REVIEW OF DIFFERENTIAL RESPONSE IN CONTRA COSTA COUNTY

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MODULE III
A DETAILED REVIEW OF DIFFERENTIAL RESPONSE IN CONTRA COSTA COUNTY

INSTRUCTIONAL GUIDE

Purpose

- To provide a detailed illustration of Contra Costa County's (CCC) model of Differential Response, including a description of the strategy for targeting services to neighborhoods most impacted by involvement in the CWS.

- To illustrate the Pathways for referral and response in CCC's DR model.

Learning Objectives

By the end of this chapter, students should be able to:

(1) Understand key practices within the CCC model of DR,

(2) Understand how strategic selection of target neighborhoods aims to impact disproportionality in the CWS,

(3) Understand the referral and response Pathways within the CCC DR model, and describe the services available to families within each of the three Pathways,

(4) Describe how the CCC DR model views community participation and understand how community involvement fits within the vision of the CWS Redesign, and

(5) Understand key partnerships between the CWS and various community-based and faith-based organizations.

This chapter can be used to foster the following curriculum competencies:

2.1 Student demonstrates knowledge of legal, socioeconomic, and psychosocial issues facing immigrants, refugees, and minority groups and is able to devise culturally competent and effective interventions.

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2.5 Student demonstrates ability to collaborate with individuals, groups, community-based organizations and government agencies to advocate for equitable access to culturally competent resources and services.

3.1 Student is able to practice basic principles and techniques of interviewing children and families for purposes of assessment, intervention, and service planning.

3.2 Student demonstrates ability to perform a preliminary safety assessment and to monitor the safety of the child through ongoing assessment of risk.

3.4 Student recognizes and accurately identifies the physical and behavioral indicators of abuse, family violence, and neglect, and can assess the dynamics underlying these behaviors.

3.7 Student is able to gather, assess, and present pertinent information from interviews, case records, and collateral sources in evaluating an abuse or neglect allegation and making effective referrals for services or further evaluation.

3.15 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income, non-traditional, and culturally diverse families and uses this knowledge to provide equitable and effective child welfare services.

4.2 Student demonstrates ability and knowledge both to utilize pre-placement preventive services, and to construct a supportive system for clients that may include collaboration with multiple agencies and disciplines.

5.4 Student demonstrates understanding of the influence of culture on human behavior and family dynamics.

6.1 Student demonstrates ability to assess the effects of family transitions and the potential impact of becoming a client of the child welfare system.

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QUESTIONS FOR DISCUSSION

1. Consider the implications of CCC's practice of a joint transitional visit in which the Emergency Response Investigator (ER) and the DR worker make contact with the family together. What might be some benefits or risks of this practice in terms of family engagement? What other impact might this practice have on the community's perception of the intervention and its affiliation with Children and Family Services?

2. In what ways do you see the CCC model of DR affecting community systems or altering community perception of the CWS? Imagine that you are the Community Engagement Specialist (CES). What do you see as being the primary goals and challenges of your position?

A DETAILED REVIEW OF DIFFERENTIAL RESPONSE IN CONTRA COSTA COUNTY

Overview of Differential Response in California

In California, the child welfare system is guided and overseen by the state government, but administered by counties at the local level (California Department of Social Services [CDSS], 2005). This allows counties to both meet the standards set by the state and implement and design programs that fit the diverse needs of California communities. Contra Costa County (CCC) was chosen as one of 11 counties to develop and test strategies recommended as part of the statewide Child Welfare Redesign (CWSSG, 2003). As a result, in 2005, Contra Costa County Children and Family Services (CFS) began to pilot and evaluate a multi-tiered DR system.

Overview of Differential Response in Contra Costa County

Contra Costa is one of the most populous and diverse counties in the state of California. Due to its relative size, the county did not receive enough funds to pilot the

provision of DR services to all families that would qualify for them (CDSS, 2006). Thus, the county chose to focus its resources on children under the age of five (the group which data suggest has the greatest likelihood of re-referral and are also one of the most vulnerable populations) in Family-to-Family Team Decision Making areas, which historically have the highest number of referrals and removals. These areas include North Richmond, the Iron Triangle area of Richmond, San Pablo, the Monument Corridor area of Concord, Pittsburg, and old Antioch.

The communities chosen for the pilot project are largely low income and African American, with an increasing Latino population (see Module VI). These communities were selected, in part, to address the concern that a disproportionate number of children of color are represented in California's CWS (CDSS, 2005). Statistics reveal that this is also the case among children in CCC, especially when comparing African American to Caucasian children. Specifically, in 2005, 25% of children referred to CFS were African American despite the fact that African American children only make up 11% of the population in CCC. Meanwhile, that same year, only 37% of children referred to CFS were Caucasian despite the fact that Caucasian children made up 43% of the population in CCC (Needell et al., 2006).

Differential Response Pathways in Contra Costa County

A review of over 700 assessed out cases in the county helped to determine the types of services needed through DR. Under CCC's DR pilot, an assessment of a report to a hotline screener leads either to a family being evaluated out of this new system,

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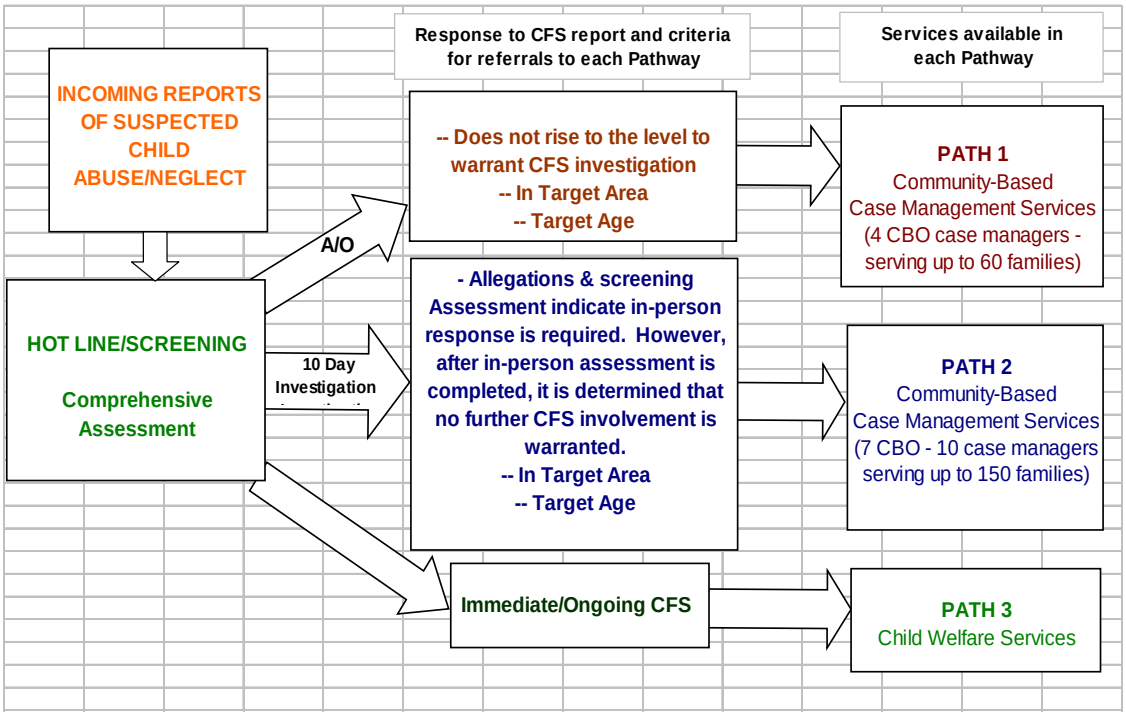
because the report does not warrant further action and/or does not meet the inclusion criteria, or to a referral to one of three paths of service.



Path 1. If a screener determines that there is not enough evidence to warrant an investigation, but the family is in need of services and supports, has a child less than 5 years old, and lives in the catchment area, the county sends out a *community engagement specialist* (CES) to do a face-to-face meeting with the family. The CES attempts to engage the family and enroll them in services with one of several community-based organizations (CBOs) based on location within the county. If the family consents, the CES refers the case to the appropriate CBO. Each CBO has one identified case manager whose full-time responsibility is to work with the CES and families in Path 1.

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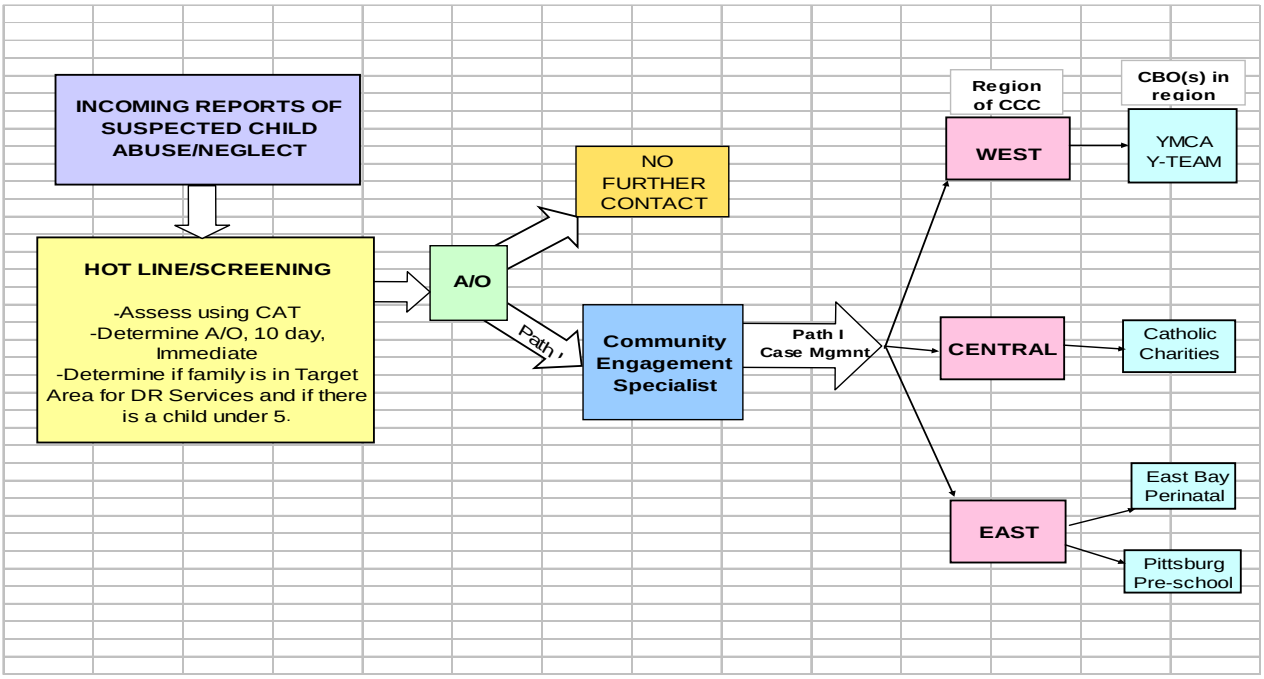
PATH 1



Path 2. A screener determines that there is enough concern to require an initial face-to-face assessment by a CFS Emergency Response (ER) social worker. If the ER social worker determines that a child welfare case will not be opened for the family, the ER social worker will attempt to link the family to community case management services to help address their needs. If appropriate, the ER social worker may attempt to coordinate with a CBO case manager from the client's region of the county to go jointly to the home for the first face-to-face assessment with the family.

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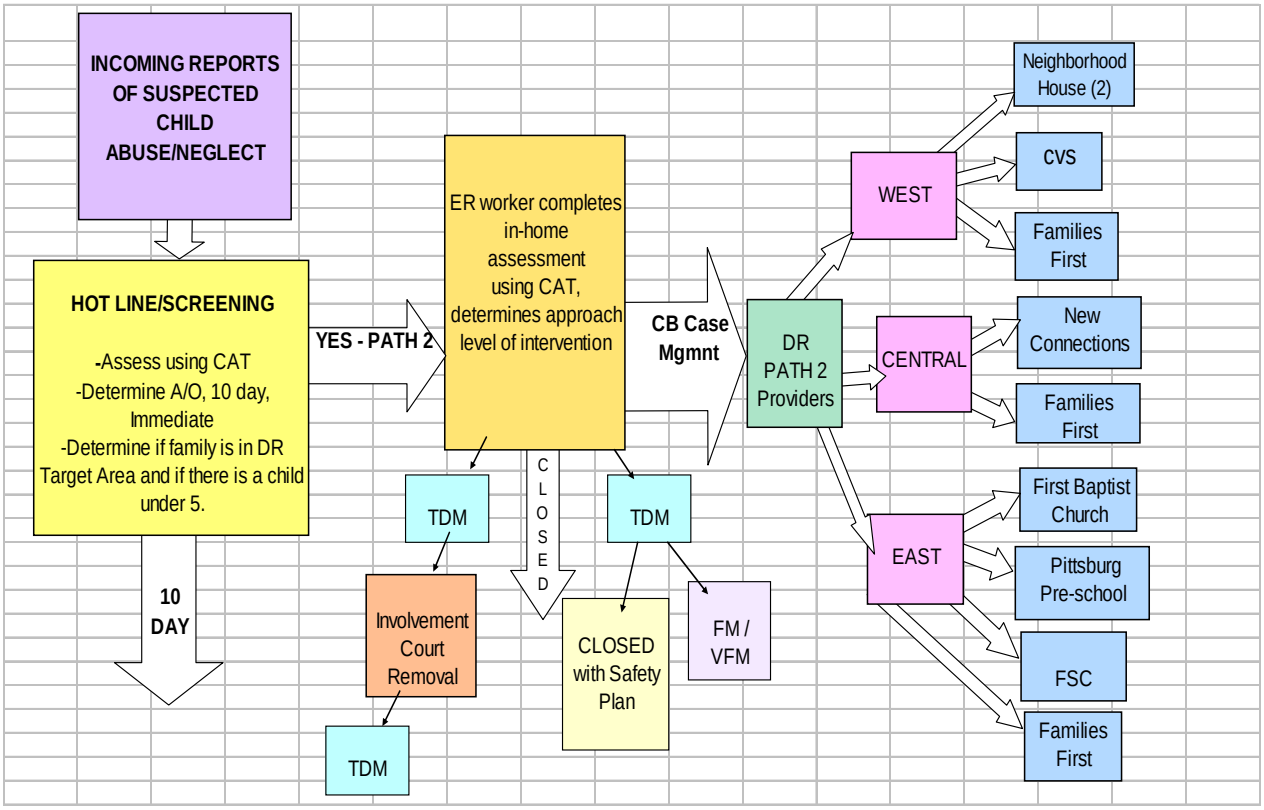
PATH 2



Path 3. A screener decides that the report does warrant investigation and that the level of risk and safety concern is too high for inclusion in Paths 1 or 2. This is a traditional child welfare investigation.

Contra Costa County Staff Overview

The table below captures information about Contra Costa County's Differential Response Staffing System. It includes staff positions, affiliation, and role.

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Table 1. Contra Costa County Differential Response Staffing System

Position	Employed with	Role description
Hotline Screener	Children and Family Services	• Takes calls and reports of suspected child abuse and neglect. • Conducts the initial screening to determine whether or not the call should be sent to the Emergency Response unit for investigation. • For assessed-out reports, makes the initial assessment to determine if the case qualifies for Path I services. • For assessed-in calls, flags potential Path II cases.
Hotline Supervisor	Children and Family Services	• Oversees hotline unit. • Reviews all assessed-out cases. • Sends all Path I referrals to the Path I supervisor.
Path I Supervisor	Children and Family Services	• Receives all Path I referrals, and checks to make sure they meet Path I criteria. • Assigns the Community Engagement Specialists to Path I cases. Oversees the work of the Community Engagement Specialists.
Community Engagement Specialist (hired from community with knowledge of local resources)	Children and Family Services (Initially contractual position; in 2008 became permanent positions with the CFS)	• Contacts Path I referrals and attempts to engage them in services. • When families engage in services, contacts a Path I case manager, and arranges a joint visit with the family, where the family is introduced to the Path I case manager. • Serves as link between CFS and community case managers. • Promotes community activities such as fairs and picnics, to boost Children and Family Services' image with the public.
Emergency Response Social Worker	Children and Family Services	• Investigates allegations of abuse and neglect. If the allegations do not rise to the level of meeting the legal definitions of abuse and neglect, closes the case. • When closed cases meet the criteria for Path II community services, makes the initial decision about whether to offer the family Path II services or not. • Collaborates with the ER supervisor to make the final determination about offering Path II services. • Collaborates with the family about services and engages the family. • When Path II services are offered, contacts an

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		appropriate CBO case manager for Path II services, and arranges to do a joint visit where the case manager is introduced to the family.
Emergency Response Supervisor	Children and Family Services	• Oversees the ER unit. • Receives referrals and assigns workers to investigate them. • Flags all potential Path II referrals. • Reviews all cases that are identified for closure. • Collaborates with ER social workers to make the final decision about offering Path II community services. • Maintains contact with community-based organizations in order to know about case openings. • Is responsible for ensuring that all workers know about Differential Response, and all relevant rules, procedures, and changes.
Case Manager, Path I	A community-based organization	• Receives referrals from the Community Engagement Specialist • Conducts a joint visit to the family with the Community Engagement Specialist when the case is transitioning from the Specialist to the Path I case manager. • Works with families for up to 1 year, providing support around the clock—24 hours per day, 7 days per week. Provides most services in the family's home. • Links families to services, ranging from mental health to day care. • Provides transportation to appointments if needed. • Teaches parents how to conduct professional business, such as making phone calls. • Provides information about how to navigate the services system. • Provides emotional support, and uses a strengths-based approach to help the family identify and reach goals.
Case Manager, Path II	A community-based organization	• Receives referrals from the Emergency Response Worker. • Conducts a joint visit with the Emergency Response Worker to the family when the case is transitioning from the Emergency Response worker to the case manager. • All of the same duties as described above for

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		Case Manager, Path I.
Case Manager Supervisor, Path I and/or II	A community-based organization	• Supervise Path I and/or II case managers. • Provide one-on-one weekly supervision to each case manager. • Keep monthly data about how many families engage, and which services they engage in; pass the information along to the county. • Inform Emergency Response Supervisors of case openings on the case managers' caseloads.

Goals of Differential Response in Contra Costa County

Goals of DR in Contra Costa County include maintaining child safety (e.g., fewer children placed into foster care), and improving well-being through access to support services (e.g., receipt of health and mental health services). The goals closely match the description of key outcomes for child welfare in California (CDSS, 2004b). Contra Costa County's DR implementation also attempts to address the role of community participation in serving families in child welfare. To this end, CFS has established contracts with 11 agencies to provide services to families referred to Paths 1 and 2. Two of these CBOs are faith-based; several are small, grass-roots organizations; and others are larger, more established agencies.

Each participating CBO has at least one case manager specifically dedicated to providing DR services. Case managers carry caseloads that range from 12-15 families. Working toward the goals listed above, case managers collaborate with families for up to 1 year using a strengths-based approach that aims to help the family identify and reach their goals. Overall, the greatest needs noted by case managers are emotional support and help navigating systems. Other typical services provided by case managers include:

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- transportation (e.g., bus & BART tickets)
- referrals for food and parenting classes
- crisis support
- advocacy
- information about services
- referral to services such as domestic violence counseling/help, substance abuse treatment, mental health services, housing, childcare, jobs, clothing, diapers, high chairs, tutoring, bilingual services, transportation

Developing community readiness and participation is an important aspect of achieving positive outcomes for children, and providing the necessary training and information to CWS and CBO staff is essential to the successful implementation of DR (Schene, 2001b). To this end, CCC dedicated much effort to training staff prior to the implementation of DR, and provides ongoing professional development opportunities and support to help DR staff meet the needs of the families they serve. As part of their effort to foster collaborative relationships among all DR partners, CFS facilitates monthly regional meetings and quarterly countywide meetings for all DR staff from CFS and participating CBOs.

SUMMARY

In 2005, Contra Costa County (CCC) began to pilot a three-tiered Differential Response (DR) system for children under 5 years in several predominately low-income minority communities. In CCC's system, a Children and Family Services (CFS) hotline screener assigns each case of alleged abuse or neglect to one of three paths. Those cases that are in the target age and geographic area, but in which the risk is not high enough to warrant a CFS investigation, are directed to Path I. In Path I, a Community

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Engagement Specialist (CES) visits the family and attempts to engage them in community-based case management services. When a case calls for an in-person assessment by a CFS Emergency Response (ER) social worker, but the worker determines that no further CFS involvement is needed, the case is directed to Path II. At this point, the ER worker connects the family to community-based case management services. The third path in the DR system is reserved for high-risk cases that require immediate and ongoing child welfare services.

The overall purpose of DR in CCC is to maintain child safety, improve well-being through community-based services, and engage the community in serving families. To meet the diverse needs of families that come into contact with the child welfare system, CCC's DR system establishes partnerships between CFS and CBOs in the county. DR staff are provided with training and ongoing professional development support to meet the system's goals.

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MODULE IV

A DETAILED REVIEW OF ALTERNATIVE RESPONSE IN ALAMEDA COUNTY

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MODULE IV
A DETAILED REVIEW OF ALTERNATIVE RESPONSE IN ALAMEDA COUNTY

INSTRUCTIONAL GUIDE

Purpose

- To provide a thorough description of the development of Alameda County's Alternative Response program—*Another Road to Safety*—including the development and negotiation of key partnerships. This chapter also details the services available to families in each of the two tracks within ARS.

Learning Objectives

By the end of this chapter, students should be able to:

(1) Describe the history of alternative response, as practiced in Alameda County's Another Road to Safety (ARS) Program,

(2) Understand the structures and partnerships that support the implementation and administration of ARS,

(3) Describe the process by which target communities were identified and how interest in ARS services was measured prior to launching the pilot, and

(4) Understand the ARS model, including services available to families within Track 1 and Track 2.

This chapter can be used to foster the following curriculum competencies:

3.1 Student is able to practice basic principles and techniques of interviewing children and families for purposes of assessment, intervention, and service planning.

3.2 Student demonstrates ability to perform a preliminary safety assessment and to monitor the safety of the child through ongoing assessment of risk.

3.4 Student recognizes and accurately identifies the physical and behavioral indicators of abuse, family violence, and neglect, and can assess the dynamics underlying these behaviors.

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3.7 Student is able to gather, assess, and present pertinent information from interviews, case records, and collateral sources in evaluating an abuse or neglect allegation and making effective referrals for services or further evaluation.

3.8 Student demonstrates ability to respectfully relate to, engage, and assess family members from a strengths-based *person in environment* perspective, and to develop and implement a case plan based on this assessment.

4.3 Student works collaboratively with biological families, foster families, and kin networks, involving them in assessment and planning and helping them access services and develop coping strategies.

4.4 Student demonstrates ability to identify service/treatment plan requirements and to construct measurable objectives for the service plan.

6.1 Student demonstrates ability to assess the effects of family transitions and the potential impact of becoming a client of the child welfare system.

8.1 Student understands how professional values, ethics, and standards influence decision-making and planning in public child welfare practice.

QUESTIONS FOR DISCUSSION

1. How did providers utilize data to identify target areas in which to pilot the ARS program? What might be some benefits and hazards of targeting services in this way? What effect do you see it having on client engagement? Is this a method of targeting services that could be replicated or expanded?

2. Among the justifications for switching to differential response cited by *The Early Intervention and Differential Response Strategies Workgroup* was that traditional CWS responses are allegation driven and incident focused. Describe how DR differs in its focus. What impact do you believe this has on families and communities?

3. *Systems change* is identified as among the goals of the DR intervention. What does systems change mean to you? How do you see DR effecting systems change, and what do you see as the role of social workers as agents of change in this context?

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A DETAILED REVIEW OF ALTERNATIVE RESPONSE IN ALAMEDA COUNTY

Overview of Alternative Response in California

The California Child Welfare Redesign, a 3-year planning effort by a wide range of stakeholders, recommended inclusion of differential response in child welfare practice (CWSSG, 2003). The predominant version of differential response currently being implemented in California involves three *tracks* or service responses. Pre-dating the California Child Welfare Services reform movement, Alameda County has, since 2002, provided a two-track alternative response approach. Track 1, known as the *Another Road to Safety* (ARS) program, serves cases screened out of the public child welfare system and diverted for community services, while Track 2 serves cases which indicate the need for court-mandated services.

Overview of Alternative Response in Alameda County

ARS offers voluntary services to those families who meet the following criteria: screened out of traditional investigation, child age 0-5 or a pregnant mother in the home, and residence in designated neighborhoods where a high proportion of child maltreatment referrals originate. The program was expanded in 2005 to a third neighborhood, which serves families with children ages 0-18. ARS clients receive intensive home visiting consisting primarily of support and mentoring and referrals to other formal service providers.

The ARS program is funded and managed through a cooperative agreement between the Alameda County Social Services Agency (SSA) and Alameda County First 5, or Every Child Counts (ECC; described in more detail below). The ARS program is

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currently in a period of transition, and these functions are being transferred exclusively to SSA, with ECC remaining involved in training and data management. Three community-based organizations operate the program in South Hayward, East Oakland, and West Oakland.

The implementation plan for ARS began with a two-site pilot phase, and is now in a phase of gradual countywide expansion. In 1999, when planning for ARS began, the Eastmont neighborhood of Oakland and the Harder-Tennyson neighborhood of Hayward had among the highest rates of child maltreatment referrals. The ARS planning team invested time in studying these communities to form an understanding of their strengths and problems. One source of information was *No Investigation Needed, Close File* (NINCF) data drawn from the California child welfare database, CWS/CMS. NINCF data offered zip-code-specific demographic information on families referred for child welfare services. To assess client interest in voluntary ARS services, SSA and ECC staff conducted in-home surveys with clients who met eligibility criteria. Despite the fact that the staff showed up at homes without prior announcement and identified the family's prior CPS report as criteria for the study, the refusal rate was a remarkably low 0.036%. Families surveyed expressed a strong interest in voluntary, in-home services. Parents who attended community forums held in each neighborhood showed similar interest in ARS program services.

Alternative Response Pathways in Alameda County

Calls to the Alameda County child abuse hotline are screened using the Structured Decision Making Tool (CDSS, 2004a). Cases are triaged for immediate

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investigation, investigation within 10 days, or no investigation needed, close file (NINCF). Investigated cases receive traditional child welfare services. NINCF cases are referred to the ARS program if hotline screeners determine that the family meets eligibility criteria listed previously. Depending on the client's zip code, one of the community-based agencies receives the referral and assigns the case to a home visitor. Although parents are offered services on a voluntary basis, families who decline services are referred back to CPS for possible follow-up.

Clients consenting to services are seen weekly, during visits lasting over 1 hour. Each home visitor carries a caseload of no more than 13 and, on average, only 9 cases. This allows the staff member to devote time to creating a relationship. Within 30 days of case assignment, each home visitor conducts a variety of assessments to guide the development of the *Family Care Plan*. The family and home visitor jointly develop the *Family Care Plan,* which outlines goals and steps to achieve them. Both the family and the home visitor work to meet the established goals during the 9-month duration of ARS services. Home visitors can offer referrals to other service providers, limited assistance from a basic needs fund, and social support. Services may be extended by an additional 3 months if a family continues to need assistance in meeting their goals.

Alameda County Staff Overview

Decisions about how to staff the program were carefully considered by ARS administrators. ARS was designed to be staffed by *community professionals,* a term preferred by public agency administrators over *paraprofessionals* because of its emphasis on the community expertise necessary to fulfill the role of an ARS home

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visitor. Striving to maximize the capacity of community professionals, ARS administrators also emphasize intensive supervision, support, and ongoing professional development for all staff. In addition to support and reflexive supervision offered by the clinical supervisors, ECC provides targeted support in the bi-weekly Specialty-Provider Team meetings, which offer staff an opportunity to consult with ECC experts in the areas of mental health and child development, among other topics. The positions, affiliations, and roles of staff involved with the ARS program are briefly described below.

Table 2. Alameda County Staffing System

Position	Employed with	Role description
Hotline Screener	Social Services Agency	• Assess calls to the Alameda County Child Abuse Hotline, using Structured Decision-Making tool • Make initial judgment to determine if NINCF calls can be referred to ARS community-based organizations, based on program criteria
Hotline Supervisor	Social Services Agency	• Review NINCF cases flagged for ARS, make final determination, and forward information on families • Contribute to training ARS home visitors on safety issues, data, and agency procedures • Participate in bimonthly Service Team Meetings (STM) with ARS staff to discuss case presentations and provide relevant information on SSA policies
Division Director, Prevention & Intake Services	Social Services Agency	• Serve as point person for ARS-CBO staff and address ongoing needs • Negotiate and manage contracts with ECC and ARS-CBOs • Organize monthly Executive Committee meetings with SSA and ECC administrators • Participate in bi-monthly STM meetings to provide guidance based on SSA policies
Contractor Liaison	First 5	• Serve as point person for ARS-CBO staff and address ongoing needs • Negotiate and manage contracts with SSA and ARS-CBOs • Participate in monthly Executive Committee meetings

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Specialty Provider Team	First 5	• Provide consultation on cases during bi-monthly STM meetings • Consult on cases by phone, as needed • Accompany home visitors on visit for in-person consultation, as requested
Clinical Supervisor	Community-based organizations	• Review and oversee case • Accompany home visitors on first visit to new clients and assist with assessments • Make cold calls to families referred to ARS to engage them in services • Offer weekly individual and group supervision to staff • Provide on-call support to staff • Help to coordinate services for clients • Assist with monthly case presentations (STM) • Participate in trainings and group and individual supervision on the topic of reflective supervision • Attend other relevant trainings • Complete monthly reports and other administrative work
Program Manager	Community-based organizations	• Handle administrative reporting requirements and other administrative duties associated with the program.
Family advocate/social worker	Community-based organizations	• Contact and visit new clients to engage them in services • Conduct safety, child development, substance abuse, and depression screens • Develop the *Family Care Plan* in collaboration with families • Assist families in meeting the goals they have established by providing referrals, basic needs funds, and support • Visit families weekly and check in by phone as needed • Identify community resources and link families to them as needed • Complete required case documentation • Attend relevant training • Participate in weekly individual and group supervision

Goals of Alternative Response in Alameda County

The ultimate goal of ARS is to ensure child safety, improve child development, and strengthen family functioning. In doing this, the program seeks to meet family-level

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and system-level goals. The Family Care Plan outlines the family's self-defined goals and structures the work with the families. Family goals fall under one of the following categories: child safety, child growth and development, parenting, school readiness, health and wellness, building family strengths, self-sufficiency, relationships, and nutrition. These same goals are contained in ARS's accountability matrix and are the basis for program evaluation. ARS services are offered for a relatively brief 9-month timeframe, so the intention is to use this period to incubate changes in parenting and life skills that will promote child and family safety and well-being.

