Summary Report of the Experience, Findings, and Recommendations from the Alternative Response Pilot and Think Tank

Prepared for
Wisconsin Department of Children and Families by

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Synopsis of Conclusions

Successful Pilot

The Department of Children and Families began the Alternative Response (AR) pilot in 2010 as part of a longstanding commitment to improve practice for all children, families, and CPS professionals in Wisconsin. This pilot project successfully advanced those goals and yielded many positive results.

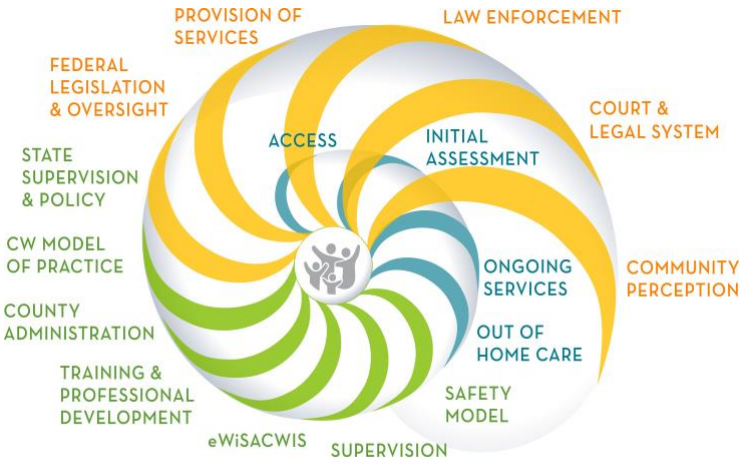
- Participating in the AR pilot required counties to fundamentally shift how they think about serving families
- Eliminating the maltreatment/maltreater determination at the conclusion of Initial Assessment (IA) allows child welfare professionals to focus more on the assessment of child safety and family needs
- Children on cases served on the AR pathway were found to be equally safe as those served in the TR pathway and the experience of families and workers improved

Challenges Encountered:

- Variation in how AR was implemented and operationalized exists at both the worker, supervisor, and county-level
- Variation impacts which families are served using an AR approach, contributing to racial differences and disparate outcomes
- Pathway assignment, as well as switching pathways, punishes families who are viewed as uncooperative

Unique innovation: Reimagine the one pathway system

These challenges are not unique to Wisconsin. In fact, some of the challenges are the result of how an alternative CPS response is defined by seven core elements identified nationally to allow for evaluation. Since AR policy and professional practices used to facilitate implementation are not mutually exclusive, the Think Tank concluded that Wisconsin can use the lessons learned about how AR practice was operationalized, shift the child welfare system, serve children and



families more effectively and equitably by reimagining a single response system rather than scaling the AR policy statewide. DCF will focus on a one-pathway system with flexibility and workforce support to engage and to serve families in a way that elevates the Wisconsin Safety Model and Wisconsin Model for Practice.

Optimize what works

The Think Tank members entered their process with the assumption that the transformational growth spurred by the Alternative Response Pilot would be maintained and advanced through the statewide implementation of a two-pathway system. The conclusion that a reimagined, restructured single pathway system was the best way to optimize what worked and address the challenges represents a paradigm shift. The decision was not made lightly and resulted from:

- A review of national data and outcomes
- Careful evaluation of process and outcome data collected in Wisconsin
- Frequent discussions between the counties implementing the AR pilot program
- Years of dedication to open dialog between the state policymakers and the county professionals, culminating in an eighteen-month Think Tank committee

The formation of the Alternative Response Think Tank

The Alternative Response (AR) Think Tank was formed in 2018 and used the critical thinking that AR pilot counties have already done and elevated it to the next level by expanding the perspectives to include research and evaluation, training and safety model expertise, CQI and consultants in the discussion. The Think Tank was facilitated by Blue Spiral Consulting, a team uniquely positioned to support the process because of their years of experience in child welfare in jurisdictions across the county, their involvement in Wisconsin's AR pilot project, as well as years of experience designing and facilitating group processes.

