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Perils, Pitfalls and Successes: Randomized Control Trial (RCT) to Examine the Effects of Differential Response in Child Welfare

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HSRI is currently evaluating the use of Differential Response in six Ohio counties, as part of a larger study sponsored by the U.S. Children's Bureau's Quality Improvement Center on Differential Response (QIC-DR). Using a randomized control trial (RCT) methodology, the study seeks to contribute to the knowledge base in child welfare by examining one of the most promising approaches to intervening with families reported for child abuse or neglect: Differential Response. DR offers an alternative pathway to the traditional investigation, whereby caseworkers conduct an assessment of family needs and provide appropriate services and supports without any formal allegation or determination of maltreatment. As each family enters the child welfare system, the agency determines whether the case meets the eligibility criteria for the alternative track; if so, the case is entered into a randomizer which assigns it to the investigation track (IR) or the alternative assessment track (AR). [The field uses the terms DR and AR fairly interchangeably, although DR tends to mean *the system that includes both an investigation response and an alternative response to a maltreatment report*, while AR tends to mean *just the alternative response track*.]

In general, RCT approaches are considered the gold-standard for establishing an intervention as an evidence-based practice. The more clearly defined the intervention model, the more appropriate it is for an RCT. The child welfare field has embraced DR as a preferred philosophy and culture, consistent with the family-centered, strengths-focused reform initiatives of the past decade, but it has yet to precisely define the intervention practice. The QIC-DR study seeks to verify whether DR is indeed an evidence-based practice.

The state of Ohio is very much committed to expanding DR in its county-administered child welfare system. The Ohio DR project, entitled SOAR (Six Ohio counties offering Alternative Response), includes a mix of jurisdictions – large metro areas as well as tiny rural counties – and county-level child welfare agencies with varying experience in DR. Ohio was the site of a 2007-2009 DR pilot project, conducted in 10 counties (1 of which is part of SOAR), which found positive effects of AR compared to IR (Loman, Filonow & Siegel, 2010[1]). And Ohio recently brought 10 more county child welfare agencies into the DR arena. All of these counties participate in a statewide Leadership Council to assure the sharing of experiences and the joint development of practice improvements.

Funding for the SOAR project began in February 2010, and will continue until September 2012. The random assignment of cases will formally begin in December 2010; a pilot period is currently underway, to enable county staff to become familiar with the new intervention model and to iron out any wrinkles in the random assignment and data collection processes. During this pilot period of implementation, the six counties have encountered numerous challenges, and have worked together to fashion creative solutions. HSRI has simultaneously identified evaluation-related issues, which it has addressed collaboratively with county representatives and with QIC-DR staff. Among the five most interesting implementation issues are the following:

[1] Loman, L. A., Filonow, C. S. & Siegel, G. (2010). Ohio Alternative Response Evaluation: Final Report. Institute of Applied Research, St. Louis, Missouri.

1. **Randomization**: The six SOAR counties and the evaluation team developed county-specific ratios for the number of eligible cases that would be randomized to the AR track versus the IR track. The ratios reflect a balance between evaluation requirements and caseworker resources in counties of various sizes.

   Randomization has presented a variety of challenges to the different counties:

   - The fact that a particular ratio is established does not mean that, for every 10 eligible cases, a precise number of cases will get assigned to AR; the ratios apply over a long period, and do not guarantee that new AR workers will immediately have a full caseload to work with.
   - To assure a consistent philosophy across AR families, counties try to have AR workers serve only AR cases. When random assignment does not generate enough AR cases to fill a caseload, IR workers may begin to perceive AR workers as having a lighter workload; counties addressed the disparity in initial workload in a variety of ways: giving AR workers other cases that were not abuse/neglect, changing ratios, sometimes causing overload, or simply bypassing the randomizer. It has taken close to two and a half months to finally bring *most* caseworkers up to their full complement of families.

2. **Data Collection**: As in all RCTs, data is being collected on both the experimental and control side. The evaluation team will be analyzing state administrative data but is also collecting survey data for a randomly chosen subset of the families (who were themselves randomly assigned to AR or IR), thus creating two levels of randomization. For each family selected to complete a survey, the caseworker is also asked to complete a survey.

   - County coordinators are responsible for tracking survey distribution and completion for families and caseworkers. So far, this has not been a major problem for small counties, but it has proved difficult for larger counties, particularly for the IR side of the study -- families who are randomized to the IR track are assigned to investigation workers located throughout the child protective agency, not grouped together in one unit as AR workers are. The IR workers tend to have less buy-in to the study overall, thinking of it as something that is associated with the AR units. They are sometimes resistant to receiving training and to doing the extra data collection work.

3. **Simultaneous roll-out of DR across the state**: To keep the RCT as 'clean' as possible, families should only be entered into the randomizer once, thus assuring that they only receive one dose of DR and that they are not subject to IR after having received DR. Ohio is actively committed to expanding DR practice across the state, and many PCSAs other than the SOAR sites are implementing DR, increasing the chance that a family in a SOAR county will have received AR already. It is not possible to identify, in advance of randomization, whether a particular family has ever been exposed to AR practice.

4. **Technology**: Technology has proven to be both a boon and a challenge.

   - Having an electronic randomizer has enabled the evaluation team to relatively easily control and change AR/IR ratios within each county. Counties have access to the randomizer via an electronic link and, as soon as they enter the family ID into the randomizer, can immediately learn how the case has been assigned. But frustration arises when the randomizer 'goes down' or is slow to respond.
   - In order to track families and their assignment to AR/IR, the evaluation team has designed its own tracking database. This is accessible to evaluators, county coordinators and screening decision makers who determine whether or not a family is eligible for the randomizer. This data base is proving invaluable as a mechanism for coordinators to track families and data collection from AR and IR tracks, but it does represent another level of complexity for county coordinators.

5. **Pilot Period**: The QIC-DR project design includes a two-month pilot period. This has proved to be an invaluable opportunity for the evaluation team to assist the counties with data collection processes, and for the counties to identify key practice issues they are experiencing. Having technical assistance at hand, from the evaluation and from the experienced SOAR county, is helping the SOAR group get ready for "going live".