Overarching the direct service goals are the management and policy goals. Chief among these is systems change. Alternative (differential) response represents a new way of engaging with families that is more tailored to family needs, less adversarial, and less stigmatizing than traditional child welfare services (Waldfogel, 1998b). It holds the hope of creating better outcomes for families by preventing the need for child removal and traditional child welfare services. The success of ARS for its clients is intended to have a ripple effect back to the systems that serve at-risk families. In this way, ARS aims to strengthen community institutions as well. Administrators hope to promote a more positive image of child welfare services in communities with historically mistrustful views of the system. ARS can also potentially relieve pressure on overtaxed child welfare systems by preventing the need for intrusive, high-cost interventions such as foster care.

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SUMMARY

Prior to the California Child Welfare Services reform movement, Alameda County introduced a two-track differential response system in 2002. In this system, child welfare hotline workers use the Structured Decision-Making Tool to screen calls and direct eligible screened-out cases to voluntary community services (a track referred to as *Another Road to Safety* [ARS]) and high-risk cases to traditional child welfare services. ARS, which began in areas with the highest concentration of maltreatment referrals, is now being expanded to other neighborhoods in the county. Funded and managed by Alameda County Social Services Agency (SSA), Alameda County First 5 or Every Child Counts (ECC), ARS involves weekly home visits to families to outline a *Family Care Plan*, in which the family develops goals and determines the steps needed to achieve them. Home visits are conducted by *community professionals*, who are lay persons with expert knowledge regarding the community's needs and resources.

As an alternative to traditional child welfare services, ARS is designed to be more individualized and based on family needs. Through goal-setting and ongoing support to the family, ARS aspires to strengthen families, protect children, and improve child development. The hope is that these positive outcomes will also improve community institutions, the image of child welfare services in the community, and the child welfare system itself.

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MODULE V

PRACTICE ISSUES

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MODULE V
PRACTICE ISSUES

INSTRUCTIONAL GUIDE

Purpose

- Drawing upon qualitative data gathered in interviews and focus groups with AR/DR providers, this chapter details practice issues, provider strategies, and *lessons learned* regarding all aspects of AR/DR services, from client engagement and provision of social support, to providing referrals to community resources and helping to meet basic needs.

Learning Objectives

By the end of this chapter, students should be able to:

1. Appreciate the special challenges faced by Home Visitors providing DR services and describe strategies employed by practitioners to overcome these challenges

2. Describe how social workers are uniquely positioned to provide DR services and understand how ARS/DR workers view their role with both clients and the community.

3. Understand how integration of child development and emphasis on attachment is essential to the overall AR/DR vision and strategy.

4. Describe the purpose of social support as well as strategies for providing support.

5. Grasp how the strengths-based, *person in environment* perspectives characteristic of social work serve to empower families.

6. Describe how DR workers tailor their efforts to respond to specific neighborhood characteristics and concerns.

7. Grasp the multidimensional nature of cultural competence and sensitivity.

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This chapter can be used to foster the following curriculum competencies:

1.1 Student demonstrates respect, fairness, and cultural competence in assessing, working with, and making service decisions regarding clients of diverse backgrounds.

1.2 Student demonstrates ability to conduct an ethnically and culturally competent assessment of a child and family and to develop an effective intervention plan.

1.6 Student understands the influence and value of traditional, culturally based childrearing practices and uses this knowledge in working with families.

2.1 Student demonstrates knowledge of legal, socioeconomic, and psychosocial issues facing immigrants, refugees, and minority groups and is able to devise culturally competent and effective interventions.

2.2 Student is able to critically evaluate the relevance of commonly utilized assessment criteria and intervention models in terms of their usefulness with diverse ethnic and cultural populations.

2.5 Student demonstrates ability to collaborate with individuals, groups, community-based organizations and government agencies to advocate for equitable access to culturally competent resources and services.

3.3 Student is able to identify the major family health, and social factors contributing to child abuse and neglect, as well as positive factors that act to preserve the family and protect the child.

3.8 Student demonstrates ability to respectfully relate to, engage, and assess family members from a strengths-based *person in environment* perspective, and to develop and implement a case plan based on this assessment.

3.9 Student demonstrates ability to engage and work with involuntary clients in a manner that includes the exercise of client self-determination.

3.10 Student understands how attachment, separation, and placement affect a child and family and how these experiences may influence a child's physical, cognitive, social, and emotional development.

3.11 Student recognizes the importance of working with biological families, foster families, and kin networks, as well as involving them in assessment and planning strategies.

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3.12 Student understands the inherent power differential in working with clients and can effectively manage and balance that power.

3.15 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income, non-traditional, and culturally diverse families and uses this knowledge to provide equitable and effective child welfare services.

3.18 Student understands the dual responsibility of the child welfare social worker to protect children and to provide services that support families as caregivers.

4.2 Student demonstrates ability and knowledge both to utilize pre-placement preventive services, and to construct a supportive system for clients that may include collaboration with multiple agencies and disciplines.

4.3 Student works collaboratively with biological families, foster families, and kin networks, involving them in assessment and planning and helping them access services and develop coping strategies.

5.3 Student demonstrates understanding of the potential effects of poverty, bias, inequity, and other forms of oppression on human behavior and social systems.

5.5 Student demonstrates understanding of how the strengths perspective and empowerment approaches can positively influence growth, development, and behavior change.

6.4 Student demonstrates understanding of the dynamics and effects of trauma resulting from family conflict, divorce, and family or community violence.

7.7 Student understands the need to negotiate and advocate for the development of resources that children and families require to meet family and service goals.

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QUESTIONS FOR DISCUSSION

1. In neighborhoods like East Oakland or North Richmond, where suspicion of the CWS may be especially high, how might you approach engagement?

2. What are some strategies for systems change that might also begin to address suspicion of CWS? In your opinion, what relationship, if any, exists between community involvement and successful family engagement?

3. Staff describe how provision of basic needs such as food and diapers can alleviate stress and in turn contribute to positive parenting. What role should AR/DR workers play in meeting basic needs? How does helping to meet basic needs fit with the overall goals of the intervention? What are the benefits and hazards of helping families to meet basic needs?

4. Unlike engagement in other services, home visiting services are likely to include family members in addition to the primary client. Do you think that inclusion of other family members is important to the intervention? How might you work to engage other members of the household? What are some challenges you might encounter?

5. Staff emphasize the importance of a strengths-based model as they develop plans and identify goals with families. Imagine a timeline of steps that you and a family might take together in forming a treatment plan. As you plan, consider the NASW Code of Ethics. What do you anticipate as the most difficult step?

6. The ARS program views child development as an integral element of child welfare and strives to promote understanding of child development among families. Why do you think this component is considered essential to the AR/DR model? What are some strategies that might create an opening to begin conversations about child development?

7. AR/DR staff discuss the balance they strive for to aid families with basic needs and empowering families to connect with their communities to access resources independently. Consider this balance and the challenges or questions that it brings up for you.

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PRACTICE ISSUES

Client Engagement

One of the greatest challenges facing home visiting programs--whether they are designed universally for all families, targeted to high-risk families, or targeted to families with identified needs, is engaging families in services (Daro et al., 2005). The work of other researchers suggests that practitioners need a window of opportunity in order to engage parents--in the case of David Olds' work, the birth of a child triggers parents' willingness to open their door to a service provider (Olds, Kitzman, Cole, & Robinson, 1997); Deborah Daro's studies highlight children's developmental milestones as an important point of entry (McCurdy & Daro, 2001). AR and DR differ from many home visiting models in that the first moment of contact is triggered by a CPS report that was initially closed by the child welfare agency. Engaging families at a time when parents may be in crisis, or may be suspicious of the child welfare agency poses special difficulties for AR/DR staff. In fact, they indicate that client mistrust of CPS (and ARS/DR's potential connection to CPS) is the primary barrier to engaging clients in services. For instance, DR staff noted that parents in Richmond believe that CPS has a hidden agenda, which is to always take their children. Similarly, parents often believe that ARS workers are acting on behalf of the child welfare agency and that separation from their children may result from further contact. One staff member remarked:

> It is scary for families to know that there is a CPS referral; and if it's untrue, more so. And they're mad and they're offended and they're like, "How can this happen? And you gotta tell me who did this!"

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To counter feelings of fear and suspicion, ARS/DR staff stress that services are voluntary, ask families about their needs, and emphasize the ways they can help. The Community Engagement Specialists in Contra Costa also try to dispel myths by hosting meetings with people in the community, attending local fairs, and hosting events for families.

Staff are honest with parents, telling them that they were referred to the child welfare agency for maltreatment and that their case was transferred to the community-based agency to offer support. According to one ARS staff member:

> I always tell them, “This is a voluntary program. We are not CPS. We are from the community. All of our services are free. What we really want is to just support you in the needs that you’re having.”

ARS staff report the possible contradiction in telling families that their case is voluntary while also warning them that they will have to refer them back to CPS if they do not participate; they question whether this is really voluntary. In Contra Costa County, a family’s non-participation is not cause for referral back to CFS.

Nevertheless, staff attempt to overcome parents’ suspicions by focusing on the services and supports they can offer, and their capacity to help parents with a variety of family needs. One worker explained:

> We help with resources. We’re their eyes. We find things and bring it to their attention. We’re a resource more than a direct agency; our service is to provide resources and linkages. We’re also there as another set of ears for them, when

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they have meetings that they might not fully understand; [we] help them interpret, break it down for them.

One DR case manager even said that offering something fun to the family, such as music lessons for the child, can be helpful because it builds rapport and gives the family something positive to consider. Similarly, an ARS worker mentioned offering free tickets to events as a fun incentive that encourages engagement and trust.

Staff also allow parents to vent their anger and listen patiently. For some parents, this can be an opportunity to share their parenting challenges and their difficulties interacting with service providers. It may be helpful for parents to express their feelings without fear of judgment or reprisal; an empathic response may help the parent accept services as well.

Yet, the first step is often getting in the door. A DR supervisor emphasized the importance of how a case manager enters a family's home:

> Entering the home is the most important key to the success of a caseworker. Enter wrong, you'll always be trying to play catch-up and apologizing and explaining. But if you enter right…The way you enter a home is paramount to the success of the intervention, because the family relaxes quicker and they trust.

One staff member shared the experience of a first visit wherein the mother was initially open to services, but the father was apprehensive about the staff members' motives. In the course of their conversation, the ARS staff member noticed a MediCal application on the table and inquired about the parents' process of completing the application. That opening allowed the father to share his frustration with the many

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service providers he had contacted, the mounting paperwork he did not know how to complete, and his frustration that his children had no access to medical and other needed services. The worker grasped the moment as her opportunity: “You know,” she stated, “I can help you with that.” At that point, the family accepted her assistance.

Staff in one ARS agency indicated that they focus their conversation on identifying the needs of young children and the special supports and services ARS can offer this age group. Early implementation results indicate that engagement rates may be somewhat higher in this agency than in other ARS agencies, possibly suggesting the promise of a child-focused strategy during the initial visits. All agencies in both counties, however, identify concrete supports they can help parents obtain, and follow through rapidly with information, contacts, and referrals so that parents can trust the sincerity of the program’s interests.

On average, approximately half of the clients that are referred to DR, and one-third of the clients referred to ARS, engage in services. These modest success rates suggest that many families who might benefit from services never take advantage of the opportunity. For those clients who *do* accept services, the approach for gaining their trust must be handled sensitively and over a period of time. One DR supervisor noted the importance of relationship-building:

> When you work in this field, you don't do [anything] without relationships. You don't make a dent in their life until you establish a relationship with that person.

DR staff offered some specific recommendations for establishing relationships with families:

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- Don't take notes in front of them. That puts people on guard and impedes your ability to connect with a family.
- Contact the family frequently—as much as 2-3 times a week in the beginning, but not so much that they feel like they are being watched.
- Don't ask about sensitive issues like domestic violence right away—allow that to unfold as the relationship develops.
- Respect families' schedules and recognize them as experts in their own homes and lives.

In summary, based upon interviews with key staff in Contra Costa and Alameda Counties, the principal components of successful engagement appear to include the following:

- Honesty about the referral from the child welfare agency,
- Thoughtful attention to the expressed and inferred needs of parents,
- A focus on the special needs young children might present,
- Offerings of concrete support, and
- Quick follow-up with information and referrals.

Special Techniques for Engaging and Providing Services for Teenagers

One agency spoke of the unique challenge presented by their efforts to engage teenagers in the family, in addition to the parents. Staff explained that because teenagers have so much autonomy by that age it requires a slightly different tactic to engage them. "I think when you talk to them with street knowledge, it helps to open the doors some," remarked one staff member. The staff member continued to explain that they work to achieve a balance between the goals and concerns of the parent and those

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of the teen. “I guess in a way I really work as a mediator, and that helps a little bit because it gets them both involved,” the worker remarked.

Staff maintained that, as when providing services to adults, it is important to find points of entry through provision of concrete, relevant services for teenagers as well. A staff member explained, “Most teenagers are at a point where they realize that they’re about to have to do for themselves and…you are offering them help with skills that they know they’re going to need for their life.” In general, staff at this particular agency emphasized the importance of flexibility and determination because their focus may be a small child, a teenager, a mother, or a grandparent.

Staff pointed out one other important challenge when working with teenagers. “The community as a whole,” one staff member said, “is a lot more harsh on that age group.” Emphasizing the importance of advocacy, she continued, “so you have to be really determined; you have to…put yourself out there and navigate systems and teach the clients how to navigate systems.”

Types of Services

Referrals

One of the fundamental activities of ARS family advocates and DR case managers involves referring families to needed services and linking them to resources in the community. Although services may be located anywhere in the county, staff are especially keen to identify services in the neighborhoods where families reside in order to increase access and the likelihood that services will be used. Part of the AR/DR

workers' job is to "be an expert on resources in their community." As one DR supervisor noted:

> The more the case manager knows about the community and the more information they have about resources in the area, the better equipped they are to support families.

Family advocates/case managers spend considerable time locating and assessing community resources themselves in order to find appropriate referrals to meet family needs. They avoid simply handing a family a phone number, as these *cold calls* may be just as frustrating for staff as they are for families. Instead, family advocates/case managers do the advance work. One family advocate offered this advice:

> Always call yourself and find out as much as you can about that agency and what they can do. And pass that information on to the family and still encourage them to call themselves and find out. Those cold calls are very important in terms of how the families feel that they can trust our assistance. And also in knowing the process. I always try to ask you know, "How long will this take?"

Monthly regional meetings offer DR staff regular opportunities to keep current regarding available community resources and to share information about resources with each other. Similarly, ARS staff in all three agencies meet twice monthly with county social services to review cases and draw upon collective knowledge and experience in order to identify the most appropriate resources for families.

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Staff in service-poor communities note the challenge of discovering and accessing appropriate community resources. Staff in West Oakland expressed interest in establishing regular community meetings as a strategy to understand the needs of the community from community members directly. They indicate that this process with the community, in combination with more interaction among other Community-Based Organizations, could help to augment their bank of community resources. They expressed concern regarding the lack of consistent community support in communities where resources are scarce. Staff observed that continuity of care, particularly in provision of Mental Health services, is difficult to achieve and cited economic factors as among the reasons for this lack of continuity, noting that families' financial limitations often dictate their choices when seeking formal support.

AR and DR staff explain that building relationships with families is a key factor in facilitating the families' process of following through with referrals. Relationships and referrals *go hand-in-hand*. Part of the process involves stepping back and allowing parents to develop personal resourcefulness. One family advocate states:

I let them do it, because we are for 9 months in their lives, and if they don't learn how to do it, then they will go back to how they were when we entered their lives.

One case manager stated that they operate on a "do what it takes philosophy," which may mean, for example, providing a family with transportation to an appointment. At the same time, as noted by the family advocate above, "We want them to be empowered to see that services are available and this is how you get there." To help families learn to access services and advocate for themselves, DR case managers do a lot of role

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playing with families to teach them how to make professional calls and conduct business on their own. Staff are especially pleased when clients begin to seek resources on their own. And according to one worker, “Clients sometimes find contact information a lot quicker than staff can.”

Some of the main referrals staff provide for families are for Medi-Cal, housing, CalWorks, childcare, counseling, legal aid, and school districts that can offer information about how to initiate the process for developing an Individualized Education Plan (IEP). Staff members make an important clarification, however, stating: “We are not in the position to give them [services]…We help with resources….We find things and bring it to their attention. We’re a resource more than a direct agency.” An administrator confirms that family advocates’ efforts emphasize identifying and assessing resources and providing support to families as they connect with those resources. This administrator underscored the fact that family advocates do not do counseling.

Some of the main lessons learned from interviews and focus groups with providers about the process of referring families to services include:

- Seek out resources in families’ neighborhoods to increase accessibility and likelihood of use.
- Balance families’ needs for immediate services with their needs to follow-through with referrals on their own, and teach them how to identify and access services on their own.
- Do the advance work. Call referral sources first to get as much information about the nature of the service provided, the eligibility criteria and/or application process, and other relevant information.

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Child Development and Parent-Child Relationships

Child welfare staff typically focus on children's safety, and on the parent-child relationship as it relates to the promotion of child safety. Less often are child welfare staff invited to consider the broader nature of the parent-child relationship, and less frequently still do staff consider child development in their deliberations of child well-being. ARS offers a departure from typical child welfare services by encouraging staff to consider and support healthy child development in the context of the parent/child relationship. According to one public agency administrator in Alameda County: "We focus on safety first, and then development….For any of this to be effective, we have to talk about child development as a course of child welfare activities."

Although the broad goal of child development is clearly articulated as among the goals of the program, and staff report that it is very helpful to be aware of child development issues in working with families, it is nonetheless often awkward to focus on these issues directly. First, the point of entry to discuss child development issues may not be obvious. Although staff use child development assessment instruments, staff indicate that parents sometimes feel judged by these assessments and worry about their children's *performance*. Other naturally occurring moments that might allow for a developmental discussion may not present themselves, although these moments may occur more frequently among families with younger children. For example, staff in one community-based agency repeatedly spoke of their work with a local science-focused children's center. ARS parents and their children are regularly transported to the center to participate in organized science, art, and other group activities. These outings allow

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parents an opportunity to engage with their children in a meaningful and often playful manner. Children and their parents work on projects together, and this experience is celebrated and honored by staff. According to one staff member:

> We see so many parents who have never played with their kids. Don't know what to do with their kids…When they're there it gives them the opportunity to focus and to share and to have fun. I mean we have so many parents that do all the crafts and that play all the games. And they enjoy it…They didn't do that when they were growing up. And also they learn that you don't need to have money to have fun with your kids…When you see that with a piece of paper you can have fun for an hour, two hours with your kid doing projects. And also they provide the book to them so they can read and find out how to do the project…and you notice when you go and do your home visit and they show you the project that they did at home. And that makes a really big difference.

Staff also spoke of the supportive benefits offered to parents who participated, indicating that group activities such as these allowed mothers to connect with one another around parenting issues in ways that they might otherwise miss.

Lessons learned regarding interventions targeting the parent-child relationship were:

- Assessments of child development can be sensitive for parents; they require trust between the parent and provider.
- Child development assessments can offer a window to educate families on developmental milestones and to provide referrals in cases of developmental delay.

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- Parents may need opportunities to enjoy their children's company and engage in play. Semi-structured activities that promote positive interactions may be an important component of programs focused on the parent-child relationship.

Basic Needs

Some evidence from the family preservation literature indicates that troubled families interfacing with the child welfare system often have a variety of concrete needs that require attention before psychological or emotional concerns can be addressed (Chaffin, Bonner, & Hill, 2001). ARS & DR families are no different and present a variety of needs to staff that sometimes require immediate attention. According to staff, the most frequent needs their clients present include the following:

- Housing:
    - Communities in which families live are considered dangerous
    - Housing is too small to accommodate family size
    - Adequate housing is not affordable
    - Many homes have maintenance problems that landlords are reluctant to pursue
    - Housing authority officials may be unresponsive.
- Childcare:
    - Availability and affordability are problematic
    - Head Start eligible children are not enrolled
- Financial struggles:
    - The cost of living in the Bay Area is especially high
    - Parents are unemployed or underemployed
    - Parents have low levels of education
    - Parents have trouble providing basic needs (e.g., food, clothing), and must show special creativity to manage their finances

- Depression and substance abuse:
    - Chronic and concrete problems can result from these concerns.
- Undocumented families:
    - Documentation status infringes on parents' capacity to locate economically secure employment, health care, or housing.

Additionally, in Contra Costa County, there are insufficient bilingual services available, and transportation is sparse in certain parts of the county. Access to bilingual services is also a problem in Alameda County, as is the cost and availability of transportation. ARS workers cite both of these challenges as obstacles for clients attempting to access services.

Since its inception, ARS staff have had a basic needs fund available to them, which could be used to purchase a range of small items such as diapers, food, and clothing as well as to support housing costs, including utility or water bills. Staff assess whether these are one-time or regular requests and work with families to develop manageable family budgets that can be sustained following ARS termination. Access to the basic needs fund has been curtailed sharply due to recent budget cuts, and ARS staff now make greater efforts to locate community resources that can be supportive to families. For example, ARS staff help to ensure that basic needs are met by connecting families to food banks where they can receive a monthly box of food or informing families about reducing their utility costs by enrolling in programs for low-income families.

Lessons learned suggest that funding to support some families' basic needs may help to overcome crises. One West Oakland worker also noted that assisting families to

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meet basic needs can create an opening and can increase parents' willingness to address other, *deeper needs*. Overall, ARS/DR staff offered the following insight regarding provision of basic needs:

- Families participating in ARS are financially stressed; even small contributions of diapers and food can make important contributions toward positive parenting.
- Other basic services received were: assistance with utility bills, transportation to children's schools and appointments, gift cards for groceries and clothing, and help with initial rent payments/deposits

Social Support

Social support is theorized to mediate the relationship between chronic or acute stress and mental health and health outcomes. A mechanism has been hypothesized connecting social support to stress reduction and positive mental health outcomes through provision of assistance and reassurance that bolsters self-esteem or a sense of identity, and encourages a sense of mastery and competence (Thoits, 1995). The relationship of social support to health outcomes may involve modeling healthy behaviors, encouraging healthy choices, and suggesting healthy options. There may even be physiological benefits to the presence of a supportive person for regulating emotional states. However, empirical evidence is lacking on the mechanisms by which social support operates (Thoits).

Studies have consistently found that people express preference for informal over formal social support, and desire professional help only when other forms of support are not available (Finfgeld-Connett, 2005). Exploratory research suggests that at least some child-welfare-involved families may be receptive to informal social support interventions

(Manji, Maiter, & Palmer, 2005). In spite of the benefits of informal support, the ARS and DR models rely on more formal supports, such as providing families with social support from staff and connecting them to formal service providers in the community.

In fact, one of the pillars upon which the models stand is the provision of social support to parents who might otherwise feel isolated and be unaware of available community resources. Family advocates and case managers work with families initially to develop rapport and gain their trust. Following the family assessment, staff identify parents' strengths and help parents recognize these qualities in themselves as well. They continue to draw on their clients' strengths throughout the duration of their work either by giving them positive feedback when they are doing well or pointing out their strengths when they see that their clients "are really lost in this fog of confusion or depression." Helping families identify their strengths and reminding them of their successes is important to staff because they recognize that "a lot of [the] families don't have that support from their own families to help them see that they're headed towards a good direction." Case managers look for anything positive, even if it's the smallest thing. One worker offered this example: "Like [if] you go into the home and there's plants thriving in the home. You know people are taking the time to water plants. Use this as a way to 'build up' the families."

ARS/DR providers remarked on the assets and resiliency of many of their clients. Some of the common strengths found among clients include:

- Engagement: Many parents have an ability to engage in relationships with staff, be somewhat introspective, and reach some goals.

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- Creativity and optimism: Staff comment that in spite of hardships, parents often remain very positive and grateful. They follow up with referrals and try to make things work out.

- Focus on the family: Staff indicate that parents try hard to keep their children, in spite of extreme circumstances. They are open to learning about children's developmental needs.

The act of home visiting is another important component of families' social support. Home visits help to remove several obstacles for families including language (when workers are matched linguistically) and transportation barriers. A clinical supervisor describes home visitors as: "Nonjudgmental, truly interested in families, (who help families feel) understood and accepted. (Parents) really like someone coming to their home; someone they feel that they can speak to." Home visitors report that this type of support appears to be especially valuable to the families they work with because so many of them experience significant isolation, either due to cultural issues, language, immigration status, or depression.

Family advocates and case managers can offer support by accompanying parents to meetings with school officials or with other institutional representatives. They can help parents interpret information, or they may ask questions that parents did not think to ask. They also help support parents in their decision-making process. Staff emphasize the value of client self-determination and dignity. One staff member suggests: "I'm not going to tell them what they need to do. I just go to suggest options that they have and let them [determine] which one is the best for them."

One home visitor explains that support should be about encouraging families to experience a sense of confidence about decision making regarding their children's well-

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being. Support is not synonymous with enabling families, but allowing families to feel the success of their own decisions and actions.

The important lessons learned about social support in the ARS & DR programs include:

- Early identification of family strengths.
- Contact with families in their own homes.
- Encouragement for parents to make their own decisions and to take action on behalf of their families.

As noted above, staff in the ARS & DR programs generally do not assist parents in connecting with informal networks. Staff occasionally do so indirectly, as with group activities organized with other ARS parents. Staff also find that even when families have social networks, these may lack resources to provide beneficial assistance. Other families within the community may suffer from similar social problems and therefore parents may not benefit from a mutual exchange of support. Staff sometimes suggest that families visit their neighborhood church, but generally they focus on providing parents with resources and formal supports to agencies and services.

Lessons learned about the role of informal support:

- Positive informal support can be a powerful motivator, source of strength, and problem solver for parents. ARS & DR could bolster their attempts to link parents to various sources of informal support.

Another Road to Safety and Differential Response Services in Ethnically Diverse Neighborhoods

When asked how ARS staff adapt the program to the unique needs of the neighborhood, they indicate that the demographic context is a critical factor driving their

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program model. In West Oakland, for example, a supervisor recognizes the extreme poverty of the community, relative to the other two neighborhoods. In this setting, staff first assess families' basic needs and attend to these, well before attempting to alter parent-child relationships. According to one staff member in this agency: "One thing about this neighborhood, with the poverty, you respond to the community's needs and pay attention to basic needs. We're talking about basic needs, being able to get the family to that point where we have food on the table today."

Staff are mindful of the history of their community and make special efforts to honor their commitments to families. Because previous programs have been offered, but have failed, West Oakland staff are attempting to grow their program methodically and to offer concrete services to families, so that community members can experience tangible benefits from program participation. The Alameda county agency that, unlike others, serves children from 0-18, introduces unique negotiations within the family and the community. West Oakland staff remind us that diversity does not refer only to ethnicity and that engaging individuals who are a different age also presents a challenge that workers must approach thoughtfully.

In East Oakland, staff are aware of the community's attitude toward CPS, and their mistrust of the system. Community suspicion is well-founded as evidence from some research in California suggests that upwards of one third of all African American children in the state will have contact with the child welfare agency through a child maltreatment referral before kindergarten. One in ten children is placed in foster care—rates approximately double that for children of other ethnic groups (Magruder & Shaw,

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2007). To alleviate some of parents' doubts about the intentions of ARS providers, ARS staff in this neighborhood attempt to gain access to families by offering concrete supports such as gift cards to local grocery stores. Using concrete supports as their initial lever of intervention, ARS staff hope to gain sufficient trust that they can then work on developing a relationship that will support family change. An additional dimension impacting ARS staff and families in this neighborhood is the concern for safety. According to one staff member: "There's safety issues, both for us as visitors and for them as residents. People may have very strong limitations on how and when we can meet because those are realities of the neighborhoods they live in."

In their early interactions with parents, staff acknowledge the challenge of parenting, and staff suggest that they can help improve parents' capacities to care for, and provide for their children. Staff in both East and West Oakland are direct with parents about the reason for their visit, and their goals. One staff member states:

> We say, "Did you know that someone called to report you?" Some say, "Yes, I know who did it." We say, "Let's try to keep them from calling again." We say, "Our goal is to keep CPS out of your house. Give us an opportunity so that someone won't call CPS again, and there's a possibility of them taking the kids away." We tell them that we are not tied to CPS.

Staff in South Hayward also distance themselves from the public child welfare agency, but their approach to parents is subtly different. There, staff focus less on the parents as access points to the family and instead concentrate on the young child, the child's development, and the child's need for a safe and healthy environment in which to

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grow. ARS staff in South Hayward acknowledge the cultural value placed on children in the Latino community and use this as a tool for gaining access to, and trust with parents.

Staff in all three of the ARS sites report that they are mindful of providing culturally appropriate services through trainings and dialogues. They explain that communication takes place both within agencies and with clients. In addition to openly discussing issues of diversity, staff also are generally diverse. Staff recognize, however, that “it’s not always just race, it’s also class.” Similarly, age and whether or not staff are parents may affect clients’ perception of staff as culturally responsive.

Like Alameda County, the three targeted areas of Contra Costa County each have distinct characteristics as described in Chapter VI. Most notable are the Richmond residents (who historically distrust CPS and lack hope of growing up and escaping poverty and violence) and the predominant Latino population in Central County. One of the ways that CPS attempts to address the distrust issues in Richmond—and the unique needs in each community—is to contract with numerous community-based organizations in each part of the county to give families options to go to the agency where they feel most comfortable. Likewise, recognizing the church as a part of many clients' culture and support network, they contract with several faith-based organizations to provide case management services.

In Central County there may be a disconnect between available services, and the nature of services that monolingual families might find helpful. One ER worker in Central County felt that there were many resources available to families, but other staff note that

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there are insufficient bilingual services or agencies that specifically focus on the Latino population. The CES for that community, who is Latino, has worked hard to establish positive relationships within the community and to clarify the role of CPS. For example, many Latino parents were under the impression that CPS was giving candy to children in exchange for reporting on their parents. One woman came forward and asked the CES if the rumor was true. The CES met with CPS staff and with about 20 women from the community, dispelling the myth. The women then returned to the community, armed with accurate information. CPS later held a meeting, co-facilitated by the group of women, in which the myths were discussed with approximately 350 community members. This example points to the significant distrust that can develop between communities and CPS, and the power of partnering with community members to reach new understandings.