Goals

The goal of the Think Tank was to use lessons learned during implementation, data collected through the AR evaluation, and perspectives of lived experiences of families and the child welfare workforce in order to understand how the implementation of AR in Wisconsin has resulted in changes to child welfare policy and practice. The Think Tank members were charged with the task of turning this knowledge into actionable insights and options for moving those lessons forward to enhance child welfare practice across the state. There was a desire to find elegant solutions for statewide implementation that built upon the current child welfare system and created the most change with the least amount of disruption.

Five Core Tenets

Tenet #1: All families deserve our highest level of service and support

This tenet is primary and forms the basis for all the other findings. The pivot from incident-focus to a more global assessment of safety improves the outcomes and experience for families and workers alike. The change in focus invites everyone to bring their best selves into the process and creates a more equitable system.

Tenet #2: Safety and well-being are possible through attention to both service and protection

This tenet describes how we organize ourselves as a system by shifting our language and thinking from “who did this?” to “what has happened?”. Recommendations in this tenet target increasing the alignment between the child welfare system as it is and the goals, values and mission of child protection.

Tenet #3: Safety and well-being are achieved through collaboration and facilitation

Everyone with a stake in the safety and well-being of children require information and tools in order to fully and effectively participate. This includes family members, informal supports, and professional partners. Transparent communication and clearly distinguishing roles are what define this tenet.

Tenet #4: Professional CPS response requires cultivation and expertise

This tenet elevates the significance of supporting the whole person in the form of the social worker. CPS professionals should expect cultivation of their expertise through training, supervisory guidance and alignment between statutes and standards. Their professionalism must be supported through attention to secondary trauma, cultural competence and manageable workload.

Tenet #5 All case decisions are directed towards child and family safety

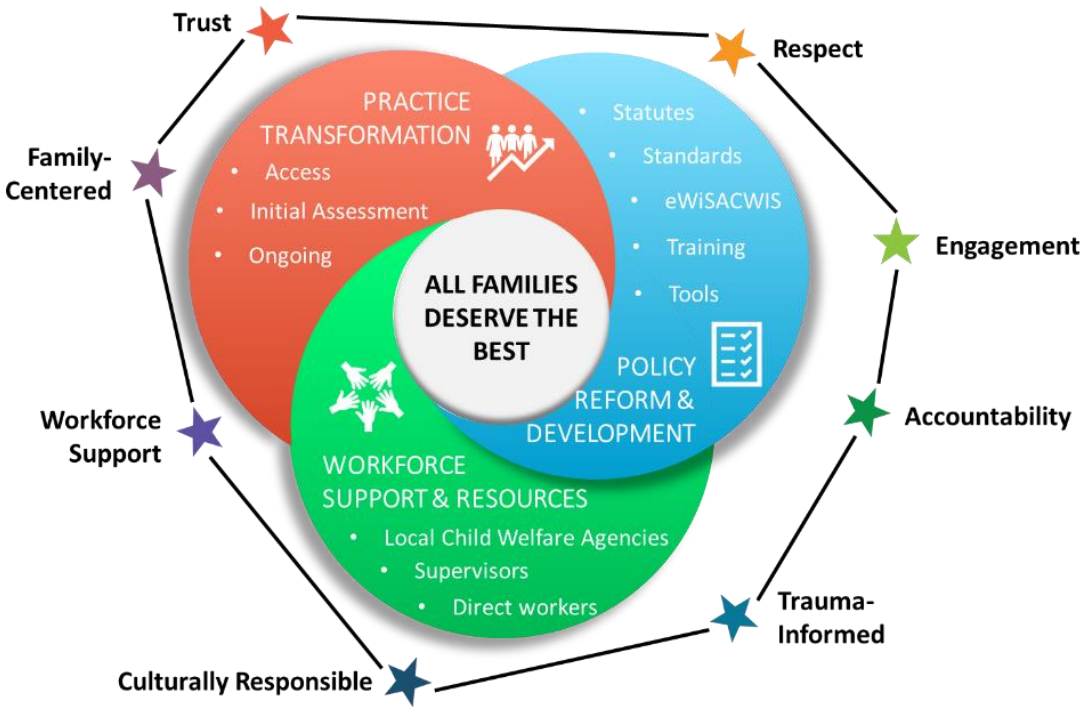
Every screened in report receives a safety decision. Attention to the significance of that finding and the quality of the information gathered to support it is a sufficient basis for continued involvement without a maltreatment determination.