Another case manager noted that it is important to realize that some cultures have many subcultures, as in different regions of a country, or different countries that speak the same language. For some cultures, the case manager remarked that even talking about culture can be considered offensive.

Lessons learned about work with diverse families in diverse neighborhoods:

- Staff should assess the neighborhood and family context of clients and approach families using this lens of understanding.
- Cultural sensitivity includes an understanding of one's economic status, age, background, and other factors in addition to race and ethnicity.
- Specific knowledge of a community's demographics and community resources is essential to providing culturally appropriate services.

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SUMMARY

ARS/DR workers contend with numerous challenges when providing services to families. These challenges relate to a broad range of issues, including client engagement, service provision, and neighborhood diversity. Being mindful of these issues is essential to the effectiveness of AR/DR workers.

Client engagement is typically the first challenge ARS/DR workers face. Often engagement is hindered by clients' mistrust of CPS and the association they have with ARS/DR and CPS. Overcoming this barrier involves stressing the voluntary nature of the ARS/DR services, asking about client needs, and emphasizing the helping role of the worker. Some workers have reported that being honest with families, focusing on serving the specific needs of the children, and building relationships can also facilitate client engagement. Serving teens presents a unique challenge; balancing the concerns of parents and teens, and helping teens navigate the service systems may help workers engage these clients.

AR/DR workers must also be prepared to effectively offer a broad range of services. To provide appropriate referrals, for example, workers must be experts on the community's resources and be willing to gather as much information about an agency as possible prior to referring families to that agency. To assess child development and parent-child relationships, workers must find naturally occurring openings for discussing these sensitive topics. Some counties have also provided supported, structured opportunities for parents to play with their children, a parenting skill many clients lack. Finally, AR/DR workers must be familiar with services that address clients' basic needs

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(e.g. housing, childcare, and financial support), and provide the family with social support. Offering social support entails identifying strengths in the family and supporting family members in making important decisions.

Engaging clients and providing appropriate services depends on adapting the AR/DR service model to the unique needs of each neighborhood, subculture, and family. In all neighborhoods, ensuring that workers are prepared to manage the practice-related challenges they will encounter, including addressing the diverse characteristics and needs of communities, is requisite to providing culturally appropriate and effective services.

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MODULE VI

ASSESSING READINESS IN DIVERSE COMMUNITIES

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MODULE VI
ASSESSING READINESS IN DIVERSE COMMUNITIES

INSTRUCTIONAL GUIDE

Purpose

- To examine the process used by AR/DR providers to tailor their services to their target population, with consideration for neighborhood resources and demographics and the resulting community strengths and needs.

- To provide an overview of disproportionality in California and an analysis of the cultural competence exhibited in tools commonly used to assess family risk.

- To offer case studies of six neighborhoods in which AR/DR operates that describe history, demographics, and industry of each neighborhood.

Learning Objectives

By the end of this chapter, students should be able to:

1. Understand how community-based agencies worked to familiarize themselves with their target population and tailor services to specific neighborhood characteristics.

2. Understand disproportionality and how AR/DR attempts to impact the disproportionate representation of children of color in the CWS.

3. Recognize how biases can impact services and interventions on both micro and macro levels.

4. Recognize biases within assessment tools and understand the importance of utilizing a culturally competent instrument.

This chapter can be used to foster the following curriculum competencies:

1.1 Student demonstrates respect, fairness, and cultural competence in assessing, working with, and making service decisions regarding clients of diverse backgrounds.

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1.2 Student demonstrates self-awareness and the ability to address and overcome personal bias in assessing and working with clients of diverse backgrounds.

1.3 Student demonstrates ability to conduct an ethnically and culturally competent assessment of a child and family and to develop an effective intervention plan.

1.6 Student understands the influence and value of traditional, culturally based childrearing practices and uses this knowledge in working with families.

2.1 Student demonstrates knowledge of legal, socioeconomic, and psychosocial issues facing immigrants, refugees, and minority groups and is able to devise culturally competent and effective interventions.

2.2 Student is able to critically evaluate the relevance of commonly utilized assessment criteria and intervention models in terms of their usefulness with diverse ethnic and cultural populations.

2.3 Student demonstrates knowledge of the rationale for and requirements of the Indian Child Welfare Act and applies its provisions in working with tribal representatives and families.

2.4 Student demonstrates knowledge of the rationale for and requirements of the Multi-Ethnic Placement Act and applies its provisions in working with families.

2.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally competent resources and services.

3.3 Student is able to identify the major family, health, and social factors contributing to child abuse and neglect, as well as positive factors that act to preserve the family and protect the child.

3.11 Student recognizes the importance of working with biological families, foster families, and kin networks, as well as involving them in assessment and planning strategies.

3.12 Student understands the inherent power differential in working with clients and can effectively manage and balance that power.

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3.15 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income, non-traditional, and culturally diverse families and uses this knowledge to provide equitable and effective child welfare services.

5.3 Student demonstrates understanding of the potential effects of poverty, bias, inequity, and other forms of oppression on human behavior and family dynamics.

5.4 Student demonstrates understanding of the influence of culture on human behavior and family dynamics.

5.5 Student demonstrates understanding of how the strengths perspective and empowerment approaches can positively influence growth, development, and behavior change.

7.1 Student is able to identify the strengths and limitations of an organization, including its cultural competence and commitment to human diversity, and can assess the effects of these factors on services for children and families.

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QUESTIONS FOR DISCUSSION

1. Consider the engagement strategies used among the different neighborhoods. Given what you know about each of the neighborhoods, do you think that the distinct styles of service delivery illustrate cultural or neighborhood responsivity, or simply a different model?

2. Research aiming to understand the etiology of the disproportional representation of children of color in the child welfare system has produced mixed results. To what would you attribute the high rates of contact with the CWS experienced by African American and Native American families? What questions or interests does this issue provoke for you?

3. What factors are most relevant in considering when and how to intervene with a family?

4. How should ethnic and cultural considerations guide your communication with a family?

5. Create an assessment or intervention tool that you believe is culturally competent.

6. What biases might you or other social workers hold when assessing risk in a family? What biases might you or other social workers hold when determining what services to give a family?

7. What ethical obligation do you have as a social worker to consider a family's ethnicity, culture, and race when making decisions that affect their lives?

8. Pretend you are walking into someone's home to meet them and their two young children. Imagine yourself walking through each room and inspecting it. What sort of behavior do you consider appropriate by the parents and the children? What types of behaviors would concern you? What do you expect the home environment to look like? What issues would concern you about the home environment? After you've imagined this, revisit your expectations and concerns and identify what values inform each expectation and concern. Where did these values come from (e.g., family, school, culture)? Are any of these values affecting your ability to make the most fair and objective assessment possible? If so, how do these values influence your assessment?

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ALTERNATIVE RESPONSE/DIFFERENTIAL RESPONSE IN THE NEIGHBORHOOD CONTEXT

Planning to Work in Neighborhoods

As described in Chapter IV, the planning stages of Alameda County's ARS program began with a two-site pilot phase, in which East Oakland's Eastmont neighborhood and South Hayward's Harder Tennyson neighborhood were selected to begin the pilot. In 1999, when planning began, these neighborhoods had some of the highest rates of child maltreatment referrals. The ARS planning team invested time in studying these communities to form an understanding of their strengths and challenges. One source of information was *No Investigation Needed, Close File* data drawn from the California child welfare database. These data offered zip-code-specific demographic information on families referred for child welfare services. To assess client interest in voluntary ARS services, the Social Services Agency and Every Child Counts staff conducted in-home surveys with clients who met eligibility criteria. Despite the staff showing up at homes without prior announcement and identifying families' prior CPS reports as criteria for the study, the refusal rate was remarkably low. Families surveyed expressed a strong interest in voluntary, in-home services. Parents who attended community forums held in each neighborhood showed similar interest in ARS program services. In addition to piloting the work with eligible families, staff planned to launch the model with an understanding of the neighborhoods in which the model would be delivered. High school students were hired to walk the streets of the communities and

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develop asset maps. This effort produced geo-coded maps of community resources in each of the two neighborhoods.

Tailoring Services to Diverse Neighborhoods

Although the general program approach is the same in each of the three communities, service providers indicate that they have customized the ARS model to meet the unique needs of their communities. Both the demographic characteristics of community members and the range of services available to families are distinctive by community. For example, the South Hayward community is heavily populated by Latino immigrant families (Barnett, 2002). The majority of families in West Oakland, however, are African American (Harvey, Espinoza, Hays, Friskin, Howard, Huynh, et al., 1999), and East Oakland, a community historically dominated by African American families, has recently grown more diverse with Latino and Asian immigrant families moving into the neighborhood (Younis, 1998).

The Resource Context

South Hayward has sustained a long-standing community collaborative composed of service providers that represent a wide spectrum of agencies and supports. Faith-based organizations and mental health, medical health, food, cash assistance, employment, and parental support services are all available to some degree in this community. The executive director of the ARS program has long been viewed as a strong community leader, and has developed a close working relationship with the majority of the service providers in the surrounding area. A neighborhood family resource center serves as the hub for these services, providing a kind of community

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living room for neighborhood residents, and a haven from daily hassles and stress. In this community context, ARS workers feel confident that they can refer families directly to needed services, and that families can access those services quickly and easily. ARS staff also see this program as a neighborhood-based intervention with the potential to serve as one component of a larger effort to strengthen the community as a whole. By connecting ARS family members to neighborhood resources, families become more embedded in the community, and parents will know how to secure assistance from within the community, should future needs arise.

In West Oakland, efforts to develop a collaborative of service providers have proceeded unevenly. Waves of philanthropic and public initiatives have been attempted in an effort to revitalize this community, but many of these efforts have floundered. In recent months, however, efforts to draw community agencies together in order to coordinate services seem to have born more fruit; ARS staff is optimistic about several new opportunities to refer families to neighborhood-based services.

In East Oakland, the resource context differs markedly. At the center of this community stands an old shopping mall, once the home of large department stores and specialty shops. The mall closed some years ago when it was no longer economically viable in the neighborhood, and the public social service agency has since converted several of the large stores into offices. An array of public benefits is now available to community residents at this location, including Temporary Assistance for Needy Families, Medicaid, food stamps, and adult services. This *service mall* offers a centrally located resource for neighborhood residents in need; however, the sheer size of the

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building and its institutional image convey a different message from the community living room suggested by a neighborhood-based family resource center such as that in South Hayward. In addition to the mall there are a large number of smaller nonprofit and faith-based services and programs, but these are not coordinated in any fashion and they are not necessarily widely visible to community residents. ARS staff does not have designated liaisons at the public agencies, nor do they have regular contact with the smaller service providers in the community. As a result, when ARS staff works with parents, they must determine the availability and accessibility of services, along with the eligibility requirements for parents, slowing their work considerably.

Beyond these challenges, the agency housing ARS services in East Oakland is not located in the community it serves. The extent to which the location influences service delivery is unknown, but staff clearly exhibits a developing knowledge of community resources that might be enhanced if all of their work occurred within the neighborhood. These combined factors contribute to a view held by East Oakland ARS staff that their service is largely a family-based intervention (rather than a neighborhood-based intervention) wherein individual workers connect with individual parents within the privacy of their own home to offer services, support, and referrals. The difference is subtle; all of the ARS providers view their work as individually based, with individual families, but West Oakland and South Hayward staff also view their work as layered and having additional impact and import to the neighborhoods in which families reside.

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The Family Context

When asked how ARS staff adapts the program to the unique needs of the neighborhood, they indicate that the demographic context is a critical factor driving their program model. In West Oakland, for example, staff recognizes the extreme poverty of the community, relative to the other two neighborhoods. In this setting, staff first assess families' basic needs and attend to these well before attempting to alter parent-child relationships. According to one staff member in this agency: "One thing about this neighborhood, with the poverty, you respond to the community's needs and pay attention to basic needs. We're talking about basic needs, being able to get the family to that point where we have food on the table today."

Staff is mindful of the history of their community and makes special efforts to honor their commitments to families. Because previous programs have been offered, but have failed, West Oakland staff is attempting to grow their program methodically and to offer concrete services to families, so that community members can experience tangible benefits from program participation.

In East Oakland, staff is aware of the community's attitude toward child protective services and their mistrust of the system. Community suspicion is well-founded, as evidence from some research in California suggests that more than one third of all African American children in the state will have contact with the child welfare agency, through a child maltreatment referral, before kindergarten. One in ten African American children are placed in foster care–rates approximately double that for children of other ethnic groups (Magruder & Shaw, 2007). To alleviate some parent doubts about ARS

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providers' intentions, ARS staff in this neighborhood attempt to gain access to families by offering concrete supports, such as gift cards to local grocery stores. Using concrete supports as their initial lever of intervention, ARS staff hopes to gain sufficient trust so they can then work on developing a relationship that will support family change. In their early interactions with parents, staff acknowledge the challenge of parenting, and suggest that they can help improve parents' capacities to care for and provide for their children. Staff in both East Oakland and West Oakland is direct with parents about the reason for their visit and their goals. A staff member states:

> We say, "Did you know that someone called to report you?" Some say, "Yes, I know who did it." We say, "Let's try to keep them from calling again." We say, "Our goal is to keep CPS out of your house. Give us an opportunity so that someone won't call CPS again, and there's a possibility of them taking the kids away." We tell them that we are not tied to CPS. "We're here to keep you out."

Staff in South Hayward also distances themselves from the public child welfare agency, but their approach to parents is subtly different. Therefore, staff focuses less on the parents as access points to the family, and instead concentrates on the young child, the child's development, and the child's need for a safe and healthy environment in which to grow. ARS staff in South Hayward acknowledges the cultural value placed on children in the Latino community, and uses this as a tool for gaining access to and trust with parents.

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OVERVIEW OF DISPROPORTIONALITY IN CHILD WELFARE AND FAIRNESS AND EQUITY IN ACCESS AND UTILIZATION OF SERVICES

Disproportionality in the child welfare system refers to, “The differences in the percentages of children of a certain racial or ethnic group in the country as compared to the percentage of children of the same group in the child welfare system” (Hill, 2006). In the United States, children of color are disproportionately represented in the child welfare system, particularly African American and Native American children. Compared to all other racial groups, African American families in California are most likely to face maltreatment referrals, substantiated allegations, and entries into foster care (Needell, Brookhart, & Lee, 2003). In 2007, 27% of children in foster care in California were African American and 12.9% were Native American, although they comprised only 7.2 and 0.8% of the total population of children in California, respectively (Needell, 2008). African Americans and Native Americans also had the highest rates of out-of-home placement for all age categories. In contrast, Caucasian children made up approximately 43% of the general population in California, but comprised only 25% of the children in the child welfare system (Needell, 2008). In most states, including California, Asian American and Latino children are underrepresented in the child welfare system (Hines, Lemon, Wyatt, & Merdinger, 2004).

Disproportionality in the child welfare system is a concern for at least two reasons. The first is that families usually come to the attention of child welfare because of crises and serious circumstances; therefore, the overrepresentation of children of color in the child welfare system may be a reflection of broader problems that

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disproportionately affect their communities. Secondly, the child welfare system, which involves investigation and government involvement in the personal and private domain of family life, may have an increased focus on families of color due to factors such as poverty and racism. Each of the three investigations conducted by The National Center on Child Abuse and Neglect, dating back to 1979, reported that no significant racial differences exist in incidence of abuse and neglect (National Center on Child Abuse and Neglect, 1981; Sedlak & Broadhurst, 1996). In addition, when factors such as family size and parental income are considered, the risk for maltreatment is lower for African American children than Caucasian children (Sedlak & Shultz, 2001). Despite these empirically based findings, African American and Native American children remain disproportionately represented in the child welfare system.

Disproportionality raises the following three questions relevant to differential response:

1. Do factors such as race and ethnicity impact the likelihood of being reported for suspected child abuse?

2. Once a family is reported to the child welfare system, does race and/or ethnicity influence whether an investigation is conducted, and the outcome of the investigation?

3. Once a family is involved with the child welfare system, does race and/or ethnicity affect what services are offered to the family and/or children?

It is important for child welfare professionals to consider questions such as these in working with families. An awareness of whether bias may affect services and interventions with families helps bring attention to the importance of providing culturally competent services. Self-awareness is a critical first step. Awareness of any biases a

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worker may hold about a particular culture or ethnicity, as well as recognition of personal values and expectations, can help to minimize the likelihood of conducting a biased assessment of a family, or implementing an intervention that is culturally dissonant. This is of particular importance in states like California, where there is a significant racial and cultural difference between the child welfare workforce and the children in the child welfare system. In 1998, 56.6% of California social workers were Caucasian, 14.5% African American, 18.8% Latino, and 0.7% Native American (CWSSG, 2002). Background information provided below will construct a framework for understanding how bias may affect the child welfare system at a macro level.

How Do Factors Such as Race and Ethnicity Impact the Likelihood of Being Reported for Suspected Child Abuse?

Data from the Center for Social Services Research indicate that African American and Native American children in California are most likely to be referred to the child welfare system and have substantiated referrals when compared to Caucasian, Latino, and Asian/Pacific Islander populations. In California, 110 per 1,000 African American children had maltreatment referrals, while 44 per 1,000 Caucasian children, and 46 per 1,000 Latino children had maltreatment referrals (Needell et al., 2003). Magruder and Shaw (2007) conducted a longitudinal study using child welfare administrative data to determine whether race and ethnicity impact rates of referral, substantiation, and placement. The study followed a birth cohort of 518,073 children born in California in 1999. The study concluded that child welfare involvement varied significantly by ethnicity. By the age of seven, 38.5% of children with African American

mothers had been referred to the child welfare system, whereas only 18% of children with Caucasian mothers had been reported. The researchers observed that this pattern of ethnic disproportionality held true for rates of substantiation and removal (Magruder & Shaw).

Studies in the literature suggest that factors such as severity of abuse or socioeconomic stressors are the primary contributors to a family's likelihood of being reported for child abuse or neglect. In one experiment, for example, researchers took 180 teachers, divided evenly among Caucasians, African Americans, and Latinos, and asked them each to review case scenarios of possible abuse of an 8-year-old student (Egu & Weiss, 2003). Of the three student cases presented, one student was Latino, one was African American, and one was Caucasian. Pictures of the students were included with the written scenarios. Each child was presented in two different scenarios: (a) with stronger signs of potential abuse (e.g., the child comes to school with a black eye and broken arm; his grades begin falling in the weeks that follow), and (b) with weaker signs of potential abuse (e.g., the child comes to school with a scrape on the arm; his grades begin falling in the weeks that follow). For each scenario, using a Likert scale, the teachers were asked to indicate their agreement with statements such as, "This child is being physically abused," and "This child should be reported for abuse." The researchers found that neither the race of the teacher or of the child significantly impacted the extent to which the teacher indicated that he or she would likely believe the child was abused, or was likely to report the abuse. The only statistically significant indicator of likelihood of reporting abuse was the severity of the abuse.

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The extent to which ethnic disproportionality is a result of race or issues of poverty is a complex, multifaceted concern. Maltreatment rates have been strongly associated with poverty. Based on a review of data from several studies about child abuse reporting and socioeconomic status, Drake & Zuravin (1998) concluded that *classlessness* in child maltreatment is a myth. That is, the socioeconomic stressors of living in poverty render impoverished families more vulnerable to child abuse. Poverty and involvement with the child welfare system have consistently shown a positive correlation. Statistics indicate that a significantly higher proportion of African Americans, as compared to Caucasians, had an annual income of less than $15,000, were headed by a single female parent, and had three or more children residing in the home (U.S. Census Bureau, 1999). Each one of these family characteristics has been shown to contribute to a higher likelihood of reported neglect (National Incidence Studies, 1996).

For instance, in one longitudinal study, 238 families who were reported to the New Jersey Department of Youth and Family Services between 1988 and 1989 were followed until 1996 (Wolock et al., 2001). The researchers examined the number of re-referrals and rates of substantiation. The re-referral rate was strongly correlated with factors of parental substance abuse, number of children in the family, the family's receipt of public aid, and poorer family functioning. The researchers concluded that these correlations did not show evidence of racial bias, but rather evidence that families who are under great socio-emotional stress are more likely to experience maltreatment (Wolock et al.).

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Poverty is not the sole cause for maltreatment. The 1999 U.S. Census Bureau statistics indicate that African American and Latino children each made up 26% of the approximately 19% of all American children under age 18 who reside in families that are below the official poverty line. This signifies that African American and Latino children made up over 50% of all American children living below the official poverty line. In spite of similar to identical poverty levels within African American and Latino communities, however, Latino children are not overrepresented in the child welfare system nearly as often as their African American counterparts.

Other research identifies race as a primary factor in a family's likelihood of being reported for child abuse or neglect. For instance, one study found that hospitals reported suspected abuse among African American children, but avoided reporting Caucasian children (Lane, Rubin, Monteith, & Christian, 2002). This 6-year cohort study looked at 388 children who had been referred to the Children's Hospital of Philadelphia for treatment of fractures to determine whether race/ethnicity yielded differential evaluation practices or differential rates of reporting to Child Protective Services (CPS). It was determined that children of color aged 12 months and older were five times more likely to have a skeletal survey requested by the medical staff to assist in determining accidental injury versus abuse even after controlling for factors such as type of abuse and medical insurance status (private vs. none or Medicaid). Further, African American children were more than three times as likely to be reported to CPS as Caucasian children.

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In sum, research findings are mixed as to the connection between race/ethnicity and the likelihood of being reported for maltreatment. Further, issues of race and ethnicity are complicated by poverty, substance abuse, and single parenthood—all factors that increase the likelihood of child welfare involvement, and issues that plague various families, including African American communities.

Once a Family Is Reported to the Child Welfare System, How Do Factors Such as Race and/or Ethnicity Influence Whether an Investigation Is Conducted, and the Outcome of the Investigation?

Author and social worker, Marc Parent reflected on the power of a caseworker's assessment and voice. He writes, "If you get a caseworker who goes to somebody's home and says it's fine, then it's fine. That's how important their voice is" (Parent, 1998). He and others emphasize how crucial it is that caseworkers conduct thorough, unbiased assessments of family circumstances. Emergency response workers in an investigative role must heed the same advice.

While the literature consistently describes an overrepresentation of children of color in the child welfare system, conflicting research exists with regard to the role that race and ethnicity play in the investigation and substantiation of child abuse claims. Some studies suggest that racial bias plays a role in overrepresentation, while other studies do not.

One study reviewed data from the National Child Abuse and Neglect Data System, which included over 700,000 children from five states. This study specifically examined the point at which the child welfare system determines whether an investigation is warranted in a given situation. The study found that African American

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children were consistently overrepresented at the investigation stage, with statistical correlates being greater than two in some states (Fluke, Yuan, Hedderson, & Curtis, 2003).

Berger, McDaniel, and Paxson (2005) found racial bias among Caucasian interviewers. In this study, African American and Caucasian interviewers were randomly assigned to conduct in-home assessments of a sample of 1,417 African American and Caucasian families with newborns. These families were interviewed in person when the child was born, then over the phone at the time the child was 12 and 36 months. The interviewers then conducted in-home assessments of the families after 36 months, using the HOME (Home Observation for Measurement of the Environment) scale to measure the mothers' warmth and level of support. The study found that Caucasian interviewers were more likely to rate African American mothers as harsh and emotionally neglectful than were African American interviewers rating African American mothers. Notably, it did not appear that African American interviewers exhibited any bias when assessing either African American or Caucasian families. Generally, it was found that African American interviewers were less likely to rate mothers negatively, regardless of race.

In one study, Needell et al. (2003) examined a sample of 137,300 cases and found that African American children in California were more likely than Caucasian or Latino children to be removed from their homes and placed in foster care following an investigation. Factors such as the reason for removal and neighborhood poverty were considered, suggesting the possibility of racial bias, however the researchers did not

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have access to a measure of maltreatment severity, which might have clarified the significance of their findings.

In a study that included 21,650 cases from the Minnesota Social Services Information System, substantiation rates of child abuse reports for African Americans, Caucasians, Asian Americans, Native Americans, and non-Caucasian Hispanics were reviewed. Controlling for other variables such as type of maltreatment, characteristics of victims, offenders, and types of reports, the study found higher substantiation rates among all non-Caucasian groups (Ards, Myers, Malkis, Sugrue, & Zhou, 2003). The researchers noted that discrimination measures in Minnesota's data were inflated due to a failure to disaggregate counties with large minority populations from those with small minority populations. Nonetheless, the study determined that racial disproportionality of substantiated cases, although small, was nontrivial.

In another study, Trocmé, Knoke, and Blackstock (2004) examined 4,402 Aboriginal Canadian cases taken from a random national sample of suspected child abuse or neglect reports. Information regarding key child and family characteristics (e.g., safety of living conditions and source of income), parent functioning, specific alleged maltreatment incidents and outcomes of child welfare investigations, was gathered by surveying a sample of social workers. The researchers found that cases involving aboriginal children were 1.5 times more likely than Caucasian cases to be substantiated when controlling for variables such as income, number of housing relocations, and form of maltreatment. However, the findings also indicated that substantiation rates were not higher for Aboriginal families when compared to

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Caucasian families when controlling for parent functioning variables such as substance use and maltreatment characteristics, implying that parent functioning concerns may have accounted for the substantiation variance between the two groups. Further, it appeared that other significant indicators of substantiation included the form of maltreatment, the number of child behavior concerns, unsafe housing, receipt of social assistance, and frequent moves.

Once a Family Is Involved With the Child Welfare System, How Do Race and/or Ethnicity Affect What Services Are Offered to the Family and/or Children?

A significant amount of research demonstrates that services offered in the child welfare system vary according to race and ethnicity. For example, although African American children in the system come from families with housing problems more often than Caucasian children, Caucasian families were offered housing assistance nearly twice as often (U.S. Department of Health and Human Services, 1997). In another study, 1,256 youth from public service systems, such as the juvenile justice and child welfare systems, were interviewed about their mental health services use and perceived need. Results demonstrated that Caucasian children were much more likely than children from other racial and ethnic groups to have received mental health services (Garland, Lau, Yeh, McCabe, Hough, & Landsverk, 2005). In Garland and Besinger's (1997) study, 142 court records were reviewed to determine whether there were differential rates of service referral across ethnic groups. Findings indicated that Caucasian youth were more likely to have been referred to mental health services than African American and Latino youth, even after controlling for the potentially confounding

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effects of age and type of maltreatment. A meta-analysis of 13 studies found that race was consistently cited as a factor influencing whether children receive mental health services (Staudt, 2003). Another study that reviewed survey data for 462 children who had been in out-of-home care demonstrated that African American children, overall, had significantly lower service use than Caucasian children (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004).

Barth (2005) reported that research consistently points to a lower range and quality of services provided to families of color in many areas including in-home services. Data also suggest that, whereas Caucasian children and families tend to receive family preservation services, African American children tend to be removed from the home. No significant difference was found between service use or removal of Caucasian and Latino children (Needell et al., 2003). Yet many families of color who are not involved with the foster care system are not offered services that could potentially prevent the removal of their children. In one study, social workers indicated that if they targeted *special populations*, such as children of color, other groups of children would not receive services (Denby, Curtis, Alford, & Nielsen, 1998). Others felt that there were insufficient resources to target groups with children most at risk of out-of-home placement. Citing data collected by the National Study of Protective, Preventive and Reunification Servcies (NSPPRS), Robert Hill's *Institutional Racism in Child Welfare* (2004) reports that African American children involved in the child welfare system are twice as likely to be moved into foster care (56%) when compared with Caucasian children in the child welfare system (28%). Furthermore, statistics indicate that while a

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significant majority of Caucasian children (72%) receive in-home family preservation services, only 44% of African American families receive similar services. In addition, a national survey of child welfare workers conducted in 1982 revealed that families of Native American children in out-of-home care were the least likely to be referred for services (Olsen, 1982 in Trocmé et al., 2004

In contrast, there have also been studies that point to other factors as significant predictors of decisions to place children in foster care. Newberger, Bowles, & Snyder, (1986) and Runyan, Gould, Trost, & Loda (1982) both as cited in Harris, Tittle, & Poertner (2005) are examples of studies that concluded that race was not a significant factor in decisions made regarding the placement of children. Additionally, a study of unsubstantiated child maltreatment reports (n = 28,039) in Missouri found that the predominant indicators of whether preventive services would be offered was whether the report was made by a professional versus a lay person, with services more frequently offered to families in which reports were made by professionals (Drake, 1996). Two studies were conducted by The Children and Family Research Center in order to assess the factors that lead to placement decisions. Both studies looked at two groups of children who had been reported as abused and neglected. The first study had a sample of 570 cases, while the follow-up study had a final sample of 393. In both studies, it was determined that race was not a significant predictor of placement. The researchers concluded that the age of the child, the number of other contacts, the risk of harm, and the number of allegation in the most recent report were indicators of placement decisions (Harris et al.).

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Race may affect how families are treated in child welfare because, according to Roberts (2002), racial disparity in the child welfare system is related directly to racial injustice. Some studies indicate that intentional and/or unintentional institutionalized racism are potential contributors to decisions made in the child welfare system, including decisions regarding what services to offer to families. In contrast, other studies highlight differential need and risk across racial or ethnic groups, possibly contributing to disproportionality. More research is needed to look at what children of color experience while in the child welfare system, in addition to how decisions at key points affect subsequent paths or trajectories in care.

UTILIZING ETHNIC AND CULTURALLY SENSITIVE ASSESSMENTS AND INTERVENTIONS

If racial and ethnic disproportionality pervade the child welfare system, social workers should be keenly aware of the role of assessment in determining children's safety and risk. Utilizing assessment strategies that are culturally competent can help to ensure that only those children and families with disproportionate need are included in the child welfare system.

Typically, families involved with the child welfare system are experiencing tremendous levels of stress. Sometimes, children are not safe and need to be removed from the home; there are other times, however, when the family may only need help with key areas that will improve functioning. Although the safety of a child must be considered foremost, the unique situation and characteristics of each family must be assessed in an objective, culturally sensitive manner. Cultural traditions and ethnic

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origins can influence a family's customs, communication patterns, and lifestyles. Culturally competent risk and safety assessments help to prevent culturally specific behaviors from being misconstrued as abuse or neglect or, conversely, from masking actual abuse and neglect. In addition, interventions must be culturally competent if they are to be effective. Occasionally, reports to CPS are made with incorrect information, assumptions, or, in the worst case scenario, mal-intent and ulterior motives on the part of the reporter. With myriad reasons behind the generation of child abuse or neglect reports, it is imperative that child welfare professionals prioritize accurate, unbiased family assessments that are attuned to cultural diversity.

Assessment is an important component of the child welfare system. In child welfare, assessment generally refers to "the prediction of future harm to a child and the indepth process of determining the family's strengths and needs in several areas that affect child and family well-being" (Young, Nakashian, Yeh, & Amatetti, 2007, p. 54). Assessment includes gathering detailed information to determine the needs of a family and appropriate intervention, if needed. Culture has the potential to significantly shape how child welfare professionals process information and interpret service needs and service delivery. It is important to be aware of this dynamic when making critical assessment and intervention decisions.

Tanner, Turner, Greenwald, Munoz, and Ricks (1996) identify a three-step process of developing and maintaining cultural sensitivity and awareness:

- The provider must first understand his or her own personal history and how it influences his/her perceptions.

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- The provider must begin to process how similarities and differences between the provider and client/family may influence his/her perceptions of the client/family.
- The provider should find common ground between his/her perceptions and the client/family perceptions resulting in effective and appropriate intervention.

This model allows the provider to identify whether personal cultural biases are operating in their decision making and to remain open to new perceptions. It also considers the importance of the client's cultural background. For example, in Latino immigrant populations, it is useful to find out information about a family's migration history, level of acculturation, and important facts about their culture and country of origin (Quintanilla, Encinas, & Cristo, 2007).

The provider should seek to process information in a way that demonstrates respect and acceptance for culturally different solutions and provides effective services that emphasize family strengths and cultural values. It is also important to remember that variation exists within different cultural groups; there may be significant differences among individuals who share the same ethnic or cultural background.

A clear understanding of personal values combined with cultural awareness and sensitivity can be the first step in forming a truly collaborative relationship that effectively serves the family. A qualitative study of Contra Costa County's differential response system interviewed 31 individuals involved in the implementation of this new system. The following quotes represent key points that interviewees considered relevant to gaining cultural competence.

Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., Geer, A., et al. (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum.* Berkeley: University of California at Berkeley, California Social Work Education Center.

Sometimes, even bringing up the topic of race and culture may be offensive.

> The assessment instrument…doesn't really address issues of culture at all…doesn't talk about any racial issues, which for some families would be offensive to have a discussion about [culture and race]. . .(Path II case manager, referring to the assessment instrument used by case managers).

Tools can only help so much—the person utilizing the tool must be culturally competent.

"I know the CAT (California Assessment Tool) speaks to cultural sensitivity. But you know, the tool is only as good as the person using it," (Emergency Response Worker).

While cultural norms and values need to be considered, abuse should not be excused because of culture.

> ....most of my cases are Spanish-speaking cases and I identify with that culture and I know the language. But I see with other workers, maybe because they only see the Latino culture in this setting, or because we only see them in this setting that we have a tendency to over generalize. In recent months we've been getting an influx of sexual abuse cases in Latino homes. And often times it's families that share housing. You know, because that's the only way to survive. So I'm conscious that people are beginning to identify the sexual abuse cases with that culture. [Also], there was an incident recently with a Tongan family, where there were multiple victims and multiple perpetrators in the same family….And it was suggested that perhaps it was a cultural issue. And I really objected because I've also heard that indication with Latino families so I think we have to be really

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careful not to excuse abuse as a cultural value, because I don't think that's really true," (Emergency Response Worker).

Ethnicity and race are not always synonymous with culture.

> Let me use an example [to illustrate that the CAT is not culturally appropriate]. Does the social environment pose a risk to the child? So you say yes. What does that mean? And in whose opinion? Is this your view of what the social environment should look like versus the client's or the family's—where they really come from? The only cultural question in there is "Have cultural issues been looked at?" Of course you're going to say "yes." If you say "no" then you're being biased. So it just doesn't accurately measure it at all. It doesn't tell you anything...in the little blank spots you could put Black, Caucasian, Latino, whatever…and it still doesn't tell you what their culture is (Emergency Response Worker when asked if the CAT is culturally appropriate).

Respect is universal.

"So basically the one thing that's universal is respect. You treat everyone with respect," (Path I case manager).

IMPACT OF NEIGHBORHOODS ON CHILD WELFARE OUTCOMES

Parents raising children in distressed neighborhoods carry a heavy burden. Caring for children and protecting them from the threats associated with poverty, community violence, and poor schools tax the strengths of even the best parents. The most vulnerable families living in distressed neighborhoods may be especially

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challenged, and mounting evidence suggests an association between maltreatment and neighborhood characteristics.

Distressed neighborhoods have been defined by several factors including: concentrated poverty, high percentage of female-headed families, low adult/child ratios, adults living in poverty, high unemployment rates, vacant housing units, a large percentage of African American residents, and residential instability. Coulton, Korbin, Su, & Chow's (1995) work suggests that a number of these factors may be associated with child maltreatment. Whereas neighborhood impoverishment is positively associated with different types of child maltreatment, including physical and sexual abuse, it appears to have the strongest association with neglect (Drake & Pandey, 1996). In addition to affecting child maltreatment, neighborhood impoverishment also appears to be positively associated with educational risk and may affect the mental health of children and adolescents, particularly in terms of exhibited externalizing problems (Leventhal & Brooks-Gunn, 2000).

Garbarino and Sherman (1980) discussed the concept of social impoverishment to describe a specific risk factor for child maltreatment found in two different neighborhoods with similar socioeconomic and racial profiles. They conducted 46 family interviews involving open-ended questions and ratings in 11 areas of family life, including the availability and use of both informal and formal support systems. Their findings revealed greater social impoverishment in the neighborhood with higher risks of child maltreatment. This study is critical to the analysis of neighborhood risk factors because it suggests an ecological model of child maltreatment that includes *social*

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factors that may lead to higher risk of child maltreatment, including *security for children* and *respect for each other*.

Another neighborhood risk factor that may be associated with maltreatment is residential instability, however the findings are mixed. (Coulton et al., 1995; Coulton, Korbin, & Su, 1999; Ernst, 2001; Sampson, Morenoff, & Earls, 1999). Instability was defined by Coulton et al. (1995) as the proportion of residents who have moved within a 5-year period, the proportion who have lived in their current homes for less than 10 years, and those who have lived in their current home for less than 1 year. Although instability was shown to have a weaker effect on child maltreatment in the former study (Coulton et al., 1995), it was second to economic disadvantage as a predictor of child maltreatment in the replicated study by Ernst.

Coulton et al. (1995) identified childcare burden as another neighborhood risk factor that may be associated with child maltreatment. They described childcare burden as the amount of adult supervision and resources available for children, as measured by the ratio of children to adults, ratio of males to females, and the percent of elderly residents in a neighborhood. Results of this study show that neighborhoods with a high child-to-adult ratio, low percent of elderly residents, and low male-to-female ratio had the highest risk of child maltreatment. Although childcare burden was twice found to be positively associated with child maltreatment (Coulton et al., 1999), these findings were not replicated by Ernst (2001) in his study of a suburban community in Maryland.

Recent neighborhood studies have identified additional risk factors associated with child maltreatment, including drug and alcohol availability and neighborhood stress

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(Freisthler, 2004; & Freisthler, Merrit, & LaScala, 2006). Drug and alcohol availability may be measured as bars per population and drug possession incidents per population, respectively. Both of these variables are related to higher rates of child maltreatment (Freisthler; Freisthler, Needell, & Gruenewald, 2006).

While much of the literature focuses on neighborhood risk factors for child maltreatment, studies show that strength factors can also result in positive outcomes for neighborhoods. Whereas these studies point to improvements in children's well-being, they do not show associations with maltreatment prevention. To date, we know little about the association between neighborhood strengths and their effects on child abuse and neglect. One study focused on residents' perceptions regarding the prevention of child maltreatment. In that study, Korbin and Coulton (1996) conducted in-depth interviews with residents of 13 census tracts in the Cleveland Metropolitan area. The interviews included both closed- and open-ended questions about whether residents believed that their neighbors and/or the government could prevent child maltreatment. The study concluded that neighborhood residents view reporting of child maltreatment as an important responsibility that could prevent serious harm and even death. This sense of responsibility can be seen as a neighborhood strength and might result in greater protection for children. Unfortunately this potential strength could be compromised by two primary concerns: fear that neighbors would be angry or upset (thus putting a strain in daily living), and fear of retaliation (Korbin & Coulton).

Ellen and Turner (1997) examined several outcomes to assess the overall importance of neighborhoods in relation to the social and economic well-being of their

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residents. Although they focused on the well-being of individuals rather than protection against child maltreatment, they provided a conceptual framework regarding potential strength factors that should be studied further. These factors included the quality of local services such as public schools, childcare centers, and medical care; availability of after school programs, such as sports, music, and art, particularly during adolescence; collective presence of adult role models; positive peer influences; positive social networks; and physical proximity and accessibility to services, information, and economic opportunities.

Sampson et al. (1999) proposed a theoretical framework to describe three main dimensions of neighborhood social organization that affect the well-being of children: intergenerational closure, reciprocated exchange, informal social control, and mutual support of children. Intergenerational closure refers to the way children and adults are linked to one another within a neighborhood. Adult/child closure can describe relationships between children and their parents or can be generalized to include any adult in the neighborhood including a teacher or a religious leader. Reciprocated exchange describes an interaction between residents in which social capital is mutually shared in the form of advice, material objects, and/or information. Informal social control refers to the notion of a collective interest in the well-being of the community. Sampson et al. concluded that collective efficacy may be achieved if there is a sense of shared expectation among neighbors.

Availability, accessibility, affordability, and quality of community resources may also influence child and adolescent outcomes (Leventhal & Brooks-Gunn, 2000).

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Community resources may include the opportunity for children and adolescents to experience caring relationships. Program evaluations, such as the impact study of Big Brothers/Big Sisters of America, have shown that caring relationships may be associated with child and adolescent well-being (Tierney, Grossman, & Resch, 1995). While there are promising research studies examining possible relationships between neighborhood strength factors and the well-being of children and adolescents, empirical research is still needed to better determine whether or not neighborhood strengths can mediate parents' maltreatment of their children.

DIFFERENTIAL RESPONSE IN NEIGHBORHOODS

Neighborhoods in Contra Costa County

Iron Triangle area of Richmond and North Richmond

> One participant in the DR survey described North Richmond in this way:
>
> …there's lack of hope to grow up and be educated, and there's no money in the schools' programs and there's no teachers that want to go there, because there is no money….You've got schools who are underfunded. They have teachers without credentials because they can't get anybody else there…and it's hard to recruit teachers in poverty areas. And the kids don't have a hope. They see people wearing fancy clothes and fancy cars and fancy wheels, but it's all drug money and dirty money. But that's better than no money at all. I mean, how do you get a kid to close his eyes to that. There's nothing there.

The city of Richmond has a rich history that includes urban reconstruction and re-organization during World War II, when it became a major ship-building center. During

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this time, the population of Richmond grew 400% as large numbers of African Americans migrated there for work. Non-African American residents resisted their presence which contributed to the development of large racial divides. As a result, African American migrants tended to take up residence in the North Richmond lowlands where the government built racially segregated housing projects. After the war many of the housing projects inhabited by African Americans were targeted for destruction, citing dilapidated conditions; however, no housing alternative was provided. Residents of these projects flooded Richmond looking for places to live, and White flight to the suburbs began, creating a racial divide that still exists today (Johnson, 1991).

North Richmond is now Contra Costa County's poorest unincorporated community with high rates of criminal activity, such as drug dealing and gang violence (San Francisco Chronicle, 1997). Approximately 14,000 people reside in this area, with the majority of the residents working in service occupations (Ask Us a Question.com, 2006). U.S. Census figures cite income levels that are below city and county averages with 75% of the residents being low income, 53% very low income and 48% living below the poverty line. High school dropout rates are high as indicated by the fact that only 24% of the residents graduate from high school or obtain a GED (U.S. Census Bureau, 2000).

The "Iron Triangle" refers to a predominantly African American and Latino neighborhood in the city of Richmond where railroads meet, forming a triangle of iron. This area was once the hub of community and retail activity. Unfortunately, this has changed over the last 30 years as evidenced by a steady decline in the quality of living

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for residents. Although many businesses have closed, there are some businesses including a clothing boutique, a performing arts center, an outdoor plaza and a number of community-based organizations. In addition, a police substation is located in the heart of the Triangle.

The Iron Triangle makes up 18% of Richmond's total population, however, the majority of the city's crime incidents take place in this neighborhood; common criminal activities include prostitution, robbery, homicide, and drug dealing. The incidence of violent crime is so high that, compared to any other California city, Black males between the ages of 18 and 34 years old have the highest likelihood of being murdered if they are in the Iron Triangle neighborhood at night (Spiker, Williams, Diggs, Heiser, & Aulston 2007). Thus, in 2004, the city of Richmond was named the most violent city in California (Morgan Quitno Press, 2005). Additionally, the many refineries and chemical plants located there have caused health concerns for residents as a result of numerous toxic leaks in recent years.

Statistics show that 18% of the Iron Triangle population arrived in the United States after 1990, with nearly 90% of those families coming from Latin America resulting in Spanish being the primary language in 40% of the homes (U.S. Census Bureau, 2000). African American and Latino students constitute the majority of high school dropouts in the Iron Triangle with 40% of Latino students and 50% of African American students dropping out.

Approximately 76% of residents commute by car (Sperling's Best Places, 2007). Public transportation is provided by a nearby Bay Area Rapid Transit (BART) station

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and an Amtrak train station located south of the neighborhood. C Transit bus lines also serve the area. However, in a recent poll, transportation was listed as the primary barrier affecting families and their access to services (Family to Family Survey, 2006).

The Monument Corridor, Concord

The Monument Corridor refers to a 10-square-mile area around Monument Boulevard in Concord. This neighborhood is one of the most densely populated areas in Contra Costa County. U.S. Census figures report that 63% of the Monument neighborhood's residents are low income, and over 40% are very low income; the poverty rate is twice that of Contra Costa County's overall poverty rate (as cited in Bolen & Pontecorvo, 2005). Residents in this area are close to one-and-a-half times more likely to experience unemployment than residents in other areas of the county (Morgan Quitno Press, 2004). The majority of households are comprised of married couples without children, followed by married couples with children under 18 living in the household.

The Monument Corridor has gone from being predominantly white to predominantly Latino, with a large number of undocumented immigrants (TEAMS, 2005). The community's Latino population grew by 300% since 1990, with the 2000 census reporting 49% of the neighborhood as Latino in 2000 (Bolen & Pontecorvo, 2005).

The educational system within the Monument Corridor has faced challenges in providing its residents with high-performing schools. The elementary schools in the Monument Corridor scored lower than the majority of schools throughout Contra Costa

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County. Forty percent of the Monument residents never graduated from high school, and 58% of Latino residents 25 years and older have not earned a high school diploma (U.S. Census Bureau, 2000). Consequently, larger numbers of residents are looking for work at lower skill and wage levels (Bolen & Pontecorvo, 2005).

With high poverty rates and lack of community resources, the Monument neighborhood faces many challenges, among them, access to services. In a Family to Family survey, the number one barrier to using services was language/cultural barriers; 32% of the population speaks little or no English. Another barrier to services, such as hospitals and health clinics, is transportation. Close to 18% of the residents have no automobile and rely upon public transportation such as BART and the County Connection bus line. Unfortunately, transportation is sometimes costly and has low frequencies during the weekdays and/or weekends (Nelson/Nygaard Consulting Associates, 2006).

A crisis center, health clinic, and police substation are in the neighborhood, and there is a strong community movement toward improving the well being of the residents in this underserved area. An example of this is the Monument Community Partnership which is a collaboration of residents, government officials, the school district, and local businesses working together to improve the Monument Corridor and its systems (Bolen & Pontecorvo, 2005).

Pittsburg & Old Antioch

Pittsburg and Old Antioch have been experiencing a large influx of people moving in from other areas, looking for affordable housing. As a result, the median price

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of homes and rents has gone up. Families with low incomes are having difficulty keeping up with the trend. In fact, a December 2007 press release identified Antioch as the city hardest hit by the nation's housing crisis and suggests that low-income, particularly minority, families have been disproportionately impacted by the crisis (Public Advocates, Inc., 2007). Since 1999, 40% of all federally subsidized housing units have been converted to market rate housing (Bolen & Pontecorvo, 2005). These conditions make it difficult for low-income families to afford necessities such as food, transportation, and health care. Due to this lack of affordable housing, some families have resorted to living in overcrowded housing arrangements, resulting in higher than average per person households when compared to most neighborhoods in Contra Costa County (Bolen & Pontecorvo).

Pittsburg is located where the Sacramento and San Joaquin rivers meet in the north central region of Contra Costa County. The city has a population of 56,769 (U.S. Census Bureau, 2000). Pittsburg was originally a river port, supported by fishing and canning industries, that has grown over time to include both rural and metropolitan areas. It has been referred to as "a city divided" because safe suburban areas are found in the southern region, while high criminal activities primarily take place in regions such as the unincorporated Bay Point area. (Ask Us a Question.com, 2006). As of the last census, Pittsburg's population was predominantly White, followed by Latino and African American. More than half of the households are comprised of married couples, with about 30% of those couples reporting the presence of children under 18 years old living the household (U.S. Census Bureau, 2000). The median family income in 1999 was

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$54,472, with 8.7% of the families and 11.5% of the population living below poverty level. The majority of the residents work in sales and office positions, followed by management and professional occupations (U.S. Census Bureau).

The unemployment rate is low, with 5% of the population reportedly unemployed. The local high school was noted as a top-rated school (GreatSchools, 2008), and 75.7% of Pittsburg residents are high school graduates. These figures indicate an opportunity for upward mobility within this city. Pittsburg residents' primary means of transportation is the automobile, with 86% commuting by car, truck, or van.

There has been a recent thrust to redevelop areas, such as the downtown area, to promote the growth of local businesses as well as the community. Community organizations include Pittsburg Better Together and Faith Works. Both organizations worked to persuade the local government to provide more housing (Bolen & Pontecorvo, 2005). Services such as perinatal/infant health and after-school child care are offered in the city; however, some families indicate that high costs and language/cultural barriers limit accessibility (Family to Family, 2006).

Old Antioch is an urban segment of Antioch that has a population of 90,879 (U.S. Census Bureau, 2000). Antioch is a region of Contra Costa County that is located on the San Joaquin River. The median family income is $64,695, with 6.5% of families living below poverty. Whites make up 65% of the Old Antioch population followed by African Americans. Immigrants from Latin American and Mexico make up the largest portion of the foreign-born population, followed by a significant number of residents born in Asia. The majority of the population is married without children, followed by a large

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portion of married couples with children under 18 years old living in the household (U.S. Census Bureau). Recent high school scores were mixed, with one high school rating competitively, while the other did not. There are also several continuation schools in the area with less than competitive test scores. The majority of residents graduated from high school or obtained a GED.

Most Old Antioch residents work in sales and office positions, followed by management and professional occupations (U.S. Census Bureau, 2000). Tri-Delta Transit, Amtrak, and BART provide public transportation, although approximately 90% of the residents commute by car (Sperling's Best Places, 2007). This may be due to large numbers of residents working in distant regions such as the East Bay and the Peninsula.

Services such as family counseling, parenting classes, and family planning are offered within the community. However, like Pittsburg, some families indicated that high costs and transportation or lack of services being offered in their community were barriers to obtaining services (Family to Family, 2006).

Comparative Rates of Child Abuse Reporting & Violent Crime

Despite the differences among these communities, the child abuse and referral rates are consistently high in all of them with 51.6 or more per 1,000 children being reported to the child welfare system in all four neighborhoods. The rate of entry into foster care is also the same among all of them (2.3 or more per 1,000 children; Needell et al., 2007).

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More variation exists in the comparative crime rates, although all four communities register higher than California's average crime index of 4 out of 10 based on an index derived using Federal Bureau of Investigation [FBI] Uniform Crime Reports data (Sperling's Best Places, 2007). The Iron Triangle is the most violent, with a violent crime rating of 8. The ratings in Pittsburg, Monument Corridor, and Old Antioch are 6, 5.3, and 5, respectively.

Neighborhoods in Alameda County

East Oakland, Eastmont neighborhood

Icons ranging from the Black Panther Party of the 1960s to *hyphy*-style rap music to Granny Goose potato chips are all associated with the Oakland area. East Oakland, in particular, has a reputation for being a rough neighborhood, plagued by crime, unemployment, and poorly-performing schools. A general characterization of the neighborhood has its borders at 47th Ave, San Leandro, 87th St, and I-580; between where West Oakland ends and where San Leandro begins. East Oakland encompasses half of Oakland's total area, stretching from Lake Merritt to San Leandro. Major streets include International and MacArthur Boulevards, and neighborhood highlights include McAfee Coliseum, Oracle Arena, Mills College, the Oakland International Airport, and the busy I-880 corridor.

The 2000 Census reported that the population of Oakland was 399,484; 31.3% Caucasian, 35.7% African American, 15.2% Asian, and 21.9% Latino. Seventy-five thousand of these individuals live in East Oakland, with demographics of 50% African American, 38% Latino, 6% Asian, and 4% White (Alameda County Public Health

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Department, Community, Assessment, Planning, and Education [ACPHD, CAPE] Unit, 2001a). Thirty-seven percent of Oakland residents speak a language other than English at home, and this is similar to the state average. Three quarters of residents have a high school diploma, and 30.9% have a bachelor's degree or higher. In 1999, median household income was $40,055 for an average household of 2.6 persons; 18.8% of residents live below the poverty line (ACS Profile Reports, 2006).

Although some parts of East Oakland are gentrifying, some have been in steady decline since industries like Granny Goose and Gerber relocated their factories in the 1960s. The unemployment rate in East Oakland was 7.7% in 2007, higher than the state average of 5.5%, with about half of jobs concentrated in the service sector. In December 1999, 33% of East Oakland residents were participating in either CalWORKs or Medi-Cal; only 9% of all Alameda County residents did (ACPHD, CAPE Unit, 2005). Over 90% of workers commute to their jobs, and cars are the primary form of transportation. Single-person cars are far more common than carpools (57.3% of commuters utilize individual cars and only 11.5% carpool), and only 16.7% use public transit (ACS Profile Reports, 2006).

In a disputed ranking, Oakland was deemed the 4th most dangerous city in America. There was one violent crime per 50 people and a property crime for every 16 people (U.S. Department of Justice, FBI, 2007). A problem with Oakland law enforcement is understaffing; proportionately, Oakland has half as many police officers as New York City and a third as many as Washington, DC, both lower-crime areas (Smith, 2007). As of December 1999, about 17 out of 1,000 East Oakland children were

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confirmed as abused or neglected—nearly triple the county average of 6 per 1,000 (ACPHP, CAPE Unit, 2005). Community services are provided by various nonprofit agencies, like the East Oakland Community Center (which provides services to the homeless), the East Oakland Recovery Center (substance abuse recovery), the East Oakland Switchboard (emergency family services), and Family and Support Services of the Bay Area (FSSBA; support to families.) A state-of-the-art library is scheduled to open in 2009.

Schools in East Oakland are generally underperforming, but regularly meet their growth targets in accordance with state standards. Representative schools include Highland and Lockwood Elementaries. Half of Highland's students are non-native English speakers, and over 75% of the student body qualifies for free or reduced-price meals; the numbers are much the same for Lockwood, with 44% and 76%, respectively (ACPHP, CAPE Unit, 2005).

Residents of East Oakland, as well as the ARS family advocates who work there, are conscious of the concerns about drug use and violence within the neighborhood, and family advocates indicate that safety concerns impact the nature and focus of their work. Nevertheless, several East Oakland residents who participated in the ARS program spoke positively of the neighborhood. For example, one mother commented, "[I] definitely like the people; neighbors are great; [they] have kids and grandkids. It's also a close knit family thing."

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South Hayward, Harder-Tennyson neighborhood

A “tough little kick-ass neighborhood” was how Hayward mayor Mike Sweeney characterized the Dixon Street neighborhood, in the heart of South Hayward. This created backlash from community advocates, who combated the negative description by creating T-shirts sporting “kick-ass neighborhood” and “KAN,” implying that the neighborhood is a proactive, can-do place. As a resident explained, “We're together. It means we're going to be here in your face for whatever you need…it's more of a community where people help each other” (O’Brien, 2006). Several parents who participated in the ARS program echoed this *can-do* sentiment as they described neighborhoods in which people look out for each other. ARS family advocates also indicated that the cohesiveness achieved through the South Hayward Neighborhood Collaborative facilitates their work because it has strengthened La Familia’s visibility and acceptance within the community.

The city of Hayward started out as a small agricultural and manufacturing community reliant on its railroads, canneries, and fertile land. After WWII, however, its population grew from 14,000 to 72,700 in a mere 10 years and has continued to grow steadily (City of Hayward, *Hayward History*, n.d.). In 1990, Hayward’s population was 121,000 (City of Hayward, *Hayward-City Profile*, n.d.). South Hayward’s population is approximately a quarter of that with about 32,700 residents (ACPHD, CAPE Unit, 2001b). Its boundaries are generally held to be the railroad tracks running along Mission Boulevard, Interstate 880, and Whipple and West Harder Roads. Neighborhood characteristics include a BART station, Dry Creek Pioneer Regional Park, and Fairway

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Park. Southland Mall is a major mall in Central Hayward, and local shopping is done along one of the main commercial streets. Lining Tennyson Road are many “family businesses catering to the diverse ethnic population, check cashing outlets, fast food restaurants, automobile repair shops, and a very high concentration of on- and off-sale outlets for alcohol” (on-sale outlets refer to businesses in which alcohol is consumed on the premises, while off-sale outlets refer to those in which alcohol must be consumed off the premises; *Grantee Details*, 2007). There is a great deal of older (built in the 1950s and ’60s) apartment-style housing that is dotted with blighted areas (Office of University Partnerships), and community groups such as the South Hayward Neighborhood Improvement Committee work to improve the neighborhood’s appearance and services.

South Hayward has a far higher Latino population (41%) than Hayward or Alameda County as a whole. The percentage of Latinos in South Hayward grew 76% (to 15,105) between 1990 and 2000, and its Caucasian population declined 38% (to 8,669). The poverty rate is either the same or slightly higher than Alameda County’s, depending on which measure is considered. In 1999, 28% of South Hayward households earned incomes of $30,000 or below, which is the same percentage as in all Alameda County households. However, there is a higher percentage of South Hayward residents participating in CalWORKS or Medi-Cal than the Alameda County average—16% vs. 9.4% (Community Assessment, Planning, and Education Unit, Alameda County Department of Public Health, Alameda County Health Services Agency, 2001). Many social services are provided by area churches, local charities, and by La Familia, a community-based counseling center for area residents. In Hayward as a whole, there is

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one violent crime per 182 people and one property crime for every 24 people (U.S. Department of Justice, FBI, 2007).

About 70% of South Hayward residents (as opposed to 85% in all of Alameda County) have high school diplomas and only about 14% (42% in Alameda County) have college degrees (ACPHD, CAPE Unit, 2001b). Area K-12 schools are Tennyson High, Cesar Chavez Middle, Bowman Elementary, Harder Elementary, and Moreau Catholic High School. These schools have high percentages of English Language Learners (ELL) and low-income students; 44.5% of Bowman Elementary's students are ELL and 58.9% qualify for free or reduced-price meals. These are some of the highest rates in all of the Hayward Unified School District. Further, the schools' API scores are lower than the state average. Tennyson High had an API score of 593 in 2007, compared to the state average of 662. A score of 800 or above is considered appropriate. Bowman and Harder's API scores fell dramatically in recent years. During the 2006-2007 academic year Bowman lost 54 API points and Harder lost 28. On a brighter note, school class sizes are relatively small. Beyond K-12 education, Chabot College and CSU East Bay serve the South Hayward area.

West Oakland

20,000 people call West Oakland home—64% of whom are African American, 16% Latino, 9% Asian/Pacific Islander, and 7% Caucasian (ACPHD, CAPE Unit, 2001c). In its heyday, West Oakland was a booming, populous port city with a vibrant economy and nightlife. The ship-building industry during both World Wars provided many jobs, helping the neighborhood become a diverse, strong working-class

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community. After WWII, the job market and commerce went into decline as the shipyard boom and 7th Street railroad service ended (ACPHD, CAPE Unit). This, in combination with changes like new housing projects and transit systems, led to vast displacement of families and weakening of the region's economy. In the 1960s, West Oakland became home to the Black Panther Party, bringing it both negative notoriety in the mainstream media and political engagement at the local level. The community has experienced significant gentrification in recent years due in large part to the neighborhood's proximity to San Francisco. Today, many West Oakland residents can no longer afford to live there. Median rents rose from $706 in 1998 to $1,302 in 2002, and the median price for a single-family home in West Oakland increased from $98,000 in 1999 to $315,000 in 2005 (as cited in Gertler, Tesolin, & Weinstock, 2006). Although progress is being made, West Oakland is the poorest part of the Bay Area, with over two thirds of households earning less than $30,000 a year. About one quarter of residents participate in either CalWORKs or Medi-Cal (ACPHD, CAPE Unit).

Community schools such Cleveland Elementary have large numbers of ESL students (58%) and students who qualify for free or reduced-price meals (64%) (ACPHD, CAPE Unit, 2001c). Cleveland also has decent API scores---842 in 2007 (California Department of Education, 2007). A score of 800 is the state target. As of 1999, about 8% of West Oakland residents age 25 and over had a bachelor's degree or higher; 24% held only a school diploma, and 45% did not have a high school degree; in Alameda County, the corresponding figures are 29%, 23%, and 18% (ACPHD, CAPE Unit).

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Drug use and crime is rampant, and tension between residents and police is evident: in 2000 four police officers were accused of falsely arresting suspects and of corruption (McKinley, 2007). There was one violent crime per 50 people and a property crime for every 16 people (U.S. Department of Justice, FBI, 2007). Pollution issues also plague the area, with factories like AMCO and the now-closed Red Star Yeast Plant producing toxic emissions. The port is the fourth busiest in the nation, but diesel emission levels are more than 90 times greater than average emission levels in the rest of the United States (Invisible5, n.d.). As a result, West Oakland children are seven times more likely to be hospitalized for asthma than are children from other parts of California (Invisible5, n.d.).

Community services are provided by various organizations, like the Prescott-Joseph Center for Community Advancement, West Oakland Health Council, West Oakland Senior Center, Stand Up West Oakland, the People's Grocery, Mandela Foods, and the West Oakland Branch Library. In accordance with efforts to reduce homelessness and substance abuse problems, and to make city parks more family-friendly, city officials are expending resources to develop DeFremery Park and Recreation Center, and Fitzgerald Park. Schools in the West Oakland area are improving but still face challenges. Prescott Elementary, for instance, has a 2007 API score of 673, a 6-point improvement from the previous year but still a considerable distance from the 800-point state target. McClymonds High School, the only high school that serves the West Oakland area, had a score of 486 in the 2004-2005 school year.