The Think Tank distilled five core tenets that are essential to the successful integration of lessons learned into a reimagined single pathway system. These core tenets offer a roadmap for reimagining a one-pathway system that is driven by the Wisconsin Safety Model and uses the Wisconsin Model for Practice as a guide. A one-pathway system can provide the structure for a unified approach to assessment and offers flexibility to child welfare professionals, guidance for families, and an authentic sincere, realistic response to statutory obligations that starts during IA and can be carried through to Ongoing Services. This is a vision for a one-pathway system that is innovative, based on experience, data, and common sense.

The Wisconsin Safety Model

A Comprehensive Solution that Supports Critical Decision Making

- Wisconsin's Safety Model proved itself to be healthy and flexible enough to sustain rigorous CPS practice through both the traditional and alternative CPS responses. Safety decisions were equally valid in both pathways and safety decisions were in no way diminished by the differences in the two approaches.
- In a re-imagined single pathway system, the Wisconsin Safety Model will drive the IA process providing CPS professionals with explicit permission to work with families in a different way by removing the focus of the allegation and substantiation and putting the emphasis on assessment of the child and family.
- The assessment of child safety is always paramount but the change in focus from investigating an allegation to assessing family strengths and needs relative to safety does more than improve family engagement it strengthens safety planning.
- The introduction of the AR approach resulted in a more robust realization of Wisconsin's Safety Model by emphasizing comprehensive information gathering that improved the ability of the CPS professional to assess the family situation including strengths, needs and existing protective capacity.
- The AR Pilot gave counties an opportunity to pay attention to protective capacity differently throughout the system; beginning at Access with the types and scope of questions asked to guide pathway assignment and throughout IA as CPS professionals approached families using more sophisticated engagement strategies. In a single pathway system that maintains these positive changes, the IA process would include a balanced assessment of the overall family functioning.
- The assessment of Parental Protective Capacities during the IA will improve how children and families receive Ongoing Services.



The Wisconsin Child Welfare Model for Practice

The GPS for System Reform

The tenets of the Wisconsin Child Welfare Model for Practice align with the information learned from the AR pilot regarding how the child welfare system is oriented towards and serves children and families

All families who are served in the child welfare system deserve a coordinated, trauma-informed response, including the assessment of needs and referral to services

As a child welfare system, we should not be treating families assigned to the AR pathway or TR pathway fundamentally different but will instead evolve a reimagined single-pathway system that exemplifies the Child Welfare Model for Practice

Next steps identified by DCF

- DCF is committed to implementing the lessons and key successes learned from the AR pilot into our statewide child welfare system and model for practice
- DCF will be phasing out the current AR policy and AR pathway for all current AR counties
- DCF will continue to gather information and collect feedback from AR pilot counties regarding how to phase out the current AR policy
- DCF is committed minimizing the impact of this transition for current AR pilot counties

Learnings from the AR pilot will be elevated and prioritized for the DSP Family First and Strategic Planning work

- DCF and DSP believe in the evolution of child welfare practice in order to best serve and meet the needs of children and families served in Wisconsin
- Many of the learnings from the AR pilot, identified through the Think Tank and AR Evaluation, can be used to inform the DCF's goal of supporting Wisconsin families to raise their child
- There are opportunities to incorporate and align many of the recommendations from the Think Tank into the DSP strategic planning process
- DCF will continue to understand how key components of AR policy and practice impact how child welfare professionals serve children and families during IA and Ongoing Services

Targeted Recommendations

Practice Transformation

- Large-scale changes that will impact and improve child welfare practice as a whole, including Access, IA, and Ongoing Services.
- Consider changing how maltreatment determinations (i.e. substantiation decisions) are made and used
- Prioritize information gathering, family engagement, and safety decisions-making
- Incorporate the assessment and use of Parental Protective Capacities (PPC) into case practice
- Elevate services over protection by prioritizing information gathering regarding the family condition over information about maltreatment allegations
- Use maltreater determinations to address public safety
- Strengthen the collaboration between local and tribal child welfare agencies

Policy Reform & Development

Changes to current policy, Standards, or eWiSACWIS and/or development of new policy, Standards, or eWiSACWIS to support improved child welfare practice.

- Streamline requirements in the CPS case process in order to reduce redundancies and inefficiencies
- Improve and connect language between Statutes and Standards
- Clarify how the child welfare system will attend to risk

- Review data regarding the number of cases that transition from IA to Ongoing
- Make changes to eWiSACWIS regarding how information is collected and used in the CPS Access Report, Services Report, and IA
- Clarify/expand existing policy/standards regarding information gathering, danger threats, response times, and screening decisions
- Limit prescriptive language in standards and enhance language related exercising professional discretion where necessary and appropriate
- Create new standards and/or policy regarding screening decisions, response times, information gather during initial face-to-face contact, and Present and Impending Danger Threats
- Update existing job aids/tools

Workforce Support & Resources

Changes to existing and/or development of new training and resources for local child welfare agencies, supervisors, and direct CPS professionals.

- Promote skill development and critical thinking for the child welfare workforce
- Provide reflective supervision, or a similar model, to all local CW agencies
- Use the Organizational Effectiveness (OE) process to support practice changes in local CW agencies
- Offer training and/or tools for using and applying the safety model in practice
- Offer implicit bias training and tools for the child welfare workforce
- Develop a webinar for external stakeholders that defines the role of CPS and local CW agencies
- Continue to work towards improving recruitment and retention efforts

Navigating the remainder of this report

This report outlines a reimagined single-pathway response to allegations of child abuse and neglect. It is innovative and builds on a history of advancement in child protection. The evolution in thinking is easier to appreciate within its historical context, provided in the next chapter. The reader may also choose to proceed directly to the chapters specific to Wisconsin's experience with the AR pilot and the findings and recommendations of the policy Think Tank.

Alternative Response was an Innovation in Child Welfare

National innovation in Child Protection Services—the introduction of Alternative Response

> *When we look at the history of innovation, it becomes clear that we can't create valuable new ideas without building on old ones. ..To innovate, we need to be able to imagine a better world. But at the same time, we have to be aware of what has come before. To create the future, we must understand the past.*
>
> *Tim Kastelle, professor of entrepreneurship and innovation at the University of Queensland, Australia*

In the mid 1990s, a two-pathway approach to child protection, most often referred to as Differential Response in national research and literature, was introduced in an effort to improve a system that had become increasingly dictatorial and penalizing in nature. Consider that the majority of families interacting with Child Protective Services are exhibiting neglect, not abuse[5].

Circumstances surrounding neglect are often characterized by lack of:

- Financial security
- Access to medical care
- Knowledge about children's developmental needs
- Skill with discipline
- Social support
- Available mental health and substance abuse treatment

Neglect is defined as the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm. [6]

Despite these existing challenges, the child protection system is structured around establishing culpability and holding caregivers accountable for harming or abusing children—even though the intent to cause harm is rarely observed. In large part because the system is organized to address the worst-case scenarios, professionals and organizations tasked with child advocacy and protection often view their two