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Although ARS workers acknowledge the community's concerns with safety and poverty, West Oakland's history of community engagement was evident in one ARS worker's comments. When asked what was unique about the area, the family advocate remarked, "People speak to you. People know each other. The community is close-knit….The community members start to recognize the family advocates and accept them as there to help families."

SUMMARY

The influence of race and ethnicity on child abuse reporting, investigation, and the provision of services must be carefully examined, as many researchers have noted racial disproportionality in the child welfare system. African American and Native American children are overrepresented in the child welfare system, perhaps due to broader, correlated challenges communities of color face or due to greater attention paid to these cases because of poverty or racism. The findings from research on racial disparities in the child welfare system are mixed. Some studies have shown that there are no differences in the rates of referral and substantiation across races when associated factors, such as the severity of abuse and socioeconomic stressors, are taken into account. Other studies, however, have found that racial bias does play a role in reporting and substantiating cases. Similarly, some research indicates that Caucasian children are more likely to receive mental health and family preservation services than children of color, but others have found that race is not a factor in determining foster care placement. The inconsistency in the literature suggests that more research is

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needed to determine the influence of racial bias on the disproportionality seen in child welfare.

Consideration of race and culture is also critical in assessment and intervention. Case workers must avoid both classifying culturally specific behaviors as abuse or neglect and allowing cultural practices to mask true cases of abuse or neglect. Interventions must also be congruent with the client's cultural values and practices. Workers thus must be prepared to examine their own personal histories and possible biases, identifying both differences and commonalities between their perceptions and those of their clients.

In addition to considering client cultural factors, AR/DR in various Bay Area neighborhoods has been customized to account for differences in resources and needs of each community. Programs have addressed the high rates of child abuse referrals in Contra Costa County's North Richmond, Iron Triangle, Monument Corridor, Pittsburg, and Old Antioch, and Alameda County's East Oakland, South Hayward, and West Oakland. Each neighborhood has a unique history, demographic profile, and set of available services that may impact the organization and delivery of AR/DR programs.

The provision of AR/DR services must account for community diversity and culture. Workers must assess the role of race and culture in reporting, investigating, and offering services to families, and examine both the risk factors and strengths present in the communities served.

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MODULE VII

CLIENT EXPERIENCES WITH ANOTHER ROAD TO SAFETY AND DIFFERENTIAL RESPONSE

Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., Geer, A., et al. (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum.* Berkeley: University of California at Berkeley, California Social Work Education Center.

MODULE VII
CLIENT EXPERIENCES WITH ANOTHER ROAD TO SAFETY AND DIFFERENTIAL RESPONSE

INSTRUCTIONAL GUIDE

Purpose

- Framed by relevant literature, this chapter discusses client experiences in Alameda County's ARS program and Contra Costa County's Differential Response program. Data for this chapter was gathered from qualitative interviews with 48 ARS participants and questionnaires completed by 51 Differential Response participants.

- Client vignettes at the end of the chapter can be used to consider real scenarios and examine how both clients and workers negotiated their circumstances. Additional discussion questions accompany the vignettes.

Learning Objectives

By the end of this chapter, students should be able to:

1. Describe why clients decide to engage in voluntary services,

2. Recognize factors that predict client engagement and understand client's experiences of engagement within that framework,

3. Describe how clients experience social support through their relationship with their home visitor and understand how social support serves to empower clients,

4. Understand how cultural competence aids in relationship building between clients and their workers,

5. Identify three types of social support and understand how clients benefit from each type,

6. Recognize advocacy as an aspect of social support that is simultaneously linked to the program's commitment to involve and educate community providers,

7. Understand the significance of neighborhoods and their potential impact on family processes and child welfare outcomes, and

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8. Recognize emphasis on child development and attachment as integral to AR/DR philosophy and vision for how to achieve change.

This chapter can be used to foster the following curriculum competencies:

1.1 Student demonstrates respect, fairness, and cultural competence in assessing, working with, and making service decisions regarding clients of diverse backgrounds.

1.2 Student demonstrates self-awareness and the ability to address and overcome personal bias in assessing and working with clients of diverse backgrounds.

1.3 Student demonstrates ability to conduct an ethnically and culturally competent assessment of a child and family and to develop an effective intervention plan.

1.5 Student understands the importance of a client's primary language and supports its use in providing child welfare assessment and intervention services.

1.6 Student understands the influence and value of traditional, culturally based childrearing practices and uses this knowledge in working with families.

2.1 Student demonstrates knowledge of legal, socioeconomic, and psychosocial issues facing immigrants, refugees, and minority groups and is able to devise culturally competent and effective interventions.

2.5 Student demonstrates ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally competent resources and services.

3.2 Student demonstrates ability to perform a preliminary safety assessment and to monitor the safety of the child through ongoing assessment of risk.

3.3 Student is able to identify the major family health and social factors contributing to child abuse and neglect, as well as positive factors that act to preserve the family and protect the child.

3.5 Student demonstrates understanding of basic child development and how developmental level affects a child's perception of events, coping strategies, and physical and psychological responses to stress and trauma.

3.8 Student demonstrates ability to respectfully relate to, engage, and assess family members from a strengths-based “person-in-environment” perspective, and to develop and implement a case plan based on this assessment.

3.9 Student demonstrates ability to engage and work with involuntary clients in a manner that includes the exercise of client self-determination.

3.10 Student understands how attachment, separation, and placement affect a child and family and how these experiences may influence a child’s physical, cognitive, social, and emotional development.

3.11 Student recognizes the importance of working with biological families, foster families, and kin networks, as well as involving them in assessment and planning strategies.

3.12 Student understands the inherent power differential in working with clients and can effectively manage and balance that power.

3.15 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income, non-traditional, and culturally diverse families and uses this knowledge to provide equitable and effective child welfare services.

4.2 Student demonstrates ability and knowledge both to utilize pre-placement preventive services and to construct a supportive system for clients that may include collaboration with multiple agencies and disciplines.

4.3 Student works collaboratively with biological families, foster families, and kin networks, involving them in assessment and planning and helping them access services and develop coping strategies.

4.4 Student demonstrates ability to identify service/treatment plan requirements and to construct measurable objectives for the service plan.

4.8 Student understands the requirements for effectively serving and making decisions regarding children with special needs, including the balancing of parental and child rights.

5.1 Student demonstrates understanding of child and youth development, including physical, cognitive, social, and emotional components and can recognize developmental indicators of abuse or neglect.

5.2 Student demonstrates understanding of the primary stages and processes of adult development and family life.

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5.3 Student demonstrates understanding of the potential effects of poverty, bias, inequity, and other forms of oppression on human behavior and social systems.

5.4 Student demonstrates understanding of the influence of culture on human behavior and family dynamics.

5.5 Student demonstrates understanding of how the strengths perspective and empowerment approaches can positively influence growth, development, and behavior change.

6.1 Student demonstrates ability to assess the effects of family transitions and the potential impact of becoming a client of the child welfare system.

6.2 Student can apply theories of human development and attachment in creating and managing effective case plans with clients.

7.1 Student is able to identify the strengths and limitations of an organization, including its cultural competence and commitment to human diversity, and can assess the effects of these factors on services for children and families.

7.7 Student understands the need to negotiate and advocate for the development of resources that children and families require to meet family and service goals.

8.2 Student demonstrates ability to negotiate and advocate for the development of resources that children and families need to meet personal and administrative goals.

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QUESTIONS FOR DISCUSSION

1. What factors predict engagement in voluntary home visiting services? Consider the theory on client engagement and apply those ideas to a situation you have encountered in which you were attempting to engage an individual or family. Is your experience consistent with the theory? Explain how it was or was not. Will your new knowledge of these theories prompt you to change your strategies for engaging families? Why or why not?

2. This chapter focuses on the experiences of individual families, yet the vision of AR/DR emphasizes community involvement and systems change. What connection do you see between the micro level interactions that are illustrated in this chapter and the overall goal of systems change? How does an individual case management style intervention generate change on a neighborhood or community level?

3. Studies have found that people typically express a preference for informal support systems over formal ones. What are some possible sources of informal support for these families? What might be some challenges in accessing healthy informal support for families engaged in AR/DR services?

4. The last two chapters have illustrated the powerful influence neighborhoods can have on child and family outcomes. What do you see as the most critical aspect of an AR/DR worker's role as it relates to neighborhoods?

CLIENT EXPERIENCES WITH ARS AND DR

Client Engagement

Engaging families in services is among the most challenging aspects of any home visiting program, regardless of the target population (Ammerman et al., 2006; McCurdy & Daro, 2001). Engaging families in ARS/DR services, however, presents a unique challenge because services are often prompted by family crisis. Consequently, the point of entry for the provider is unclear, as services are not initially invited by the family. It is important to bear in mind, however, that as social workers experience this

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challenge of client engagement, the families do as well. A family's initial contact with a worker typically occurs during periods of high stress, and learning of the CPS report that prompted outreach from AR/DR workers may provoke additional stress and induce fear and suspicion of the child welfare system (CWS). Creating new opportunities to invite family participation in voluntary services is an essential element of California's Child Welfare Services Redesign plan, which, as exemplified in the ARS/DR models, emphasizes efforts to preserve families and restore their capacity to care for children without imposing punitive measures.

McCurdy and Daro (2001) identify a range of factors at the individual/family, provider, program, and neighborhood levels that are correlated with enrollment and retention in voluntary services. Qualitative studies involving a sample of 48 families who participated in Alameda County's Another Road to Safety program (ARS) and 51 families who participated in Contra Costa County's Differential Response program aimed to identify strategies for client engagement and retention that support and resonate with clients' needs. Several patterns emerged when clients were asked to recall their initial and ongoing impressions of the program as well as what their worker said or did to encourage their participation. Clients' remarks about their decision to enroll and remain in the program appeared consistent with three of the factors theorized by McCurdy and Daro: individual factors, or services that respond to individual need; program characteristics, or the auspices and requirements of the program; and provider characteristics, or delivery style. Participants most commonly expressed interest and

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gratitude that the program offered access to community resources, was voluntary, and that the workers displayed sincerity in their efforts to engage and help families.

Clients consistently reported that the possibility of accessing resources for the whole family eased their fears and also allowed them to acknowledge that they needed help. Parents' individual recognition of need, coupled with the providers' focus on serving the whole family, proved crucial to families' engagement. One mother recalled, "At first I was shocked. I thought I was getting in trouble." She went on to explain that she had recently separated from her children's father, and that she knew she needed help. The mother commented that once her worker mentioned accessing help for her and especially for her daughter, she felt more confident about participating. Another mother indicated that initially she was "kind of skeptical" because of the situation that precipitated her referral to the program, but she also commented that she felt relief when she learned that her worker could help her find a new job and help register her son for school. Another mother said that learning about the possibility for assistance with legal services "really sparked my interest because I really needed help because I'm filing for custody." Several mothers expressed a sense of relief and indicated that only in hearing the offers for help did they recognize their need for the help being offered. One mother commented that her impression of the program, after overcoming her initial fear, was "they're here to work with kids, for orientation, and support. I needed that very much."

Parents who chose to participate in the ARS program consistently reported that they appreciated the fact that workers emphasized that the program was voluntary. This

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program characteristic proved critical for easing parents' anxieties about participation and encouraged their engagement. One mother said, "I cried at first because I thought they would take my children from me," but when her worker clarified that participation was voluntary, she said that she felt "more confident." Another parent remarked that learning that participation was voluntary reassured her and removed the pressure. Yet another participant explained that she felt reassured when her worker described the program as a "voluntary outreach program" that can connect her to resources for new mothers. Additionally, although the most prominent reason for participation among clients who received AR/DR services was that they needed help and saw the program as opportunity, others felt like they had to participate due to the fact that they were reported to CPS.

Provider characteristics and service delivery style were also essential to the engagement process. Parents reported that their workers' patience, sincerity, and non-judgmental approach made them feel comfortable participating in the program. "She just seemed really sincere," one mother said. She remarked that her worker talked about "helping [to put] families together again," and she said, "That made me listen." Another mother said that she felt comforted by the fact that her worker said, "[we] just wanted to make sure everybody was okay." She said that she was especially grateful that the worker did not judge her living situation.

Several parents recalled that the ARS/DR workers explained that they were responding to a referral from Child Protective Services. This honesty encouraged parents' participation, according to their statements. Parents indicated that, although

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mention of CPS frightened them initially, their workers careful explanation of how the program worked allayed their anxieties. “At first,” one mother said, “I felt like, ‘oh no, here comes CPS in my business.’ Then my worker told me that nothing would be reported to CPS and explained that they could provide help, even for me.” Another mother described how her worker’s style inspired trust. “I put my trust in them because of how they came to me. They were really honest with me. She explained everything to me. She explained the CPS report.” One mother’s comments revealed a combination of the strategies for client engagement, emphasizing both the fact that the program is voluntary and also that it can provide services: “She told me that they’re here due to a report….But she said [the program] is like counseling, but voluntary—no obligation. Then I thought, ‘OK, they’re not forcing me.’” Given this explanation, she acknowledged, “I wanted that help, that counseling.”

Recognition of need seems to have motivated willingness to engage in services for a number of participants. This illuminates what McCurdy and Daro (2001) identify as individual factors that lead to “intent to enroll” In this case, need as measured by their assessment of risk, determines an individual or family’s attitude towards the services, and ultimately yields intent to enroll. McCurdy’s and Daro’s framework suggests, and client feedback confirms, that initially individual factors, such as need, weigh most heavily on the decision to enroll. Provider factors, such as a sincere and non-judgmental delivery style, were also cited as factors that contributed positively to client engagement and retention. These will be discussed at greater length in the next section, which focuses on client/worker relationships. Program factors, such as the program’s affiliation

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and whether the program is compulsory, also impacted families' decisions to participate. Many, for instance, noted their concern about the possible affiliation with CPS, and staff cite this presumed affiliation as a reason other families declined services.

Client/Worker Relationship

Once families engage in services, their success and their ability to achieve positive change relies in part on their own readiness to change, but it also relies heavily on the relationships they build with their workers. As noted above, McCurdy and Daro (2001) cite "provider factors," including service delivery style and the relationships that result, as critical to a client's retention in a program and how they access social support. Furthermore, the positive relationships clients describe with their workers are indicative of "perceived" social support, or the belief that a supportive presence is available to provide a buffer during stressful situations (Thoits, 1995).

This study asked families to describe their relationship with their workers. In general, most participants expressed positive feelings about their relationship with their worker. Many families expressed appreciation for the open relationships they had with their workers and praised their dependability as well as their accessibility. One mother remarked that she appreciates that her worker does not act rushed and is willing to take a few moments at the end of a visit to talk about additional issues that were not part of that day's focus. "That pleases me and makes me feel more comfortable," she said. Several participants commented on the friendly nature of the relationship with their workers. "[I] wouldn't say that we have a professional relationship because she allows me to be open with her, but [I] also wouldn't say we're best friends...I think that she is

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either a counselor or a sounding board, or both. She acts as both." Several parents characterized their relationships with their workers as being akin to close friends or family. Two mothers described their workers as guardian angels as they enumerated their workers' positive qualities, noting especially how their workers were always available to talk and listen.

DR clients also identified numerous qualities that they appreciated about their case managers. Most commonly, participants described their case managers as nice, good listeners/attentive, helpful/resourceful, and trustworthy/dependable/on time. Participants also stated that their case managers were like friends or family members; and that they are understanding, easy to talk to, patient, supportive, and nonjudgmental. The following statements illustrate some of the qualities clients appreciated in their case managers:

- "It seems like she really wants to do what she's doing and that instills confidence in me."
- "She's very friendly and makes me feel comfortable."
- "She supports the decisions I make."
- "She's kind hearted, understanding, available, and helps me out 100%."
- "My case manager is a real person who comes to me as a regular person and doesn't assume what I need, but talks to me about what I need and makes me feel comfortable."
- "My case manager listened to me before giving opinions."

When asked about certain characteristics, all 51 DR participants reported that their case manager was knowledgeable, respectful, truthful, organized (7 participants

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said “somewhat organized”), helpful, warm/caring, encouraging, supportive, good listener, and flexible (6 said “somewhat flexible”). Most also felt that their case manager was aware of and helped them address their needs.

ARS/DR staff expressed their commitment to cultural competence; workers endeavor to provide services and to discover strategies that resonate with their clients’ cultural backgrounds as a strategy for helping families achieve positive change. Reflecting this, the vast majority (90%) of DR participants felt that their case manager understood and showed respect for their culture/ethnic backgrounds. McCurdy and Daro’s (2001) framework also suggests that cultural competence is an essential dimension of provider factors that contributes to client retention. They define cultural competence as “[possessing] an awareness of, sensitivity to, and responsiveness to the parent’s cultural background and history” (p. 116).

This study explored the role that cultural, ethnic, and linguistic identity play in client engagement and retention. Several of the participants whose first language is not English expressed gratitude for being paired with a worker who spoke their native language. The literature on social support hypothesizes that cultural matching may be important for developing the relationship, as clients are often more willing to accept guidance from people who they identify as similar to themselves (Thoits, 1995). One mother said, “She speaks my language. We talk about when I was in Mexico. She has brought books in Spanish for my child so he won't lose his language and culture.” Another mother explained that, although she and her worker did not have the same ethnic background, their cultures shared certain values. “Our culture is very family

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oriented," she said, "and right now I live with my mom and my sister." This mother indicated that her worker showed respect and seemed to understand the importance of extended family within this culture. Additionally, most Spanish speaking DR clients highlighted having someone they could talk to as the important "service" that they received from the program.

Ethnic matching did not always prove necessary for demonstrating cultural competence or for building supportive relationships between workers and clients. One mother mentioned that she and her worker are not the same race. When asked whether and how her worker demonstrates understanding or acceptance of the family's culture, the mother remarked, "She comes to my neighborhood even though it's a safety risk; she says 'Hi' to everybody…[It's] just normal conversations. She's been with the people; she's so natural and so warm." Another mother commented that she did not think that her worker completely understood her cultural background, but praised her openness.

> I don't want to say that she understands, not completely....But I think she is respectful of…the differences that she may encounter because of my socioeconomic background. She is patient and understanding. She's really just good at following through to make sure that I have everything I need.

This mother went on to explain that she believes that a person cannot completely understand something that they have never lived, but asserted, "She's got the right attitude." This mother's comment revealed another dimension of cultural competence that program staff also noted, which is that it necessarily includes an understanding not only of ethnicity but also of socioeconomic status and other factors.

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The previous section on client engagement identified a strong association between desire for material assistance and initial engagement. However, families' descriptions of their workers tended to emphasize more general supportive qualities and attitudes rather than specific acts of support, an expression that further signals the saliency of perceived social support.

Social Support

The social support literature distinguishes between perceived and enacted support and suggests that perceived support often has more powerful effects on stress (Thoits, 1995). As mentioned above, perceived support is the belief that unconditional support is available, whereas enacted support describes concrete acts or gestures of support. AR/DR staff members provide social support to their clients, which is theorized to improve mental health and relieve stress (Finfgeld-Connett, 2005, Thoits). The notion of social support has been operationalized by House (1981), who asserts that social support manifests in three main types of support: emotional, informational, and instrumental, which provides concrete goods. Each of these types of social support is evident in the nature of the relationships AR/DR workers maintain with their clients as well as in their strategies for creating sustainable connections within the community. AR/DR workers' interventions reveal the often-blurry lines among the three types of social support, as interventions often serve multiple functions.

Emotional Support

Emotional support can consist of providing a comforting presence and reassurance, simply listening attentively to somebody, or by normalizing situations

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(Finfgeld-Connett, 2005). One mother described how her worker creates a space for her to reflect. “We just talk,” she said. “She encourages me to think about how I do things.” Another mother described how her worker normalizes the challenges she experiences as a parent. “[My worker] is very validating,” she said, “so I feel a little bit more comfortable, more confident.” Many families reported that the encouragement offered by their workers helped to propel them towards their goals. One mother remarked, “She allowed me to realize all the things I’ve overcome, and that made me feel proud.” Another mother said, “They’ve really empowered me. They’re never looking down on me…[My worker] is a concerned, passionate person.”

Informational Support

Workers also provided informational support. Families described receiving information about how and where to access services as well as assistance in interpreting information and identifying options. One mother described how her worker helped her problem solve and think through her alternatives: “[My worker] says he can't tell me what to do but we look at different options.” This mother expressed appreciation for her worker’s validation and willingness to examine different possibilities.

Other informational support that families received from their workers included pamphlets, videos, and discussions about parenting and discipline. One mother said that she and her worker watched a video about positive discipline and commented, “[the worker] helps me put it into practice.” Workers engage in conversations with families about discipline and acknowledge the challenges they face as parents. One mother said that these types of conversations with her worker have helped her with her daughter.

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“Now I know how to calm my daughter down if she tantrums.” A grandmother remarked that her worker has helped her learn new ways to relate to and redirect her granddaughter, who has Down Syndrome. “I am finding her way,” she said of her process of acquiring new techniques for managing and supporting her granddaughter. These examples, like many, reveal a combination of informational and emotional support.

Still other parents found social support in their worker’s efforts to provide information about how to create a resumé and complete job applications. This process included everything from offering access to a computer to discussing job experience and employment goals, an example that again reveals a combination of informational, emotional, and instrumental support.

Instrumental Support

Instrumental support is an essential aspect of the workers’ efforts. Instrumental support includes provision of concrete goods and linkages that respond to an expressed need by the families. Finfgeld-Connett (2005) suggests that instrumental support might include child care, transportation, assistance with household tasks, or financial assistance. As illustrated above, the distinction between informational and instrumental support can be nebulous, as families often receive information about services that will help to meet their expressed needs. For example, offering information about how to apply for food stamps or the low-income programs available to assist with electricity bills illustrates the provision of both informational and instrumental support. Additionally, workers might simultaneously provide instrumental and emotional support by helping

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families to follow through with referrals and break down the steps they need to take in order to meet their goals. One mother described how her worker motivates her and also helps her to lay out her plan step-by-step: “When I tell her everything that’s going on, she’ll say, ‘Ok, what do you need to do first?’ and if I say ‘I don’t know,’ she says, ‘C’mon Sarah[4] (said with encouraging tone).’ And then she’ll help me if I need it.”

Advocacy

Advocacy is a critical dimension of social support, as it unites emotional and instrumental support and bridges the micro and macro systems. Advocacy includes offering validation, encouragement, and reassurance to families so that they feel empowered to assert their needs and to seek out services within the community. Workers help families navigate social service systems, and in the process, workers teach families about their rights so that they feel empowered to advocate for themselves in the future. A critical aspect of advocacy is that it allows families to do for themselves and to retain a sense of personal control, which in turn allows them to increase their sense of self-efficacy and make positive change (Bandura, 1977 in Eckenrode & Hamilton, 2000; Thoits, 1995).

Advocacy often includes education for community providers and facilitating connections among various community systems so that they can better serve families in the future. Participants described how their workers advocated for their families’ needs in a variety of settings, such as MediCal or CalWorks, at schools, and with landlords.

[1.] Client’s name changed.

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One mother praised her worker's persistence in helping to reactivate the family's MediCal case: "We waited a long time for MediCal…She made calls even though it took a long time and sometimes they were rude to her. She tried hard and insisted. She's very attentive." Another mother said that her worker advocated for her CalWorks benefits and also facilitated communication between the CalWorks worker and the employment counselor. This mother also mentioned that her worker accompanied her to speak with the landlord about baby-proofing the apartment. She expressed gratitude in simply having her worker present as she negotiated this situation. This scenario reflects the significance of the perceived social support offered by the worker. One mother described a different form of advocacy. She explained that she was going through a divorce and was in the process of custody hearings and said that her worker wrote a letter for the court to verify her participation in the program.

The worker/client relationship itself forms the base of the social support system (Eckenrode & Hamilton, 2000), and the workers' acts of social support—whether emotional, informational, or instrumental—serve to solidify the workers' intent to respond to clients' material needs and to guide families towards community resources that will continue to serve them. ARS/DR staff described building trust and rapport as critical steps in the provision of services and the creation of a plan for each family. Staff explained that among their strategies in providing social support is to celebrate a family's successes and to build upon their strengths, a strategy that illustrates emotional support and validation. Workers recognize that many families have felt isolated from their communities for a variety of reasons, and part of their goal in offering social

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support is to help families begin to feel connected to their communities and motivated to work towards their goals. The AR/DR model acknowledges the relatively short time period in which they are available to provide social support to families and therefore adheres closely to Eckenrode and Hamilton's (2000) assertion that the social support provided by home visitors should be viewed as a means to an end rather than as a primary source of social support. Ultimately, by providing emotional, informational, and instrumental support, the aim is to instill confidence in families and create linkages with community resources so that families can activate and grow their own social support systems.

Connections to Community Resources

The relationships that clients build with their workers, coupled with the increased empowerment parents feel as a result of the support and advocacy provided by their workers, often leads to new connections to community resources, which contribute to families' pathways towards change. Creating linkages to community resources is an example of the ongoing informational and instrumental support provided by AR/DR workers. Workers describe how the process of referring families to appropriate agencies is essential not only because it represents an effort to respond to immediate need, but also because it illustrates the workers' efforts to teach skills and create sustainable linkages that families will continue to access after they complete the program.

As discussed in the previous chapter, the neighborhood is the third variable in this equation that strives to create sustainable connections to community resources. Research suggests that neighborhood factors such as infrastructure, social service

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organizations, and community relationships can have powerful effects on family processes and outcomes (Furstenberg & Hughes, 1997). Neighborhood institutional resources models (Jencks & Mayer, 1990; Leventhal & Brooks-Gunn, 2000), a framework that exists within the larger body of theory on how neighborhoods impact their residents, postulate that the presence of neighborhood resources that promote learning and positive social environments can impact child development outcomes. The following domains of community-based resources are among those that the theory identifies as essential to fostering positive social environments: learning, social, and recreational activities; child care; schools; medical facilities; and employment opportunities. The array of services in these domains can benefit children's cognitive and physical development, behavioral functioning, and physical and mental health.

Leventhal & Brooks-Gunn (2000) submit that the impact of these key neighborhood resources hinges on four main dimensions—availability, accessibility, affordability, and quality of resources. AR/DR workers strive to optimize each of these four dimensions when they refer families to community resources. Workers remark that it is a priority to find services that are in the family's neighborhood, easily accessible, and linguistically appropriate. Results from interviews with the 48 ARS families suggest that workers were successful in connecting families to in-home services or to services within their neighborhood approximately 77% of the time. Similarly, clients in the 51 DR interviews suggest that most or all needed services were located in their neighborhood, and that needed services were always (69%) or sometimes (22%) available.

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Family advocates and case managers are conscious of the fact that many families are socially isolated and unaware of beneficial community resources. Small (2006) suggests that the degree to which neighborhood institutions can facilitate further connection and help families access resources represents an additional mechanism by which neighborhood institutions impact child outcomes. The function of ARS/DR, therefore becomes like a "resource broker," as defined by Wilson (1987; 1996). Wilson observed that institutions such as churches and recreation centers, which often maintain connections to various non-profit and governmental agencies, are able to utilize those connections to help community members access services provided by those agencies. Involvement with "resource broker" neighborhood institutions gives an advantage to children and families because it grants access to other essential community-based resources.

As resource brokers, ARS/DR workers facilitate connections to community resources that fall within the domains of key community resources mentioned above. Parents who participated in ARS described how their workers facilitated their relationships with important community resources, such as health programs, low-income utility programs, therapy, and adult education programs. One mother, for example, explained that her worker helped her apply for an asthma education program, which she said offered information and resources that have helped her manage her son's asthma. Several parents mentioned having received referrals for both family and individual therapy, which most said was instrumental in their family's improved communication and coping. One mother whose daughter has received therapy

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explained that, after experiencing a trauma, “[my daughter] became very fearful due to that experience.” This mother reports that the therapy has helped her daughter and that “she doesn’t have any more fear since she’s been participating in therapy.”

Clients who participated in DR also cited how the program facilitated their sense of connection to the community. More specifically, more than 75% of participants reported feeling more connected to the community during or after participation as compared to before they received DR services. In particular, many Spanish-speaking clients noted that access to a Spanish-speaking case manager increased their sense of connection to the community.

Despite workers’ efforts to maximize the four dimensions of successful community connection (accessibility, availability, affordability, and quality), reports from both ARS workers and families reveal the challenge in accessing adequate community resources due to lack of availability. Among the barriers to services for some families is the lack of Spanish language providers. One mother commented, “The waitlists for Spanish speaking clients are very long, so I still haven't been able to participate in counseling even though I'm involved with this program.” This mother indicated that she had attempted to access counseling services prior to her involvement in the ARS program but was unable to do so. Several families also mentioned that long waitlists for childcare and preschool programs prevented them from accessing services when they needed them. Several theorists note that this scarcity of resources is likely a function of the neighborhood’s socioeconomic characteristics (Aber, Gephart, Brooks-Gunn, Connell, & Spencer, 1997; Jencks & Mayer, 1990; Pebley & Sastry, 2003). Furthermore,

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it is probable that demand for such services is greater in high poverty areas like those in which ARS typically works.

Neighborhoods

As illustrated above, neighborhoods—their infrastructure, their capacity to provide resources, their level of safety, and their ability to instill a sense of collective identity and build social capital—can have powerful effects on outcomes for children and families (Furstenberg & Hughes, 1997). Perception of both opportunity and risk inform families' decisions to seek out and access neighborhood resources. While referrals and information from ARS/DR workers can augment families' knowledge of community resources, sometimes other neighborhood factors, such as safety, have a greater influence on families' ultimate decisions to access services.

Interviews with families inquired about the neighborhoods where they live and asked about available support services; positive characteristics of their neighborhood; and challenges, or worrisome aspects within their neighborhood. Among the support services that families identified were: Boys and Girls Clubs, parks, schools, recreation centers, libraries, and churches. A majority of families who participated in ARS or DR indicated that their neighborhoods offer some of these services where their children can play safely or where they can seek support.

Relationships with neighbors were also cited by some families as a source of support. A significant number (48%) of ARS families indicated that they have a positive, trusting relationship with at least one neighbor. Several others indicated that although they did not have many close relationships with their neighbors, they characterized their

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neighborhood as one in which people will help and look out for each other. One mother who lives in East Oakland and who cited violence as a primary concern within her neighborhood also said, “[I] definitely like the people, neighbors are great…a close-knit family thing.”

Safety was expressed as a primary concern for many families. A significant number (44%) of ARS families expressed concerns about violence, theft, drugs, and gang activity within their neighborhoods. Of these, however, a majority expressed feeling connected to their community, either because of supportive neighbors or because of access to parks, schools, libraries, or churches. One mother explained that although she has safety concerns within her neighborhood, she visits the library frequently. “I like to go to the library very much and I hope to get my children used to going there.” This mother’s willingness to utilize community resources even within a neighborhood in which she “[does] not feel safe” is inconsistent with previous research, which finds that residents of high risk neighborhoods are often less likely to access recreational services than residents in low-moderate risk neighborhoods (Garbarino & Sherman, 1980). It is possible that in this case, positive neighborhood relationships mitigate some of the negative effects of community violence.

Meeting Basic Needs

Much of the strategy in AR/DR’s home visiting model is rooted in Maslow’s (1954) Hierarchy of Human Needs, which posits that the realization of need is organized in a hierarchy in which lower, more basic needs must be satisfied in order to progress onto deeper needs. ARS/DR staff describes their initial efforts with many families as

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being focused on achieving stability and meeting basic, physical needs such as food, security, and housing. However, even their strategy in meeting basic needs reveals a cognizance of how to simultaneously provide instrumental support, or tangible goods, and also informational support and advocacy so that families know how to meet their needs in the future.

Interviews with staff revealed that a principal concern for them when offering referrals to families is to balance the families' needs for immediate services with the need to learn to access services on their own. The results of this balancing act were evident in provision of services for basic needs. One mother explained that ARS helped her pay a PG&E bill "because I had 48 hours to pay." She recalled that her worker explained that the program could pay for one month but also emphasized the importance of paying on her own the following month. Meanwhile, another mother was simply referred to the low-income programs offered by PG&E and EBMUB so that her bills would be more manageable. A significant number of ARS families (71%) received assistance or donations to help them meet basic needs. Families reported receiving the following donations: food baskets and gift certificates to grocery stores, diapers, assistance with a utility bill, and bus passes or transportation to appointments. One mother said that she received "emergency aid" from ARS, and another said that ARS helped her pay an initial deposit on a new apartment. One mother who received food, clothes, and a bus pass, said that her one suggestion for the program is "Just to make sure that [the families] have resources like bus passes, diapers, food…stuff that we really need." This statement seems to express the urgency that many families feel when

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basic needs are not being met. Consistent with Maslow's theory, this sentiment resonates with ARS/DR staff belief that efforts to help meet basic needs can alleviate stress and therefore make important contributions towards positive parenting.

Parent-Child Relationship

An underlying tenet of AR/DR is that positive, enjoyable relationships between parents and children can be a powerful mechanism for change. Therefore, AR/DR emphasize child development and parent-child attachment as an integral part of child welfare services, not as separate elements. John Bowlby (1969) and Mary Ainsworth (1973) pioneered the notion of human attachment, and their work illustrates how imperative it is for a child to feel emotionally connected to a caregiver who will protect and nurture them. To this end, ARS workers encourage families to engage with their children and emphasize the value of play for learning and for building healthy, secure attachments with parents and caregivers.

One Alameda County agency invited families to participate in a series of science classes where children and parents learned and played together. All of the families who participated in this program expressed positive feelings about the experience. One mother remarked on how it helped prepare her son for preschool. Another mother expressed her enthusiasm for the program and said that she learned from it: "

> It was a nice experience and it taught me that the kids come first—they bug you and bug you, but they just want 5 minutes of your time…It was cool; I never had that when I was a kid.…that day was cool, because I got to be with them.

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While this program with the South Hayward agency was the only program that provided admission and transportation to activities and cultural events, parents mentioned that they learned about other activities and resources such as children's museums, story time at the library, and "Mommy and Me activities." One first-time mother said, "I knew that there were places that had those kinds of things, but didn't know where to look, so that in itself was helpful, someone who already had that information." This mother expressed appreciation for the information and the opportunity to get out of the house and do activities with her baby.

Developmental Screenings

Developmental screenings are a standard part of ARS services for most young children, and staff observe that conducting these screenings often opens a window for larger discussions about child development and the importance of the parent-child dyad, both of which are central to the program's theoretical framework. ARS's emphasis in the parent-child dyad encourages parents to strengthen their understanding of their child's development, and the screenings also present an opportunity for families to establish connections with formal community supports. Some screenings lead to a referral to a developmental specialist, a speech pathologist, or the local school district. Several parents noted that the school district and Individual Education Plan (IEP) meetings were the sites where advocacy often took place.

One mother whose daughter was referred to a developmental specialist and then to the school district for an IEP said that her worker advocated for her at the school district. This mother also mentioned that her worker referred them to a support group for

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parents of children with special needs. “She wants to make sure that we’ll continue to work with someone that will help us,” the mother commented. This mother’s situation and the worker’s intervention reveal an integration of various social supports; the worker simultaneously provided informational support that allowed the parent to access formal services, advocacy so that the parent would feel empowered to continue pursuing formal support, and a sustainable link to emotional support where the family’s challenges would be supported and normalized.

Another parent explained that the results of her child’s developmental screening led to a referral to a speech therapist and to an audiologist. The mother explained that she and her worker are looking into special preschool classes that emphasize speech and language. Several families identified their workers’ willingness to advocate for their needs as essential to their relationship and their progress. “When [my worker] stepped in with her advocacy, the process went faster,” one mother remarked as she explained how her worker had advocated for her child with the school district. This case also reveals that advocacy and informational support provide the bridge to a family’s connection with formal community resources.

Client Perspectives on Family Changes

Many families who participated in the ARS and DR programs said that the program, their worker, and new contacts within the community helped them to achieve changes in their life and/or the lives of their families. Some reported physical changes, such as feeling healthier and having increased energy. Others reported changes in housing: two mothers in the ARS program indicated that the biggest changes for them

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were having gone from a shelter to a new apartment. Several reported improved relationships and communication with partners and children. Many participants expressed feeling a new sense of comfort and pride as well as increased confidence in accessing resources within their communities.

One mother described changes in her household and said that the biggest change is that her child's father moved out of the house. "The house is being baby proofed," she added. She paused and then remarked, "I'm more comfortable in my own skin. I'm willing to do all the things I need to do to get things done." Another mother reflected on how her perspective and priorities have changed: "I want to do things with my kids, and I want to spend the most time I can with my kids…[I] always felt like that about my kids, but now for sure, they are my priority." One mother noted positive changes in her husband and in their communication. "My husband has changed," she said. "He talks more, [we have] improved communication. [He] has participated in workshops and helps more."

Mothers and grandmothers commented on changes and improved relationships with their children and grandchildren. One grandmother, who is the guardian of four of her grandchildren, remarked, "My granddaughter was very rebellious. She did not want to study….she has been working with the psychologist. It has been a total change—a triumph." This grandmother added that she has learned a lot from her experience with the ARS program. "I am 70 years old, but I am still learning new things..." A mother described the challenges precipitated by her separation from her children's father but spoke of how relationships with her children have improved. "It's just me and the kids

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now," she said, "I'm a single mom….I'm setting my own goals now….My family dynamic changed overnight. My son is a lot happier, more open. We have a better relationship."

Several mothers described how their community connections and commitments have changed. "A lot has changed," one mother said. "I began to think, 'How can I make a difference?" She described how new confidence and gratitude after having been supported inspired her. "I used to kind of hide myself from the world," she concluded. This woman's comment reveals her own progression from meeting basic needs to the gradual realization of other desires, as is theorized in Maslow's hierarchy. Additionally, this mother's commitment to reciprocity, or giving back, is consistent with the literature on social support, which suggests that reciprocal relationships are an essential component of social support (Finfgeld-Connett, 2005).

Another mother remarked, "I'm juggling a lot more now." Since becoming involved with ARS, she explained that she has started working and two of her children have enrolled in school. "It's worth it, having two kids in school," she said even as she described how difficult it is to drop the children off at school, be at work, do volunteer hours at school, and find childcare for the other children. This mother also indicated that she appreciated the importance of giving her children the opportunity to be in school. Another mother expressed feeling more confident and better able to access resources because of information provided by her worker. "Now I have an idea where to go if I need help," she asserted.

Similar to the ARS findings, DR clients also noted positive changes as a result of their participation in the program. More specifically, almost all participants (94%) noted

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life changes as a result of the program, and they credited their case managers as helping them to make these changes. They also reported an improvement in overall quality of family life with 73% reporting that family life is a lot better as a result of program involvement and 20% reporting that it's a little better.

Suggestions for Improvements

Families were asked to think about ways that the program might be improved. Most responded that they thought the program was fine the way it is and did not identify any necessary changes. A few families shared some of their ideas for improvement or expansion of the program. One mother, who has an infant, mentioned that interruptions like diaper changing or preparing a bottle sometimes limited the total time she had with her worker and suggested that weekly visits be longer to ensure that the parent receive a full hour with the worker.

One mother said that she hopes that the ARS program can offer more general orientations about this type of service within the community. She explained that prior to her enrollment in the program she searched for help at doctors' offices, but did not find what she was looking for. She suggested trying to involve the community more and even using families like hers to promote the program. Another mother offered a similar suggestion, which was to extend the program to other areas.

SUMMARY

Client engagement is one of the greatest challenges AR/DR workers contend with. This is partly because they serve clients during periods of crisis and may initially induce more stress in an already stressed family. Overcoming this difficulty requires

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recognition of the factors associated with successful engagement. Specifically, engagement has been linked to various individual factors, program characteristics, and provider characteristics, including the client-provider relationship.

Social support is a particularly important component of the services provided by AR/DR workers. It comes in three forms: emotional (e.g., offering reassurance and validating experiences), informational (e.g., indicating where clients can access services), and instrumental (e.g., providing childcare, transportation, or financial assistance). Social support is the basis of the client-worker relationship and is needed to connect families to communities and resources. While performing the role of resource broker, workers also attempt to optimize the availability, accessibility, affordability, and quality of community resources. Many have found the lack of available services to be a significant barrier to meeting AR/DR goals.

In addition to recognizing barriers to client engagement and offering social support, AR/DR workers also focus on specific areas associated with child and family outcomes. These efforts include addressing neighborhood factors (e.g., resources, relationships with neighbors, and safety), meeting basic needs, building positive parent-child relationships, and using developmental screenings to strengthen the parent's understanding of child development. Clients have indicated that AR/DR workers helped them achieve positive changes in various areas of life, including improvements in relationships and self-sufficiency. Nevertheless, families have suggested areas for program improvement, including expanding programs to other areas, involving the community to a greater extent, and lengthening weekly home visits.

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VIGNETTE #1

BEATRICE AND VANESSA

Beatrice and Ricardo have three children: Vanessa (11), Carlos (3), and Yasmin (newborn). The family is from Mexico, and neither Vanessa nor her parents have immigration documents. Ricardo is often under- or unemployed. Beatrice is currently unemployed because she is caring for Yasmin, but Beatrice has had a fairly steady employment history. The family shares a house with another family, so Beatrice, Ricardo, and the children all sleep in one bedroom.

The family became involved with ARS because Vanessa disclosed to a school counselor that she had been sexually abused by her uncle when she was 7 years old. The school counselor reported Vanessa's disclosure to CPS, who referred the case to ARS. Prior to ARS involvement, the school also contacted the police, who began an investigation. However, the family's fears about speaking with law enforcement caused the police investigation to stall out quickly. The school counselor attempted to engage Vanessa further, but after the disclosure Vanessa expressed an unwillingness to talk about the incident. Beatrice, hesitant to push her daughter, decided that it was best for Vanessa to put the incident behind her so did not pursue counseling through the school.

When ARS staff visited this family in their home and spoke with Beatrice, she was immediately willing to participate in the program. She cried as she told her worker about their situation. Beatrice described significant tension in the family and told the worker how her husband blamed her since it was her brother who had abused Vanessa.

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The ARS worker helped the family develop a plan. The family identified several goals. Beatrice's first priority was to access therapy for Vanessa. Ultimately, both Vanessa and Beatrice received therapy paid for by ARS.

Another family goal was to connect to more community resources and to meet basic needs. ARS helped the family pay for 1 month of rent and helped Beatrice connect with the Family Resource Center, which provides food and clothes. Beatrice also contacted the Healthy Start Program and set a goal of getting developmental screenings for Carlos and Yasmin. The family also participated in a program at Lawrence Hall of Science where the family engaged in educational and play-based activities together.

At the end of the 9-month program, Beatrice and Vanessa had completed 3 months of therapy, and Beatrice was working full time. Ricardo never fully engaged in services, and he never agreed to participate in couples' therapy with Beatrice. Tensions between Beatrice and Ricardo persisted, but Beatrice was becoming increasingly independent.

QUESTIONS FOR DISCUSSION

1. What types of challenges in family engagement might you encounter when working with families that have experienced sexual abuse?
2. What sort of information about the family's culture might help you engage and collaborate with this family to build a family care plan?
3. What are some strategies for engaging a hesitant parent/caregiver, like Ricardo?
4. Given what you know about the stages of human development, what might have deterred Vanessa from engaging in counseling after she initially disclosed past abuse?

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VIGNETTE #2
RUBY AND AMOS

Ruby is a 44-year-old immigrant woman who lives with three of her children: Amos (14), Brenda (11), and Gladys (10). Ruby has older children who still live in her home country. Like many immigrants, Ruby's migration experience was difficult. The family was referred to ARS because Amos, the 14-year-old boy, displayed angry and violent behavior towards his family, and he was regularly truant from school. In addition, he was believed to be dealing drugs. Ruby suspected that Amos was selling drugs because he would come home with money and new clothes that she could not afford to buy.

When the ARS worker initially made contact with Ruby, she immediately expressed interest in the program. Ruby acknowledged that she was struggling to set limits for her children, and especially for her teenage son. She recognized that, given her son's violent behavior, she often did not make any attempt to set limits because she was afraid of what he might do. She knew that she needed support.

The family's primary source of income was CalWorks, which does not provide a sum that leaves extra money for teenagers to buy the things that many of their peers have. The family's poverty may have contributed to Amos' frustration and aggression because he did not have the resources to buy things that he wanted.

The ARS worker's intervention focused on connecting Ruby to counseling services that would support her self-confidence in her parenting and help her to set

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limits for her children. Support services and counseling for Ruby included addressing symptoms of PTSD from traumas she endured prior to her immigration. Interventions also focused on supporting Ruby's relationships with her children.

With support of the ARS worker, the family achieved many of their goals. Ruby attended an adult education program, which she completed with honors. The ARS worker connected the children to summer programs and also helped transfer Amos to a different school, which he now enjoys. Ruby and Amos continue to work with the school on Amos' Individualized Education Plan (IEP). Amos' behavior has improved, and the ARS worker observes that Amos is increasingly able to express his needs and articulate his goals.

The family completed the ARS program and continues to do well.

QUESTIONS FOR DISCUSSION

1. Community life and parenting practices can be distinct in other countries, so immigrant families face a multitude of changes in their environments as well as the social norms governing those environments. What are some of the adaptations Ruby and her family might be experiencing? How might these changes impact their overall wellbeing?
2. Imagine that you are the family advocate assigned to this case. What sort of information about the family's culture or country of origin would you like to have prior to your first visit with the family? Do you anticipate any special challenges with family engagement?
3. Given what you know about human and adolescent development, what might Amos have been experiencing as he adapted to his new life in the United States?

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VIGNETTE #3
GABRIELA, MIGUEL, AND JUSTIN

Gabriela and her husband Miguel separated and have recently been engaged in a custody battle over their 3-year-old son, Justin. The family was referred to ARS after Gabriela reported Miguel to CPS, alleging that Miguel did not feed Justin during his visits with his father. In the course of the custody hearings, Gabriela displayed symptoms of depression and became increasingly anxious about the time that Justin spent with Miguel. Pursuant to a court order, Gabriela and Miguel met twice a week at the police station, where Justin was delivered into his father's custody for overnight visits.

Gabriela reported that when Justin returned home from visits with his father he exhibited significant emotional distress. Gabriela noted a change in Justin's behavior and believed that he was reacting to maltreatment by his father. Consumed by upcoming court proceedings, Gabriela focused on collecting evidence for the custody case. As a result, she videotaped Justin's tantrums and weighed him before and after his visits.

When ARS became involved with this family, the ARS worker attempted to refocus Gabriela's attention to her son, rather than to her custody dispute. The ARS worker expressed empathy and acknowledged that the separation had been difficult, but also emphasized the importance of keeping Justin as the focus of their work. The ARS worker attempted to engage Gabriela in therapy, but she refused. Therefore, the ARS

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worker focused his energies on providing support to Gabriela so that she could maintain a home environment free of conflict and tension in which to care for Justin. The ARS worker invited Gabriela and Justin to participate in family science classes offered at Lawrence Hall of Science. Gabriela was enthusiastic for this opportunity, and she and Justin participated regularly. Gabriela mentioned to her worker that the quality time with Justin motivated her to create more opportunities for two of them to spend time together and play.

The ARS worker asked Gabriela whether she would object if he met with Miguel and then accompany Justin on a visit to his father's home. After her initial rejection, Gabriela agreed, and the ARS worker contacted Miguel, who also expressed hesitancy initially. The ARS worker met with Miguel and emphasized that the ARS goal was to support parents to meet their child's needs. The ARS worker observed one visit in Miguel's home with Justin. The ARS worker reported to Gabriela that Justin and his father interacted positively together and that Justin exhibited a strong attachment with his father. Gradually, Gabriela's anxiety diminished, and eventually Gabriela and Miguel reconciled.

ARS staff were surprised and somewhat concerned by the couple's reconciliation because Gabriela had revealed a history of domestic violence. When the ARS service period ended, the ARS worker offered a variety of referrals for domestic violence education and encouraged Gabriela to consider counseling for herself and for Justin.

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QUESTIONS FOR DISCUSSION

1. What types of challenges might come up when working with families engaged in custody battles? What types of interventions might you try to respond to these challenges?
2. How might the needs of the parents and the child be balanced in a case like this one?
3. Given what you know about child development, what would you say that Justin needs most right now?

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MODULE VIII

OUTCOMES FROM CONTRA COSTA COUNTY

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MODULE VIII
OUTCOMES FROM CONTRA COSTA COUNTY

INSTRUCTIONAL GUIDE

Purpose

- To provide an overview of key outcomes from the DR program in Contra Costa County. Guided by the primary goals of DR to promote child safety and well-being, the study examined rates of family engagement and sought to understand child or family attributes that predict engagement in voluntary services. The study also examined rates of re-referral to CPS and rates of child removal. This chapter illustrates results of those analyses.

Learning Objectives

By the end of this chapter, students should be able to:

1. Critically assess the outcomes from CCC's DR intervention,
2. Identify predictors of family engagement,
3. Understand the impact of engagement, or receipt of services, on rates of re-referral and removal, and
4. Consider the practice and policy implications of DR's results.

This chapter can be used to foster the following curriculum competencies:

7.8 Student understands the purpose of outcome measurement and is able to seek client, organization, and community feedback for purposes of monitoring practice, service refinement, and outcome evaluation.

8.10 Student understands how to use information, technology, and evidence-based research to evaluate and improve policy, practice, and program effectiveness.

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QUESTIONS FOR DISCUSSION

1. Based on what you learned in this chapter, what were the main factors that predicted families choosing to engage in DR services? What are your thoughts on why these factors influenced engagement? As a social worker, how would you use this information to engage families?

2. The outcomes data revealed that, in some cases, families with prior experiences with the child welfare system were less likely to engage in DR. What are your thoughts about this trend? Brainstorm possible strategies and approaches for CFS to engage these families?

3. Based on the outcomes data outlined in this chapter, do you feel like DR services are effective? Why or why not?

OUTCOMES FROM CONTRA COSTA COUNTY

The ultimate goal of Contra Costa County's differential response system is to promote the safety and well-being of children, thereby reducing their likelihood of entering the child welfare system. To measure its effectiveness, two primary measures were considered: child welfare re-referral rates and child removal rates within 1 year following the initial referral to the child abuse hotline. In addition, because the DR program is voluntary, the outcomes study looked at the engagement rate to better understand families' likelihood of engaging in services.

The study included a sample of 499 children eligible for Path 1 services between October 2005 and September 2006. (It is possible that some siblings are included in this data file; we were unable to select a single random child per family.) These data were obtained from administrative records completed by DR service providers and

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CWS/CMS. Children referred to Path 2 were not included in this analysis because of insufficient information about whether or not they actually received services.

Engagement

Of the 499 children eligible for Path 1 between October 2005 and September 2006, only 164 (33%) were offered services. The remainder were not served due to lack of capacity (59%) or inability to contact the families (8%). Of those who were offered services, approximately half (49%) actually engaged in (i.e., received) services (n = 80). In an attempt to better understand possible predictors of engagement, the following factors were considered for these 164 children: ethnicity, age, type of allegation, and prior referral history of the family. Of the 143 children for whom ethnicity information was available, 15% were Caucasian, 36% were Black, 41% were Hispanic, and 7% were Asian/Pacific Islander. There was a significant difference observed in engagement rates of Hispanic clients as compared to clients from other ethnic backgrounds. As illustrated in Figure 1 below, Hispanic families were more likely to engage in services (66%) than families of any other race/ethnicity. Anecdotal information gathered through client interviews indicates that this differential rate of engagement may be due to a variety of factors. For instance, Hispanic clients may have been more likely to feel that they had to participate; they also may have welcomed support due to inadequate existing supports, particularly those offered in their language. However, more research is needed to fully understand these differences.

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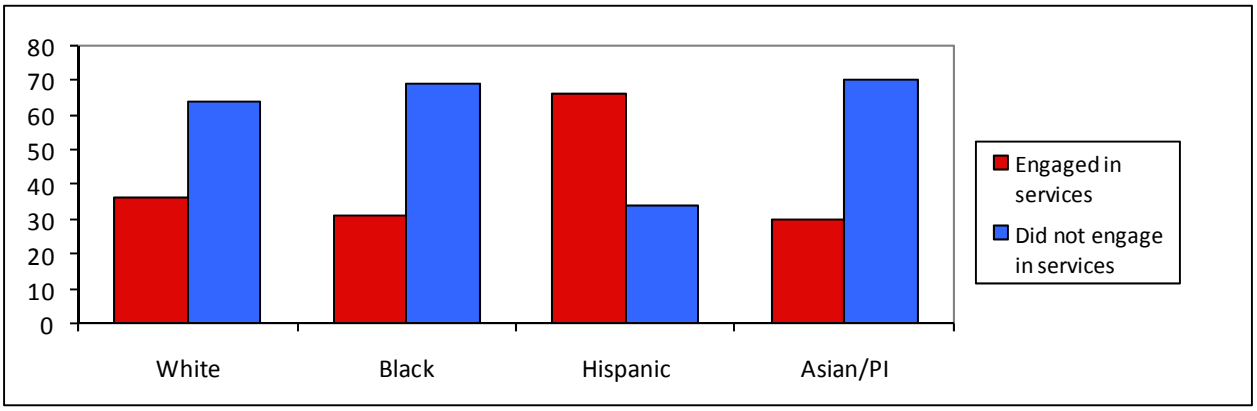
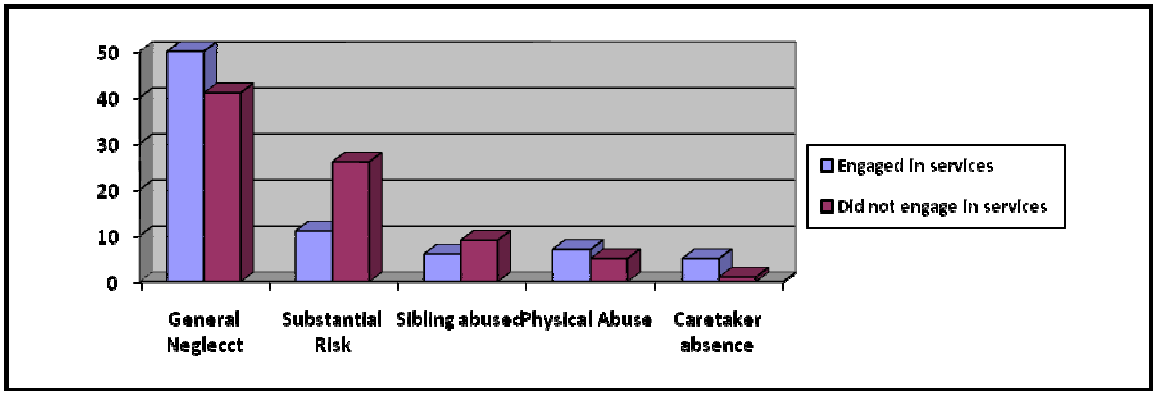
Figure 1



The age of the child did not seem to affect a family's likelihood of engaging in services. However, the initial allegation type did (see Figure 2). Overall, general neglect was the primary allegation type for the majority of the cases (55%). Although only 2% of the sample had an initial allegation of Caretaker Absence/Incapacity, this group was most likely to engage in services (83%). Conversely, those with an initial allegation of substantial risk were least likely to engage in services (30%).

Figure 2



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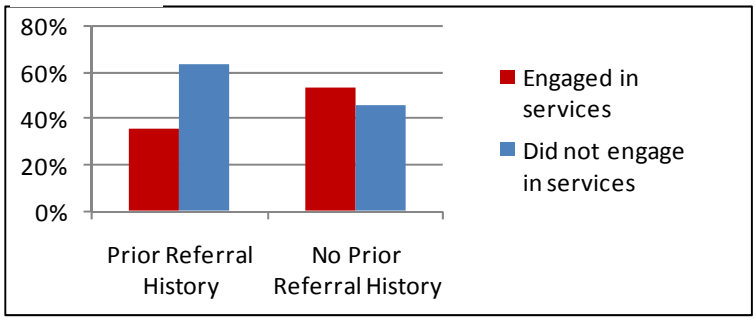
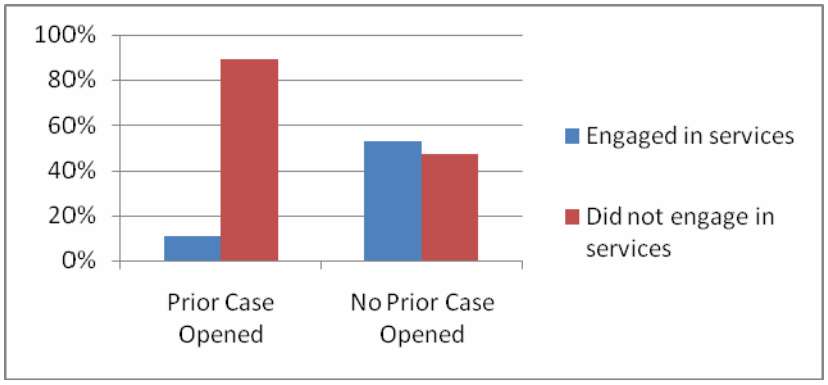
Families who had a history of child welfare referral prior to September 2005 were less likely to engage in services than those who did not have a prior referral (Figure 3).

Figure 3



Families who had a case opened prior to the current referral were even less likely to engage in services (11% vs. 53% for those who did not have a prior case opened; Figure 4).

Figure 4



Child Safety: Re-Referral

Logistic regression analysis was used to determine the impact of certain factors on the likelihood of re-referral to Children and Family Services. Engagement in services did *not* appear to impact re-referral rates. Approximately 28% of children from families engaged in DR services were re-referred for maltreatment, and 30% of children were re-referred among families not engaged in services. One possible partial explanation for this is the "surveillance factor;" that is, because case managers spend so much time in

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families' homes, they may be more likely to observe situations or behaviors that are reportable, thus increasing the likelihood of re-referral.

Predictors of Re-Referral

Families participating in DR were no more or less likely to be re-reported for maltreatment than families who were not offered the service. The only significant predictors of re-referral were ethnicity and prior referral history. In fact, the odds of re-referral for a non-Caucasian child were 5.9 times the odds of re-referral for a Caucasian child, controlling for all other variables. Specifically, the re-referral rates were 42% and 37% for Blacks and Hispanics, respectively, but only 9% for Caucasians. Additionally, the odds of re-referral for those who had a prior referral history were 3 times the odds of re-referral for children whose families did not have a prior referral history. These findings were consistent with existing research literature that suggests that minority populations and families with prior referrals have higher re-referral rates.

Child Safety: Removal

Logistic regression was not utilized to examine the data on removal because of the small sample size. However, crosstab analyses show important differences between the families who were offered services but did not engage, and all other groups. These families were more likely to see their children removed from their care. All other groups, whether they engaged in DR services or were offered no services due to program capacity, were equally likely to see their children removed within one year following an initial child maltreatment report. It is important to note that the families offered services

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were generally identified as the most "difficult or needy" according to Contra Costa County staff. Therefore, the group that was not offered services due to program capacity may have been lower-risk cases.

Table 2

Service engagement	Removal within 1 year		Total
	No	Yes	
Services engaged	78	2 (3%)	80
Services not engaged	74	10 (12%)	84
No capacity	285	12 (4%)	297
Unable to contact	36	2 (5%)	38
TOTAL	473	26 (5%)	499

The data suggest that Caucasian and Black children are more likely to be removed than Hispanic children. However, it is important to note that these data include *all* children who were offered DR services. Looking only at the 80 families who actually engaged in services, the two children who were subsequently removed were both Hispanic.

Table 3

Ethnicity	Removal within 1 year		Total
	No	Yes	
Caucasian	19	3 (14%)	22
Black	46	6 (12%)	52
Hispanic	56	3 (5%)	59
Asian/Pacific Islander	10	0	10
TOTAL	131	12 (8%)	143

This is something that can be explored further and with greater confidence with a randomized controlled study that is currently being conducted, comparing clients and families who receive DR services to a control group that does not receive them.

SUMMARY

Contra Costa County measured the effectiveness of its Differential Response (DR) program by examining child removal rates and child re-referral rates within one year following the initial referral. Of the 33% of the total sample who responded, the Hispanic respondents were 66% more likely to participate in DR services than any other

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ethnicity. The type of initial allegation that was reported affected the chances of DR participation with an allegation of Caretaker Absence/Incapacity being most likely to engage in services and an allegation of substantial risk being the least likely to engage in services. Additionally families who had a history of child welfare referral or a case opened prior to the DR referral were even less likely to engage in services than those who did not have a prior referral or open case.