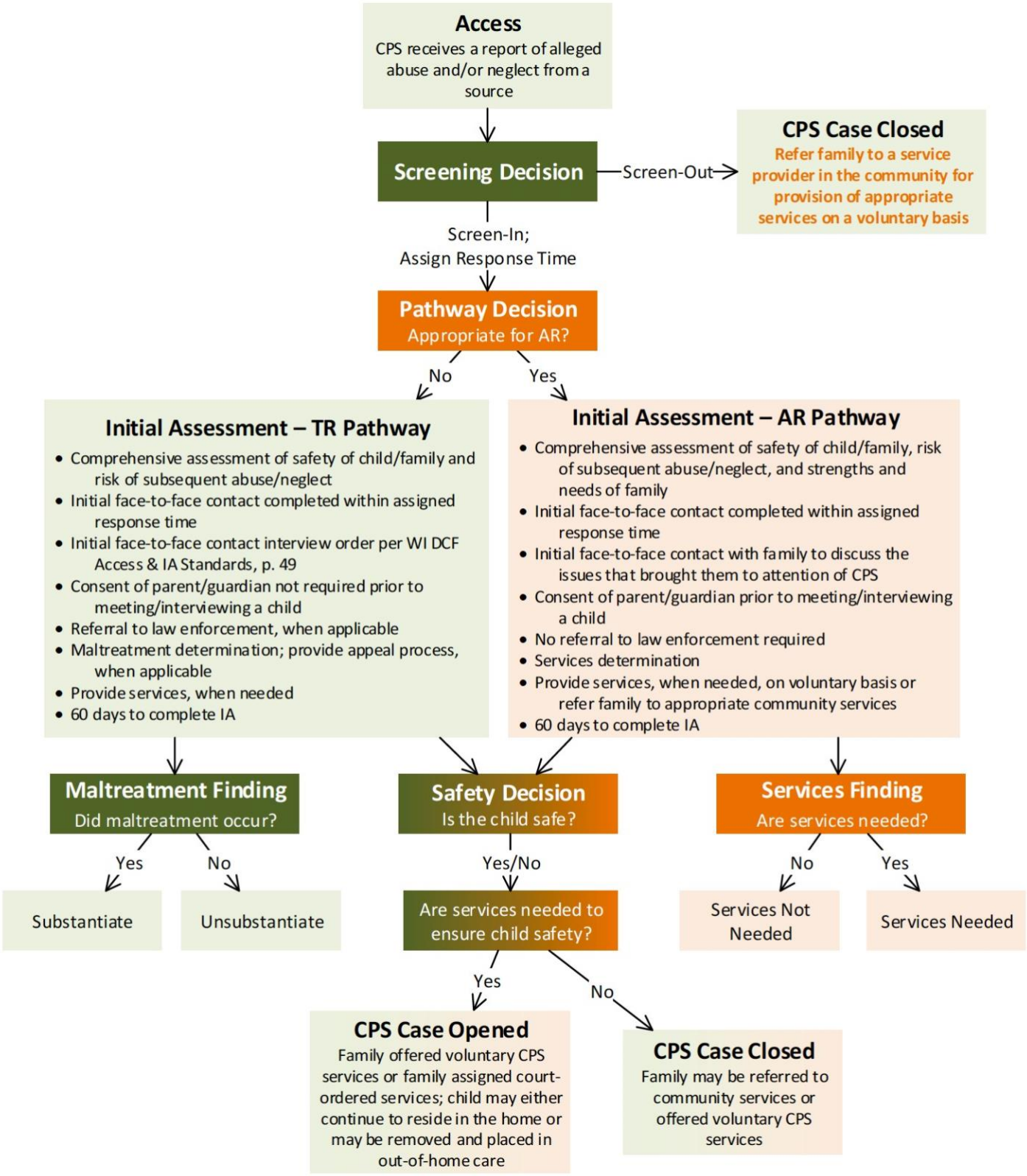


FIGURE 1: THE ADDITION OF AN ALTERNATIVE CPS RESPONSE IN WISCONSIN AS DEFINED IN THE WISCONSIN AR EVALUATION REPORT

primary objectives, protecting children and strengthening families, as contradictory.