Participation in DR did not impact re-referral rates. The findings in Contra Costa were consistent with existing research literature suggesting that minority populations and families with prior referrals have higher re-referral rates (3 times higher). Families who refused DR services were move likely to have their children removed than any other families. The data suggests that Caucasian and Black children are more likely to be removed than Hispanic children.

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MODULE IX

OUTCOMES FROM ALAMEDA COUNTY

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MODULE IX
OUTCOMES FROM ALAMEDA COUNTY

INSTRUCTIONAL GUIDE

Purpose

- To present an overview of outcomes from Alameda County's ARS program, tracking the following: time to re-report, investigated re-report, and substantiated re-report of child maltreatment following the 9-month alternative response intervention. Analyses examined whether treatment affected investigation or substantiation and whether treatment yields different effects depending on clients' prior report history.

Learning Objectives

By the end of this chapter, students should be able to:

1. Describe how the treatment and comparison groups for this study were constructed and understand the significance of the hazard ratio,

2. Identify the potentially confounding variable in this analysis and describe its implications,

3. Critically assess the outcomes from Alameda County's ARS program, and

4. Consider the practice and policy implications of the ARS program's results.

This chapter can be used to foster the following curriculum competencies:

7.8 Student understands the purpose of outcome measurement and is able to seek client, organization, and community feedback for purposes of monitoring practice, service refinement, and outcome evaluation.

8.10 Student understands how to use information, technology, and evidence-based research to evaluate and improve policy, practice, and program effectiveness.

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QUESTIONS FOR DISCUSSION

1. Based on the outcomes data outlined in this chapter, would you characterize the ARS intervention as a success? Why or why not?

2. As you assess the data presented in this chapter, consider the overall family and systems-level goals described in Chapter IV. How would you define success of the ARS program?

3. The Alameda County Social Services Agency has invited you to present your analysis and your recommendations based on the findings from the evaluation of the ARS program. What are the key messages you want to offer to the SSA?

4. It is suggested that surveillance bias may influence outcomes for some families in the treatment group. How do you think this bias might occur?

OUTCOMES FOR ALAMEDA COUNTY

While the ARS program has many proximal goals—increased connections with community resources, provision of temporary social support, elimination of unmet basic needs, and improvement of parent-child relationships—the overarching individual and systems-level goal is to reduce the likelihood that families will enter the child welfare system. The outcomes portion of this study examined time to re-report, investigated re-report, and substantiated re-report of child maltreatment following the 9-month ARS intervention for families who participated in the ARS-South Hayward program, in contrast to a comparison group. The hazard ratio is reported with its significance level for each outcome type. This number represents the odds that a family, given treatment, will experience the event. It compares the hazard rates of the treatment and comparison groups. A hazard ratio of greater than 1 indicates an increased likelihood of the

outcome among the treatment group, while a hazard ratio less than 1 indicates a reduced risk.

The hypothesized effects of ARS treatment on subsequent child welfare system involvement are somewhat complex due to the potential bias that may arise from increased surveillance of families referred to the program. ARS clients may be more likely to be re-reported or investigated than members of the comparison group because they are known to the system and have regular contacts with the community providers to whom they have been referred by the ARS program. This potential source of bias must be kept in mind when interpreting results.

The sample for the outcomes portion of the study is composed of 161 clients who were referred to and engaged in services with ARS-South Hayward from May 1, 2002 to November 15, 2007. Only one sibling (from each sibling group) age 5 or younger was kept in the treatment group to preserve the statistical assumption of independence, making this a family-level, not child-level, analysis. The comparison group is composed of 511 cases initially reported to the Alameda County Child Abuse hotline and evaluated-out of investigation between May 1, 2002 and November 15, 2007. These cases met eligibility criteria for the ARS program (child ages 0-5 and residence in South Hayward) but were not referred due to program capacity. Like the treatment group, only one sibling was kept in the analysis.

Before we turn to the outcome study, we briefly summarize rates of engagement for clients offered ARS services. Examining data from 2002-2007 we find that the proportion of families who engaged in services differed among the three community-

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based agencies. In East Oakland, 35% of clients engaged in services (337 families were referred for services), in South Hayward, 33% of clients engaged in services (611 families were referred for services), and in West Oakland, only 12% of families engaged in services (this agency received 84 referrals over a period of only 2 years: 2005-2007). Unlike Contra Costa, data were not available in Alameda County to determine the characteristics of families more or less likely to engage in services.

Descriptive Statistics

There were some significant differences in demographics between the treatment and comparison groups. Gender distribution is nearly equivalent: 50% of the treatment sample and 55% of the comparison group was male. The most significant difference with regard to ethnicity between the samples was that ethnicity was more frequently reported as unknown for the treatment group (27%) than the comparison group (6%). In cases where primary ethnicity was known, there were significant differences: 28% of the treatment group and 39% of the comparison group was Hispanic; 12% of the treatment group and 22% of the comparison group was African American; 18% of the treatment group and 24% of the comparison group was Caucasian; and 16% of the treatment group and 10% of the comparison group was Other. The treatment group had a higher proportion of younger children: 44% of the treatment group and 35% of the comparison group were infants ages 1-2; 45% of the treatment group and 27% of the comparison group were preschoolers ages 3-4; and 10% of the treatment group and 38% of the comparison group were kindergarteners age 5-6.

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A significant difference between the treatment and comparison group is contact with the child welfare system prior to ARS referral for the treatment group, or index report for the comparison group. Ninety percent of the treatment group had one or more prior child maltreatment reports (with 31% of these having two or more prior reports), contrasted to 66% of the comparison group (of whom 13% had two or more reports). These numbers seem too dramatically different for mere coincidence, suggesting that hotline screeners may have more frequently referred clients with a history of prior reports to ARS. This would hardly be surprising, given that prior re-report is a well-established risk factor for future re-reports (Baird, 1988; Baird, Wagner, & Neuenfeldt, 1993; Marshall & English, 1999; Schuerman et al., 1994). Because re-report is associated with referral to the ARS program as well as the outcomes of re-report, investigated re-report, and substantiated re-report, it is likely to be a confounder in the analysis.

Risk scores from the Structured Decision Making tool (SDM) were available for ARS clients, though not for the comparison group; risk scores therefore were not included in the statistical models. ARS home visitors, together with their clinical supervisor, complete the SDM during an initial meeting with families. For the 160 clients included in the treatment sample, 29 were missing risk scores. Of those with risk scores, 2% were identified as low risk, 49% as moderate risk, 40% as high risk, and 9% as very high risk.

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Outcomes

The treatment and comparison groups were fairly similar in the experiences of subsequent re-report, investigated re-report, and substantiated re-report, with a few notable exceptions (see Figures 5 and 6).

Figure 5

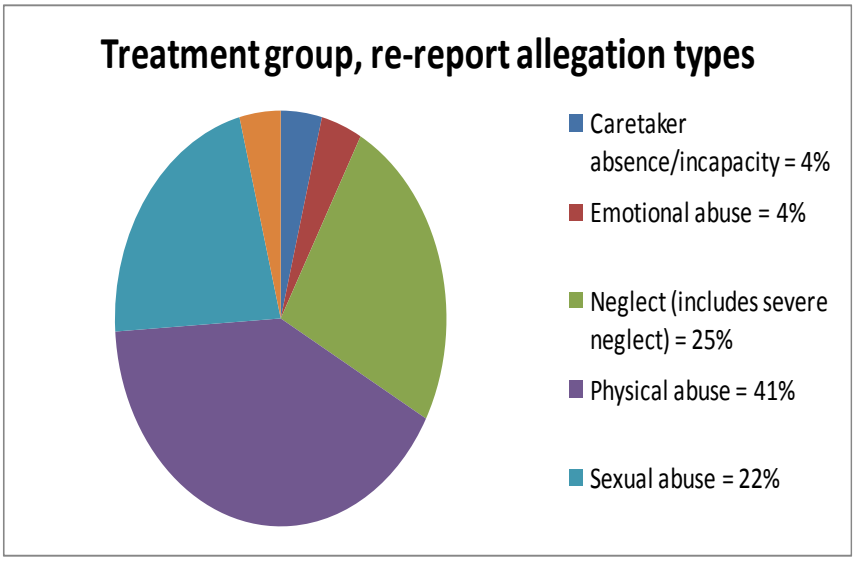
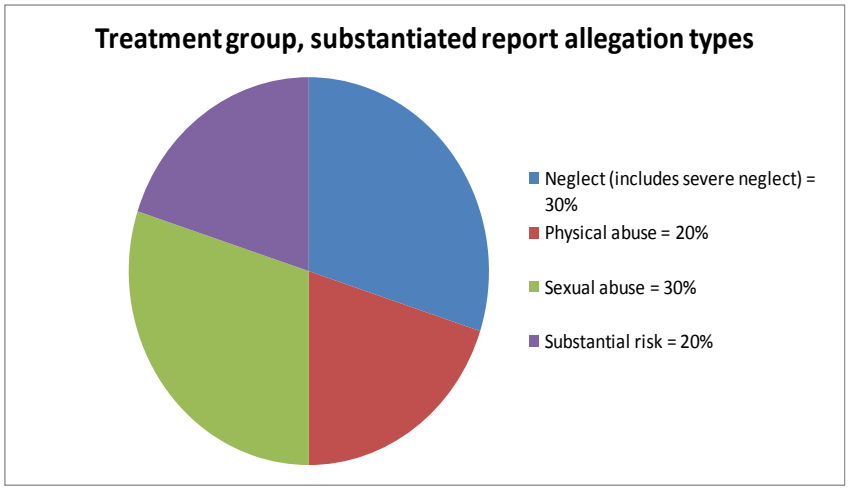


Figure 6



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In both cases, about 30% of the sample experienced a re-report (n = 51 for the treatment group and n = 163 for the comparison group). Re-report tended to occur faster among the treatment group: the ratio of the average time to re-report for the treatment and comparison groups is 281:485 days following the 9-month timeframe for treatment. Neglect and physical abuse were the most common re-report allegation types for both groups: neglect constituted 25% of reports for the treatment group and 37% for the comparison group, and physical abuse constituted 41% of reports for the treatment group and 31% for the comparison group.

Re-report

Two nonparametric approaches, which made no assumptions regarding time to event distribution, were first used to examine the data for re-report as an outcome. First, a log-rank test was conducted to see if there was evidence that one of the groups was failing faster. The null hypothesis is that the survivor functions of the two groups are the same. There was no evidence to reject the null. A Kaplan-Meier survivor function was also plotted.

The treatment group appeared to fail faster than the comparison group. In the first wave of parametric analysis, a Cox regression was fitted with treatment and other covariates. The initial model, with treatment alone, yielded a hazard ratio of 1.14 (confidence intervals 0.84, 1.57) and p-value = 0.39. There is only a very slight trend of increased risk for the treatment group, and the confidence interval is fairly evenly distributed around 1, suggesting no effect of treatment on re-report. Binary variables representing the demographic information were added independently with treatment to

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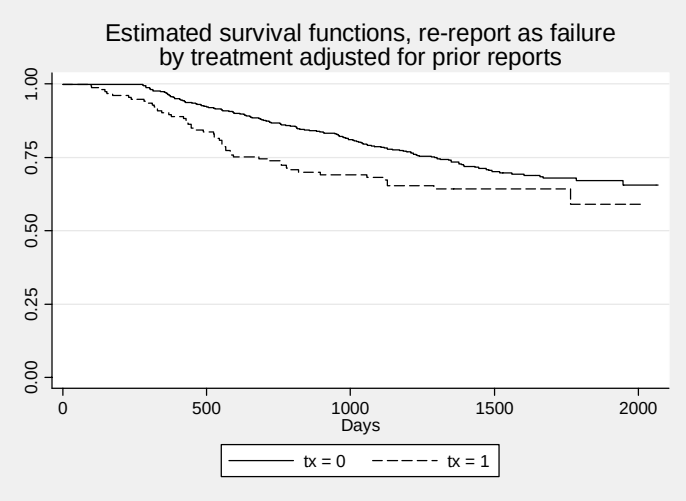
fit several models: Male gender, Hispanic, African American, Caucasian, Ethnicity-other, Infant, Toddler, and Preschooler. Sample sizes for reports with pregnant/newborn children and elementary school-age children were too small to allow for inclusion. The only significant covariate was prior reports, with a hazard ratio of 1.77 (1.31, 2.4) and p-value <0.001. When adjusting for prior reports, the hazard ratio for treatment dropped to 0.77 (0.53, 1.11) with p-value = 0.16. Plot is based on Cox model, with prior reports set to average value (see Figure 7).

Figure 7



The proportion of children with prior reports is significantly higher in the treatment group than in the comparison group, and number of prior reports may affect both assignment to treatment and the outcome of re-report. A variable representing the interaction between treatment and prior reports was created and added to the regression keeping both main effects. This model suggest possible interaction (p = 0.103); treatment effects differ depending on whether clients have prior reports. The

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effect of treatment on re-report among those with one or more prior reports is HR = .898 (0.378, 2.13), p-value = 0.807; for those with no prior reports the effect of treatment is HR = 6.058 (0.721, 50.861), p=value = 0.097. There is a trend toward an association between treatment and reduced likelihood of re-report for those with prior reports, and treatment and higher likelihood of re-report for those without prior reports. Because there is little information on clients without prior reports (n = 16), the estimate of treatment effects for those with no prior reports shows poor precision, with a very wide confidence interval that spans 1.

Investigated and Substantiated Re-report

The next series of analyses examined whether treatment affected investigation or substantiation. As was mentioned previously, it is conceivable that the treatment would not reduce re-report due to surveillance bias but would improve family functioning and the severity of a child maltreatment incident and thus likelihood of investigation. For the entire sample, 135 families experienced an investigation; of these, 100 were in the comparison group and 35 were in the treatment group.

Fitting parametric models to the data with investigation or substantiation as outcome yielded a similar pattern as re-report (see Figures 8 and 9). There were no statistically significant differences between families receiving ARS services and families receiving typical child welfare services.

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Figure 8

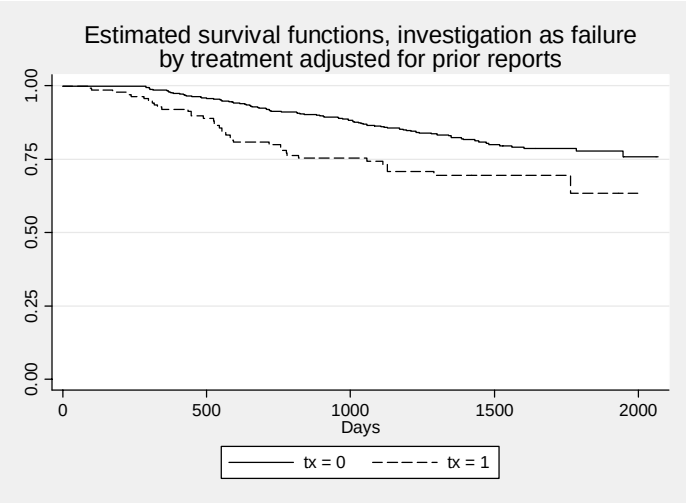
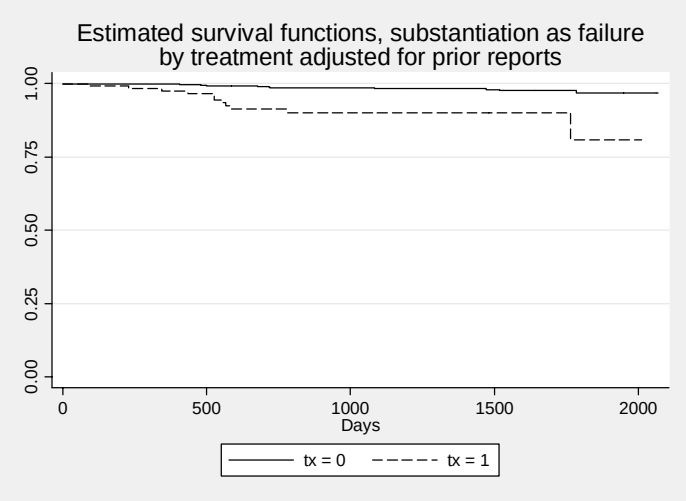


Figure 9



SUMMARY

The ARS program in Alameda County does not appear to make a substantial impact on recidivism to the child welfare system via a repeat child maltreatment referral. Nevertheless, findings from this study suggest that the program offers important benefits to families. Many families attest to the importance of social support, connection

to community resources, assistance with meeting basic needs, and renewed capacities for attending to their children's needs. While these family support endeavors may not be sufficiently robust to maintain family health and prevent maltreatment, they are likely essential to families during a time of significant stress and substantial need.

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MODULE X

IMPLICATIONS FOR POLICY AND PRACTICE

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MODULE X
IMPLICATIONS FOR POLICY AND PRACTICE

INSTRUCTIONAL GUIDE

Purpose

- To present an analysis of outcomes from the studies conducted in Alameda and Contra Costa County's Alternative and Differential Response programs and to consider future directions for AR/DR intervention models.

Learning Objectives

By the end of this chapter, students should be able to:

1. Appreciate the complexity of efforts to prevent child maltreatment,

2. Identify benefits and limitations of the AR/DR interventions, as practiced in Alameda and Contra Costa Counties, and

3. Understand effective methods for evaluating AR/DR programs and identify potential confounding factors that should be taken into consideration.

This chapter can be used to foster the following curriculum competencies:

3.17 Student understands the value base of the profession and its ethical standards and principles, and practices accordingly.

3.19 Student understands state and federal policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.

7.1 Student is able to identify the strengths and limitations of an organization, including its cultural competence and commitment to human diversity, and can assess the effects of these factors on service for children and families.

8.1 Student understands how professional values, ethics, and standards influence decision-making and planning in public child welfare practice.

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8.5 Student understands how leaders/managers use the collaborative process for the purpose of planning, formulating policy, and implementing services.

8.10 Student understands how to use information, technology, and evidence-based research to evaluate and improve policy, practice, and program effectiveness.

QUESTIONS FOR DISCUSSION

1. It is suggested that the planning stages of DR/AR carefully consider the neighborhood context. Imagine that you have just been assigned to conduct an initial neighborhood assessment. Identify the steps you would take and the information you would hope to gather in this process.

2. Currently, evaluations of AR/DR programs have focused on the degree to which they have reduced occurrences of child maltreatment. However, the intervention has other proximal aims as well, such as improved family functioning, etc. You and a team of child welfare professionals have just been assigned to devise a new method for measuring effects of AR/DR interventions. First, identify what you believe the fundamental objective of AR/DR ought to be. Next, identify all the effects you hope to measure and then develop a system for conducting this evaluation. What are some challenges you might encounter in executing your new evaluation?

IMPLICATIONS FOR SOCIAL WELFARE POLICY

Differential/Alternative response systems have grown out of the belief that, with intensive family support and services provided by community-based organizations, children who come to the attention of the child welfare system (CWS) but do not otherwise meet the criteria for CWS involvement can remain safely with their families. At this point, there appears to be neither strong empirical evidence nor robust theoretical support connecting AR/DR interventions to the ultimate goal of child maltreatment prevention.

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Unfortunately, weak or neutral findings for programs seeking to prevent the occurrence or reoccurrence of child maltreatment are the rule rather than the exception. In Geeraert, Van den Noortgate, Grietens, & Onghena's (2004) meta-analysis of 19 child maltreatment prevention studies, and in MacLeod and Nelson's (2000) meta-analysis of over 50, positive results were found, but the overall effect size on reducing maltreatment averaged only about 0.20 in both reviews—an effect size considered small by conventional standards (Cohen, 1988). A majority of studies conducted on differential response have found that re-report rates are similar 6 months after treatment for families who receive DR compared to those who receive traditional services or no services (Center for Child and Family Policy, 2004; English et al., 2000; U.S. Department of Health and Human Services, 2005). Findings from Alameda and Contra Costa counties were consistent with this. It is worth considering the possible surveillance bias that exists when families receive home-based services. That is, to what extent are families more likely to be referred to CWS because they are having more regular contact with mandated reporters than families who may maltreat their children but are not receiving services? This issue could be further explored by determining whether re-referrals of these families are by AR/DR staff and, if so, correct for this in statistical modeling of outcomes.

A preliminary look at data from Contra Costa County suggests that there were no differences in outcomes between children referred for DR and served, compared to those eligible for DR but not served due to program capacity. Similarly, children served by DR were equally likely to be removed from their families within 1 year (approximately

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3%) compared to children who were not served due to program capacity (approximately 4%). The only families at greater risk of removal (approximately 12%) were those who were offered DR services, but who did not elect to become involved in the program. Because of the small sample size and lack of a randomized control group, we cannot draw firm conclusions regarding these outcomes. The randomized study currently underway in Contra Costa County should provide more reliable information in the future.

Examination of Alameda County data suggests outcomes for the treatment and comparison groups were fairly similar in their experiences of subsequent re-report, investigated re-report, and substantiated re-report, with a few notable exceptions. In both cases, about 30% of the sample experienced a re-report for maltreatment. Re-reports were substantially more likely to be investigated for the treatment group than for the comparison group, yet substantiation rates were roughly similar between groups.

The findings from both counties, while generally similar, fall in line with findings from other studies of Differential Response. Previous studies reported mixed results, with some states reporting positive effects of the program on subsequent re-reports of maltreatment (Minnesota), and other states reporting no effects. These findings, on balance, appear to run counter to the great promise of Differential Response to reduce families' future contact with the child welfare system.

The field of child welfare continues to struggle to find effective interventions that can prevent maltreatment for vulnerable families. Differential Response is just one of many programs that have been launched to impact this significant social problem; none have been proven to have strong effects for these challenging families. Lack of impact

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on child maltreatment may in part be due to the limited ability of the child welfare system to impact the larger contexts in which families live, such as poverty, the lure of drugs and alcohol, or the strains brought about by mental illness and intimate partner violence. Prevention of child maltreatment may require multi-modal, intensive, long-term services that have not yet been evaluated.

The conclusion that AR/DR services have little impact on maltreatment, however, should not herald the closure of this program. ARS in Alameda County, for example, is intended to impact parents' social support, their access to community resources, and their positive relationships with their children—in addition to maltreatment prevention. While these proximal outcomes were not included in this study, they are important programmatic goals from which families could derive significant benefits. These alternative outcomes might not be sufficient to prevent maltreatment, but they fall comfortably under the broader rubric of family support.

The research literature on the effects of family support programs generally suggests modest benefits to families related to parenting attitudes, knowledge, and behavior as well as family functioning (Powell, 1994). Based on comments from clients served by the ARS program and DR, it can be surmised that something beneficial is happening for families. Clients' perceived level of support and assistance received from ARS/DR workers, as well as their perceived increased connection to their communities, should not be minimized. Ultimately, ARS/DR administrators will have to decide if these types of outcomes justify investment in the program. Indeed, this is also a question for the broader field of child welfare. Differential response, with its emphasis on voluntary,

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strengths-based, community support for families suggests a family support approach (Tilbury, 2005). To justify public expenditure, particularly the diversion of funds from other child welfare activities, child welfare administrators must clarify the purpose of differential response. If it is family support, then the field will have to be content with the goal of strengthening families who may have never entered the system. If the goal is child maltreatment prevention and fewer families entering the formal child welfare system, then services will need to be targeted and program models scrutinized to determine whether there is a clear causal chain between services delivered and outcomes expected. The enthusiasm for this approach could easily turn into cynicism if promises are not borne out by research findings, as was the case for an earlier child welfare "silver bullet"—family preservation services.

Importantly, other models of Differential Response suggest a change in practice designed to improve the experience of families' contact with the child welfare system and—at the least—ensure that children's safety is not compromised (Ortiz, Shusterman, & Fluke, 2008). These programs, targeted to families whose case has already been opened by the public child welfare agency, are designed to offer services to families with an approach that is non-punitive, non-authoritarian, and strengths-based. The purpose is largely to ensure that families gain access to the services they need to effectively parent their children—not, necessarily, to prevent future contact with the child welfare system.

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The only other study which has attempted to examine family impacts beyond child safety examined the Differential Response program in San Mateo County, California. In that study, families who had been investigated by a public child welfare worker and whose case was closed were offered DR services by a staff member from a community-based agency. Families were assessed using the North Carolina Family Assessment Scale for General Services (NCFAS-G) pre- and post-services. Families participating in this study showed minor to modest improvements in most domains, including parental capabilities, family interaction, family safety, and child well-being (Kirk, 2008). While this study is extremely limited as a comparison group was not included, the findings suggest the need for future research to better understand the range of impacts Differential Response can have for children and families beyond maltreatment prevention.

AR/DR is part of a host of initiatives intended to reform the child welfare system by involving communities in child protection. Descriptions of AR/DR emphasize community partnerships and reliance on community-based services, yet more work is needed to ensure that program planning and policy reflect an understanding of the neighborhood context. Policy makers and program administrators might consider a number of steps toward this end. Prior to implementing DR, community assessment may be useful for identifying services availability, service gaps, and accessibility challenges. Using GIS to map services can help supply this information. To have a truly sustainable impact on families' lives, child welfare agencies might consider taking a leadership role to improve local service arrays, thereby improving availability and quality

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of services, and—potentially—client outcomes. For instance, prior to implementing DR, Contra Costa County CFS made some efforts to utilize mapping to identify needs and gaps in community services. Alameda County staff, in collaboration with Every Child Counts, engaged in a similar community assessment. Additionally, every 3 years, Contra Costa CFS conducts a survey, developed in collaboration with community partners, to identify ongoing needs and gaps in community services. Based on the needs identified through this survey, CFS awards mini-grants to help community agencies address these gaps.

Comprehensive assessment of clients' experiences with DR would naturally include assessment of their experiences with referrals—whether they followed up on referrals, barriers they may have experienced, and their experiences and satisfaction with services from referrals. Without this information, there is an incomplete picture of the effects of DR programs. Recognizing this need, Contra Costa County CFS has been collecting information about barriers to service accessibility, and they are currently developing a database that will enable them to analyze these and other relevant data and better utilize the information for program improvement.

FUTURE RESEARCH

From this research, certain broader questions have emerged about the differential response approach. First and foremost, more research is needed to help determine the types of program models that might be effective in reaching the goal of preventing low-to-moderate risk families from entering the child welfare system. The studies reported here were unable to answer these questions in part because we did

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not have comparable data on risk for the comparison group in Alameda County, and in part because almost half of the families served by ARS in the Alameda County sample were identified as high or very high risk. Different jurisdictions have taken a number of approaches, and it is time to identify and study successful models. A rigorous evaluation of Contra Costa County's Path 2 would help to inform policy decisions about the benefits and challenges of a three-track system compared to a two-track system like ARS. Also, more research is needed to explore the benefits and limitations of different configurations and uses of community-based providers (e.g., contracting with multiple agencies in each district [Contra Costa model] or one in each district [Alameda model]).

Second, further research is needed to understand the strategies that are successful for engaging clients in DR services. Importantly, data on Contra Costa County suggested that the families impacted least by the program were those who were offered services, but who declined. Client engagement is a challenge because the point of entry for DR is a child abuse report, and many families do not accept services out of suspicion of child protective services. Yet the more we know about how to gain access into the homes of vulnerable families, the greater the likelihood that programs such as DR can be tested for their effects.

Third, more research is needed to identify the outcomes of DR in domains other than maltreatment prevention. As noted above, re-report of child maltreatment is a limited measure and undue emphasis on this single variable runs the risk of characterizing the program as a total failure, when other as-yet unmeasured variables might yield positive findings. Beyond simply reducing maltreatment, DR seeks to build

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protective factors; these would be important to measure. Because administrative child welfare data are limited, new methodological designs and methods of data collection must be devised.

An evidentiary base on the intensity, duration, targeting, staffing, and content of differential responses services is needed to inform policy and practice. Much of the current literature in this area is descriptive, not empirical. The Administration for Children, Youth, and Families (Children's Bureau) has recently funded a *National Quality Improvement Center on Differential Response in Child Protective Services*. The purpose of this center will be to generate knowledge on differential response practice models and to support infrastructure development at state and local levels for implementation of services. This move toward building the knowledge base around DR is exactly what is needed, as the field of child welfare begins to separate the hopes from the realities in terms of what can be achieved through preventative, voluntary, strengths-based community services to families screened out of traditional child welfare services.

SUMMARY

Unfortunately, there is no extant evidence that AR/DR interventions prevent maltreatment. In Contra Costa County (CCC), researchers found no difference in child welfare outcomes between those families served by DR and those who were eligible for, but not offered DR services. Similarly, in Alameda County, the ARS treatment group and a control group had similar re-report outcomes. Although the treatment group's re-report cases were more often investigated, re-reports in both groups had similar rates of

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substantiation. These results are similar to the findings of AR/DR program evaluations in other states.

Although there is no evidence that AR/DR reduces child maltreatment, further research may indicate the positive impact of AR/DR on other related outcomes, such as access to community resources, parent-child relationships, and social support.

The development of effective interventions to prevent child maltreatment depends on further assessment and research. For example, AR/DR programs should utilize community assessments to identify communities' unique needs and existing gaps in available services. In addition, more research may help identify program models that prevent entry into the child welfare system, successfully engage families, and produce other positive child and family outcomes. This much-needed research may be used to inform both policy and practice.

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APPENDIXES

Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., Geer, A., et al. (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum.* Berkeley: University of California at Berkeley, California Social Work Education Center.

METHODS FOR ALAMEDA STUDY

A mixed-methods design was used for this study, including qualitative and descriptive data to answer Questions #1 & #2, and for quantitative data in response to Question #3.

> *Question #1:* What are the experiences of ARS staff with service delivery, and clients with the services they receive, focusing on the main interventions of attention to basic needs, promotion of attachment in the parent-child relationship, social support, and connection to institutional resources?
>
> *Question #2:* How does the availability of institutional resources in neighborhoods influence ARS implementation?
>
> *Question #3:* Is ARS successful in preventing future child welfare system involvement?

STUDY SITE AND POPULATION

As described in Module II, the Another Road to Safety program is implemented in three diverse, low-income neighborhoods in Alameda County, California. The program is operated by a different agency in each neighborhood: La Familia Counseling Services in South Hayward; Family Support Services of the Bay Area in East Oakland; and Prescott Joseph Center for Community Enhancement in West Oakland. Two agencies are involved with program administration, training, and data management: Social Services Agency of Alameda County and First 5 of Alameda County.

The study population for Question #1 (on the experiences of staff and clients with interventions provided by the ARS program) includes all current administrators, line staff, and clients. Administrators were invited to participate either by phone or during a monthly oversight meeting that involves administrators from the Social Services Agency

Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., Geer, A., et al. (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum.* Berkeley: University of California at Berkeley, California Social Work Education Center.

and First 5. Staff from the three community-based organizations were informed of the study by their supervisors and invited to participate in two voluntary focus group sessions. Staff invited clients to participate in the study during a routine home visit. To prevent memory bias, current administrators, staff, and clients were selected for participation, rather than staff involved in the past or clients who have completed services.

Question #2, on the influence of institutional resources on program implementation, is addressed through Geographic Information Systems (GIS) data collection and analysis. This portion of the study involves using GIS to compare service need (operationalized as child maltreatment reporting rates) with service availability (operationalized as the location of services relevant to families). The population involved in the GIS portion is all reports of child maltreatment in Alameda County, aggregated by geographic location to the census tract or zip code. Data were available for 3 years by zip code (2003-2005) and for 2 years by census tract (2004-2005) from the California Child Welfare Archive. Housed at UC Berkeley's Center for Social Services Research, the Child Welfare Archive is the repository of data on child welfare services and clients for the state of California.

To answer Question #3, on the child welfare-related outcomes of ARS clients, data were collected on clients who were referred to and accepted services from the most established ARS program site (La Familia in South Hayward) from May 1, 2002 to November 15, 2007. The beginning of this timeframe corresponds to the program's initiation. The end of this timeframe allows for the passage of 9 months of ARS services,

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plus a 3-month window of time to assess subsequent child welfare involvement, for the clients with the latest enrollment dates. Analysis was restricted to ARS-South Hayward because the researcher and ARS administrators concurred that the program model was most established and mature, with the least staff turnover. Outcomes for a comparison group of clients who were eligible for treatment, but not referred due to program capacity, are contrasted to those of ARS clients. Data were drawn from the Child Welfare Services Case Management System by Alameda County Social Services Agency staff.

SAMPLING

Sampling for the qualitative study (Question #1) included all current administrators, staff, and clients involved with the ARS program (see Figure 4). The entire population of staff was included in data collection. Interviews were conducted with administrators at the three community-based organizations and the two oversight agencies (n = 16). Two focus groups were conducted with line staff at each of the three agencies, with six focus groups in total, involving 12 staff members.

A non-probability accidental sample (Hoyle, Harris, & Judd, 2002) was assembled for client interviews. All English- and Spanish-speaking clients enrolled from April 1, 2007 until April 1, 2008 were invited to participate by their home visitor. During a regularly scheduled home visit, staff described the research study to clients, using a script developed by the researcher for guidance. Staff distributed a brochure to clients, which clearly outlined the purpose of the study and the participants' rights, as well as two copies of a consent letter and a stamped, self-addressed envelope to return a

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signed copy of the letter to the researcher. Clients elected whether or not to participate in interviews. A total of 50 clients participated in telephone interviews.

Sampling for the GIS portion of the study (Question #2) involved all cases reported for child maltreatment in Alameda County over the 2003-2005 timeframe. The entire population that fell within this parameter was included. Data were aggregated by census tract and zip code for addresses reported.

The sample for the outcomes portion of the study (Question #3) is composed of 161 clients who were referred to and retained for services with ARS-South Hayward from May 1, 2002 to November 15, 2007 (see Figure 5). “Retained for services” means that families at least initially agreed to participation in services, though they may not have completed services. Only one sibling (from a sibling group) was kept in the treatment group to preserve the statistical assumption of independence, making this a family-level, not child-level, analysis. The entire population that met these criteria was kept for the treatment group. The comparison group is composed of 477 cases initially reported to the Alameda County Child Abuse hotline and evaluated-out of investigation between May 1, 2002 and November 15, 2007. These cases met eligibility criteria for the ARS program (child ages 0-5 and residence in South Hayward) but were not referred due to program capacity. Like the treatment group, only one sibling was kept in the analysis. This comparison group represents the population of cases that meet the ARS eligibility criteria but were not referred to the program, with the exclusion of siblings.

Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., Geer, A., et al. (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum.* Berkeley: University of California at Berkeley, California Social Work Education Center.

STUDY DESIGN

Research Question #1 was addressed using qualitative research methods. The experiences of administrators with program design and implementation were assessed through in-person interviews. Interviews were guided with a standardized script of mostly open-ended questions. Front-line staff was asked about their experiences of serving families and the influence of the neighborhood context during two 1.5 hour focus groups. A script was also used, with open-ended questions. Telephone interviews were conducted with clients to explore their experiences with ARS services and neighborhood organizations, as well as their experiences of raising children in their neighborhoods. Interviews lasted approximately 30 minutes, and were guided by a script with a mix of open and closed questions.

In Differential Response, the community context plays a significant role with regards to the availability of institutional resources to which families may be connected. Preliminary interviews with staff indicated that the three neighborhoods where the program is implemented (South Hayward, East Oakland, and West Oakland) differ significantly by demographics and social services availability. To supplement qualitative findings on institutional resources, Question #2 involves looking at neighborhood social services arrays using Geographic Information Systems (GIS) software for data management and analysis. Based on comments from line staff and clients about the most commonly needed services, and the Levanthal & Brooks-Gunn (2000) framework of institutional resources types, address data were collected on services relevant to children and families (see Table 3). Data on neighborhood resources were geocoded to

Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., Geer, A., et al. (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum.* Berkeley: University of California at Berkeley, California Social Work Education Center.

identify the geographic coordinates for each service location, using ArcGIS 9.0 software. A layer was built for *service availability* using these geographic coordinates and aggregating to the zip code and census tract levels. Service availability was categorized by quantiles as *low, medium*, and *high*, with equal numbers of zip codes/census tracts in each category. These categories were automatically calculated by ArcGIS 9.0 to ensure that each contained one third of the total services. A layer was also built for *service need* based on average rates of child maltreatment reports, by zip code and census tract, over several years. Service need was also categorized by quantiles as *low, medium*, and *high*, with equal numbers of zip codes/census tracts in each category. *Availability* of services was compared to *need* for services by examining spatial patterns and running correlations. Descriptive patterns of service availability and service need were analyzed for the county, particularly with reference to ARS target zip codes.

Research to address Question #3 on client outcomes utilized a quasi-experimental static-group comparison design (Hoyle et al., 2002). An experimental design was not possible, because this researcher could not control assignment of clients to the treatment. Comparison groups of referrals similar to ARS clients were instead selected. All clients who were referred to the ARS-South Hayward program and agreed to participate (as indicated by a signed consent form) constitute the treatment group; four comparison groups were chosen from the California Child Welfare Services Case Management System (CMS/CWS) and matched on month of child maltreatment report and one or both program referral criteria: child aged 0-5 or pregnant mother in

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home and residence in ARS target zip codes. While there are inherent limitations to a study in which treatment group assignment cannot be controlled, this design maximizes the comparability of groups by matching on referral month and program criteria. Comparison group #1 (consisting of families who met both program criteria but refused the intervention or were unable to be contacted) controls for child age and zip code of residence, as does comparison group #4, which consists of families eligible but not referred for ARS services. Comparison group #2, made-up of families with children ages 0-5 who reside in a non-ARS zip code, controls for age of the child. Comparison group #3, composed of families who reside in the ARS-South Hayward target zip codes with children ages 6-18, controls for zip code of residence. By selecting four comparison groups, the statistical power is increased because the *n* size is larger.

DATA COLLECTION, DATA MANAGEMENT, AND ANALYSIS

Question #1 was answered through face-to-face interviews with administrators, focus groups with line staff, and telephone interviews with clients. Interviews with administrators and clients were typed verbatim during interview sessions. Focus groups were either audiotaped and later transcribed, or transcribed during the focus group session. All interview and focus group records were entered into Atlas.*ti* for data management and analysis. Data analysis for staff interviews and focus groups and client interviews involved coding for emergent themes. Records were reviewed using inductive and deductive processes to identify major themes. Coding was conducted by the doctoral researcher and by a graduate student researcher, to increase reliability and

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validity. Regular debriefings were held to detect and prevent bias and negative case analysis, and to ensure the development of an audit trail (Padgett, 1998).

Question #2 builds on the examination of institutional resources through an analysis of spatial patterns of neighborhood resources and their relationship with child maltreatment report rates. Data on social services locations in Alameda County were procured from a number of sources. The data collected were the name of the agency, the service type, and the address (some sources also included additional information not utilized in the analysis). The most comprehensive source of data was Eden Information & Referral, a nonprofit agency that collects data on social services and makes this information available to the general public. Child care data were accessed through the three Alameda County child care resource and referral agencies. Data on health and mental health agencies contracted by the county were provided by Alameda County Behavioral Health and the Health Care Services Agencies of Alameda County. The final source of data was the internet, for data on resources such as churches and Alcoholics Anonymous and Narcotics Anonymous meeting sites that were not otherwise available. Zip-code level and census tract child abuse and neglect referral rates were provided by the California Children's Services Archive, a child welfare data repository housed at UC Berkeley.

Once the geographic data were acquired, they were cleaned and prepared for analysis. ArcMap 9.0 was used for geocoding, to convert street addresses into geographic coordinates, using the ESRI Streetmaps USA as the reference file. For unmatched addresses, Google Maps was used to check the address in order to

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determine if part of the data, such as the zip code, was incorrect and preventing a coordinate match. An overall match rate of 99% was achieved, using these methods. Once ready, the geocoded service locations data were joined to a zip code and a census tract file for Alameda County, using the option “falls completely within polygon.” After joining the data, frequencies were run of the social services data for each zip code and census tract. With the realization that administrative boundaries such as zip codes and census tracts are artificial barriers, a 1 mile buffer was constructed around each zip and tract polygons and all services within the buffer area were calculated. Using the frequencies with the buffer and the area of each census tract or zip code and its buffer, a new variable of service density was calculated.

Maps for the county were developed by census tract and zip code for service availability, categorizing the service density variable as *low*, *medium*, or *high*. The same was done for maps depicting service need, categorizing the variable of average annual child maltreatment reports as *low*, *medium*, or *high*. These maps were visually analyzed for trends related to service availability and service need. Data were extracted from the GIS file format and entered into SPSS. Correlations were run for the relationship between service availability and service need, again by zip code and census tract.

In response to Question #3, data were drawn from administrative records in CMS/CWS in the Alameda County Social Services Agency. The referral identifier numbers for all families who agree to receive ARS services from ARS-South Hayward were checked for records of contacts with the child welfare system (in the form of a re-

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report) post-completion of ARS. The same was done for comparison group families who were referred to the program in the same timeframe.

Survival analysis was used to compare the re-report rates and substantiation rates for clients who agreed to services with ARS-South Hayward and completed services in different timeframes. For longitudinal event data, survival analysis is superior to ordinary multiple regression in its capacity to account for censored data (for those cases in which the event of interest did not occur in the observed timeframe) and time varying explanatory variables (Allison, 1984). Failure events were counted beginning 9 months after referral to ARS (for the treatment group) or 9 months after initial evaluate-out report (for the comparison group). Measuring the outcome post-service rather than post-referral minimizes the *surveillance bias* (Socolar, Runyan, & Amaya-Jackson, 1995), since ARS home visitors are in their clients' homes weekly and must report any incidents of child maltreatment as mandated reporters. The lasting effects of service completion are also evaluated by the choice of this timeframe.

MEASURES AND INSTRUMENTATION

The dependent variables for Question #1 are the main ARS interventions of attention to basic needs, promotion of attachment in the parent-child relationship, social support, and connection to institutional resources. These variables were operationalized based on the theoretical framework outlined in Module III, which was used to develop codes for thematic analysis.

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Comments were coded for basic needs when the concept of concrete need for materials such as food, shelter, clothing, etc. was mentioned. Codes for basic needs included:

- Basic needs types
- Referral for basic needs
- Use of basic needs fund

Interventions focused on strengthening the parent-child relationship or creating opportunities for parents to delight in their children were coded as promotion of attachment in the parent-child relationship. These codes were:

- Information on child development
- Modeling of appropriate parenting behaviors
- Activities for parents and children

Social support was considered to be perceptions or acts of social support provided by staff to clients. The following codes were developed for social support:

- Perceived social support
- Supportive characteristics of staff
- Enacted social support: Emotional
- Enacted social support: Instrumental
- Enacted social support: Informational

Connection to institutional resources was operationalized as referral to social services and assistance in following up on service enrollment. Codes as follows were used for connection to institutional resources:

- Institutional resource type: Learning, social, and recreational activities
- Institutional resource type: Childcare

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- Institutional resource type: Schools
- Institutional resource type: Medical facilities
- Institutional resource type: Employment opportunities
- Availability of institutional resources
- Accessibility of institutional resources
- Quality of institutional resources
- Affordability of institutional resources
- Competition for institutional resources

These variables were measured through focus groups with line staff and interviews with clients. To guide the focus groups and interviews, scripts were developed that included questions on basic needs, parent-child relationships, social support, and institutional resources. Both tools were developed with reference to the ARS manual and in consultation with ARS staff, thereby increasing construct validity by drawing on the same information in both cases.

The dependent variable for Question #2 is child maltreatment report (for aggregated populations by zip code and census tract), with service availability as the independent variable. The independent variable is operationalized as those services most frequently used by ARS families, according to focus groups with staff, and those resources hypothesized to improve child and family outcomes, according to institutional resources theory (Leventhal & Brooks-Gunn, 2000).

The dependent variable for Question #3 is involvement with the child welfare system for families who accepted ARS services, compared to similar families. The variable is operationalized as a re-report after 9 months of ARS referral (or initial

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evaluated-out report for the comparison group), investigated re-report, and substantiated re-report. The independent variable is acceptance of ARS services by both agency and family. Other factors, such as child's ethnicity, gender, and number of prior reports, were examined as potential confounders of treatment effects.

HUMAN SUBJECTS

Approval for this study was secured from Berkeley's Committee for the Protection of Human Subjects. Permission for the qualitative portion of the study was provided on July 21, 2006 (CPHS Protocol #2006-5-21). Renewal for the qualitative study and permission for the outcomes study was provided on August 8, 2007 for data collection and analysis through August of 2008 (with the same protocol number). Measures were taken to protect human subjects through the data collection, data management, and analysis phases of the study. For the qualitative study, client participation in interviews was voluntary. Clients were invited to participate in interviews by their home visitor. Home visitors also distributed literature on the research project, in the form of a brochure describing the study, the participants' rights and including a letter of consent. Clients were told verbally and in writing that refusal to participate would not affect service delivery and that their comments would be kept as confidential as legally possible. Prior to interviewing ARS staff, administrators, and collaborators, the researcher verbally informed them as to the voluntary and confidential nature of their comments. Quotes from ARS clients or staff that appear in this dissertation or related publications are not attributed. Consent forms from clients and staff were kept in a locked file cabinet at the Center for Child and Youth Policy. No human subject issues

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were raised for the map development, as all sensitive child welfare data were in aggregate and non-identified forms. For the outcomes study, client identifier numbers and records of child welfare histories were kept on an external hard-drive on a non-networked computer and stored in a locked filing cabinet when not in use, as were hard copies of client information.

Table 4: Data on Service Types (Total Services = 7,952)

Alcohol and drug treatment	Hospitals
Alcoholics Anonymous & Narcotics Anonymous meeting sites	Immigrant social services
Basic needs social services	Legal social services
Childcare	Libraries
Churches	Medical facilities
Dental programs (publicly funded)	Mental health (agencies and school-based programs)
Employment social services	Youth development social services
Health (agencies and school-based programs)	

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Figure 10: Sampling, Data Collection & Analysis for Qualitative Study

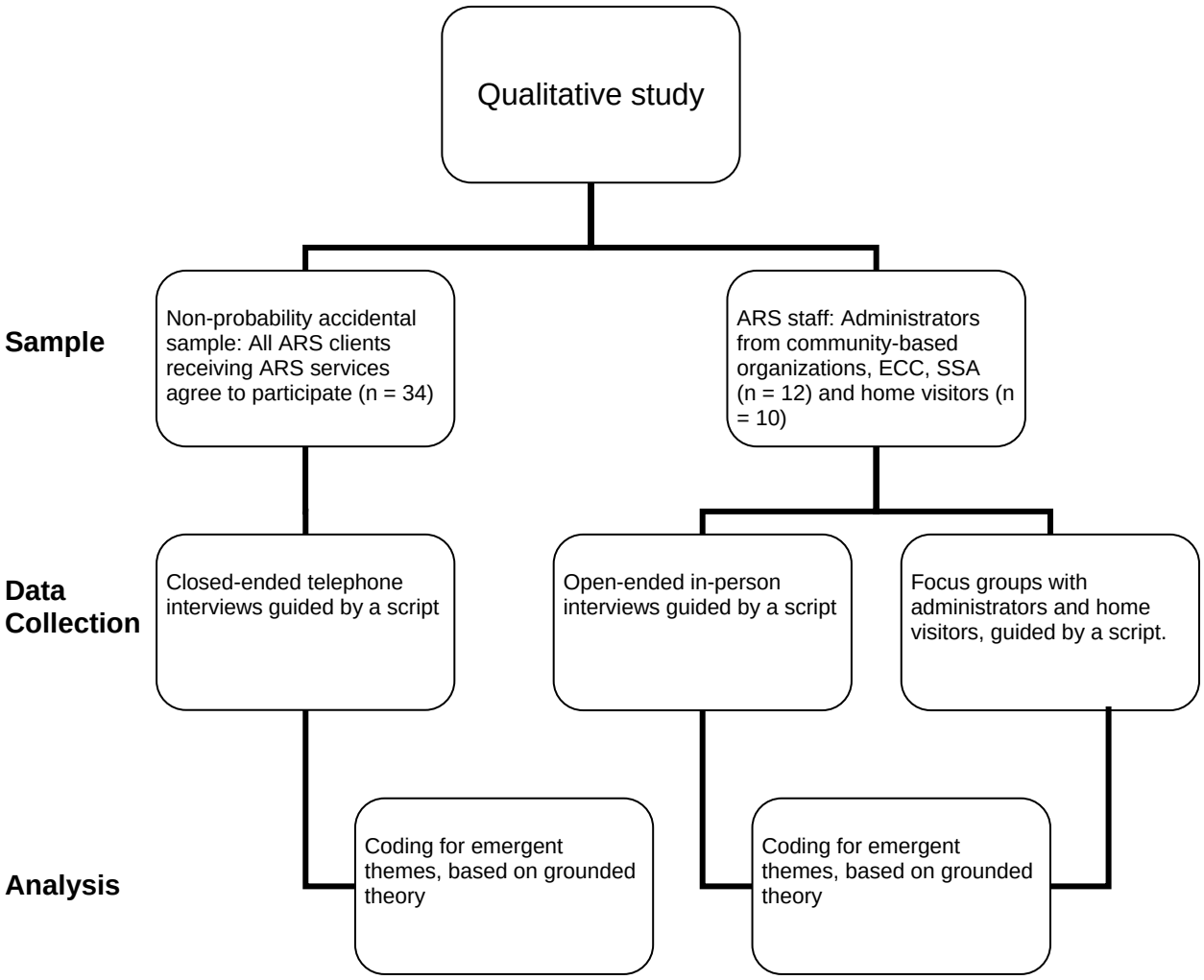

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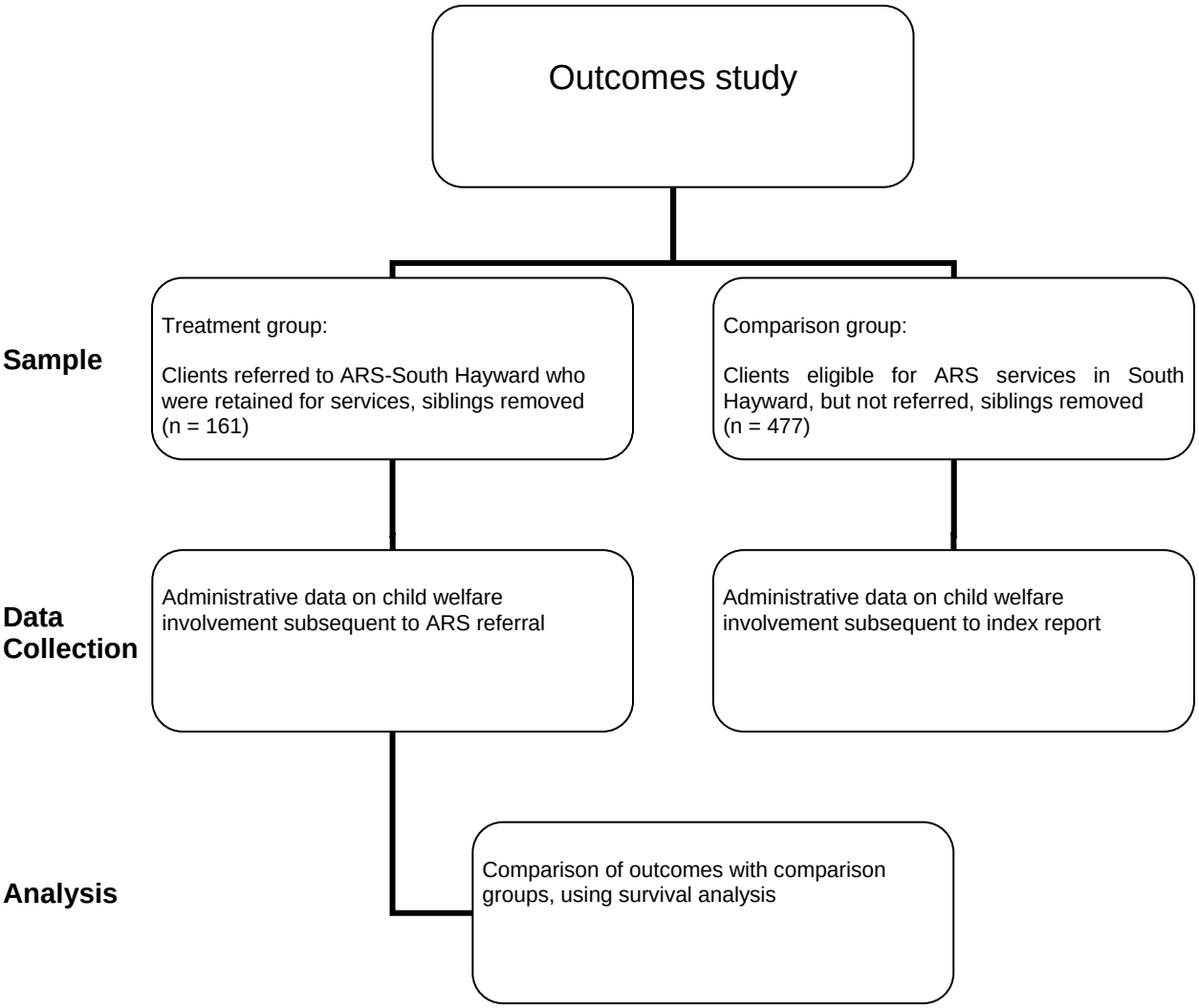
Figure 11: Sampling, Data Collection & Analysis for Outcomes Study



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METHODS FOR CONTRA COSTA STUDY

A mixed-methods design was used for this study. Qualitative and descriptive data were collected to address the first three questions noted below, and quantitative data were used to answer the fourth question.

> Question #1: What are the experiences and opinions of DR staff with regard to client engagement, service delivery, interagency community, and the overall program?
>
> Question #2: Who is served by DR in Contra Costa County?
>
> Question #3*:* What are the experiences and opinions of clients with regard to the availability and quality of services they received; the engagement process and relationship with DR staff; and their satisfaction with the program, specifically its effectiveness at helping them to feel more connected to the community, access resources, and gain specific knowledge or skills related to things such as parenting, child care, household management, and self-care.
>
> Question #4*:* Is DR successful in preventing future child welfare system involvement?

Study Site and Population

As noted in Module III, DR in Contra Costa County is implemented in six communities throughout the county. Services are provided by 11 community-based organizations (CBOs), through contract with the county's Children and Family Services, which also provides training, oversight, coordination, and evaluation.

The study population for Question #1, on the experiences of staff, included administrators and line staff from Children and Family Services (CFS) and the participating CBOs.

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The study population for Questions #2 and #3 included clients who were actively receiving Path 1 or Path 2 services for a minimum of 1 month at the time of the interview.

To answer Question #4, on the child welfare-related outcomes of DR clients, the Contra Costa County Children and Family Services staff provided data collected on clients referred to Path 1 services between October 1, 2005, and September 30, 2006. The data were drawn from the Child Welfare Services Case Management System (CWS/CMS) and administrative records completed by DR service providers. They included information on who was referred; who engaged versus did not engage in services; and re-referrals, substantiated referrals, and removals up to 1 year after the initial referral was made. Data from clients referred to Path 2 services were not included because there was not accurate tracking of engagement; thus it was unclear who received services and who did not.

SAMPLING

Sampling for the qualitative study of staff experiences (Question # 1) included 29 current administrators and staff involved with the DR program. Invitational letters were sent to the administrators and all the line staff from the 11 community based organizations, as well as the following CFS staff: the Path 1 supervisor, the 2 Community Engagement Specialists, the three ER supervisors (1 from each county office—East, Central, and West), the hotline supervisor, 3 hotline screeners (2 of whom participated), and 6 ER workers (5 of whom participated). Follow-up calls were then

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made to schedule specific times for individual, in-person interviews, which were conducted at the participant's worksite during 2006-2007.

Any English- or Spanish-speaking client who had been receiving Path 1 or Path 2 services for at least 1 month between November 2007 and May 2008 was eligible to participate in the qualitative client component of the study (Questions #2 and #3). All CBO direct line staff involved in Path 1 or 2 were sent packets of materials to invite client participation. These packets included an informational flier; an invitational letter; a consent form; a self-addressed, stamped envelope; and a script to guide the case manager's description of the study. All materials were available in English and Spanish. During routine home visits, case managers used the script to explain the study to clients, presenting the material to them, and inviting clients to sign and return the consent form if they were interested in participating. This was intended to prevent clients from feeling like they had to participate, and to ensure that their decision about whether or not to participate was confidential. In reality, however, it became clear that many case managers were submitting the consent forms to the researchers on behalf of their clients. As consents were returned, clients were contacted by phone to schedule individual telephone interviews. In total, 51 client interviews were conducted between November 2007 and May 2008.

The sample for the outcomes portion of the study (Question #4) was derived as follows. Contra Costa County CFS provided data for 1,800 children referred to the DR program between October 2005 and September 2006. These dates were chosen because the program, which began in 2004, was fully implemented by that time, and it

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provided an opportunity to evaluate the re-referral of a family for at least 1 year after the initial DR referral was made. The sample was reduced from 1,800 to 499 for the following reasons: (a) children older than 12 years of age were omitted; and (b) all families initially referred to Path 2 or 3 were omitted because there were no data indicating whether or not services were actually provided for families referred to Path 2, and Path 3 is traditional child welfare services. Unfortunately, family grouping information was not available, so it is possible (in fact, likely) that some sibling groups are included in the sample. Also, although the target population is children under 5, exceptions were made for older children with a sibling under the age of 5, and some children from 5 to 12 years old selected at the discretion of the county supervisor.

Further analysis was conducted of a subsample of 164 children whose families were actually offered services. The remaining families were not offered services due to lack of capacity or inability to contact the family.

STUDY DESIGN

Research Questions #1, #2, and #3 were addressed using qualitative research methods. The experiences of staff were assessed through in-person interviews, which were guided with a standardized script of mostly open-ended questions regarding program development, implementation, and effectiveness; and client engagement and services. Telephone interviews were conducted with clients to explore their experiences with DR services, as well as their experiences of raising children in their neighborhoods. These interviews were guided by a script with a mix of open and closed questions. Staff

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and client interviews each lasted between 30 and 40 minutes. Approximately half of the client interviews were conducted in Spanish.

Research to address Question #3 was conducted using unmatched comparison groups. Although CFS currently is conducting a randomized controlled study of DR in Contra Costa County, it had just begun at the time this research was completed. However, it was possible to compare cases in which the family engaged in services to those whose families were offered services but did not engage. Further comparison of re-referral and removal rates also was done on the following groups:

- Those who engaged in services;
- Those who were offered services but did not engage;
- Those who were not offered services due to lack of capacity; and
- Those who were not offered services due to inability to locate family.

DATA COLLECTION, DATA MANAGEMENT, AND ANALYSIS

Question #1 was answered through face-to-face interviews with administrators and line staff. These interviews were audiotaped and professionally transcribed. The information was then entered into Atlas.*ti* for data management and analysis. Two graduate student researchers worked with the Program Coordinator to code for emergent themes and review records.

Questions #2 and #3 were answered through telephone interviews with clients. These interviews were conducted by three graduate student researchers (2 in English and 1 in Spanish), who recorded responses during interview sessions. The interview

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responses were entered into an SPSS database. Responses to the open-ended questions were either recoded or manually reviewed to identify trends and patterns.

In response to Question #3, data were drawn from electronic records in CMS/CWS and administrative records completed by DR service providers. To protect confidentiality, a numerical identification code was assigned by the county for each child. The referral identifier numbers for all families who were referred to DR services were checked for subsequent records of contacts with the child welfare system (in terms of re-referral and removal) 1 year after the time of the initial referral. Data analysis occurred in a number of steps. First, descriptive statistics were computed to provide a profile of the sample on the primary study variables--ethnicity of the child, age of the child, type of allegation, and prior referral history of the family—and to compare profiles of those whose families engaged in services to those who were offered services but did not engage. Second, a logistical regression analysis was conducted to examine the relationship between the dependent variable, re-referral to CFS, and the independent variables of engagement in Path 1 services, primary ethnicity of the child, age of the child, allegation type, and prior CFS referral history for the child.

HUMAN SUBJECTS

Approval for this study was secured from Berkeley's Committee for the Protection of Human Subjects. Permission for the staff interview component of the study was provided on August 7, 2006 (CPHS Protocol #2006-5-35). Permission for the portions involving client interviews and quantitative analysis of county outcome data was provided on September 18, 2007 (CPHS Protocol #2007-7-22). Measures were taken to

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protect human subjects through the data collection, data management, and analysis phases of the study. For the qualitative study, client participation in interviews was voluntary. Clients were invited to participate in interviews by their case manager. Case managers also distributed literature on the research project, in the form of a flier describing the study and the participants' rights, and a letter of consent. Clients were told verbally and in writing that refusal to participate would not affect service delivery and that their comments would be kept as confidential as legally possible. DR staff also was informed verbally and in writing of the voluntary and confidential nature of their comments. Quotes from DR clients or staff that appear in this curriculum are not attributed. Consent forms from clients and staff were kept in a locked file cabinet at the Center for Child and Youth Policy. For the outcomes study, these researchers were never privy to client identifier numbers or records of child welfare histories, which remained with the county at all times.

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