In actuality, these two objectives are symbiotic and mistakenly placed in opposition by a punitive system. The implementation of an alternative CPS response by Wisconsin and other states represents efforts to evolve the child welfare system, particularly in the area of child protection. The addition of a second, alternative response to child protection was introduced to move beyond a false perception that protecting children is separate from strengthening families, and to evolve an organized approach to safety that accounts for the complexities of families and societal conditions.

What makes an Alternative CPS Response different?

At its most basic, an alternative CPS response to allegations of abuse and neglect is the addition of a non-investigatory option for families that meet established criteria. As you can see in the flowchart above, the differences can be found in:

- The scope and focus of the IA
- The addition of options for initiating contact with the family
- Identification of services needed instead of a determination of maltreatment

The term Alternative Response, or AR, means different things to different people. It is necessary to clearly define terms and distinguish the factors contributing to transformation in casework practice and its supporting system. If we cannot pinpoint the factors driving the change, we cannot replicate them.

- **Alternative Response System –** as described nationally by the seven defining elements found in Figure 2 below (QIC-DR, 2014)
- **Alternative CPS response –** the additional IA pathway as illustrated in the flowchart (Figure 1)
- **AR Policy Addendum (2010) –** the set of specific policy guidelines that expand the options available to the CPS professional within that second pathway
- **Alternative Response (AR) Pilot –** overall project implementation in Wisconsin

The most important place to clarify language is where it specifically describes changes in direct work with families. The shorthand term “AR approach” is often used, yet fails to articulate specific skills, tools, engagement strategies, or the skillful use of authority applied by CPS professionals. All of these factors impact the effectiveness of assessment and decision-making in the CPS system.

Seven Defining Elements of a Differential Response System

1. Use of two or more discrete response pathways for cases that are screened in and accepted;
2. Establishment of discrete response pathways is codified in statute, policy or protocol;
3. Pathway assignment depends an array of factors, such as the presence of imminent danger, level of risk, number of previous reports, source of the report, and/or presenting case characteristics, such as the type of alleged maltreatment and the age of the alleged victim;
4. Original pathway assignment can change, based on new information that alters risk level or safety concerns;
5. Services are voluntary in a non-investigative pathway
    1. Families can choose to receive the investigation response or
    2. Families can accept or refuse the offered services if there are no safety concerns
6. Families are served in a non-investigatory pathway without a formal determination of child maltreatment; and
7. The name of the alleged maltreater is not entered into the central child abuse registry for those individuals who are serving through a non-investigative pathway.

FIGURE 2 SEVEN DEFINING ELEMENTS OUTLINED BY THE NATIONAL QUALITY IMPROVEMENT CENTER ON DIFFERENTIAL RESPONSE IN CHILD PROTECTIVE SERVICES (QIC-DR 2014)

It is important to describe these professional approaches to facilitate deeper examination and to draw connections between this shift in practice and the wider implications for the child welfare system. Attention to the specific, observable changes in practice and the organizational structures required to support those changes will inform statewide integration of the lessons learned from Wisconsin's AR pilot project.

Research Findings and Outcomes

National data comparison is made possible by seven defining elements

These are the elements that officially describe Alternative Response at a national level. These elements are useful because they create a classification of CPS response

and allow researchers to compare data and examine outcomes. An alternative CPS response is not a model for practice, it is an attempt to evolve a complex system.

National and state-level qualitative and quantitative data and outcomes

A comprehensive review of AR evaluation outcomes outside the scope of this report. However, there are a few observations that consistently emerge and are worth noting.

- Increase in CPS worker satisfaction
- Increase in family engagement
- More holistic assessment of family functioning
- Earlier access to services
- Safety measures are consistent for all children regardless of pathway assignment
- No decrease in removals (although there is some evidence for briefer stays in out of home care and longer time between subsequent CPS reports)
- Gaps in services are often spotlighted and point to inadequate funding
- AR is often misunderstood as an effort to reduce out of home placement, which results in misinterpreting data as a failure

For those interested in further exploration, there is an extensive list of resources available in the bibliography.

Will the children still be safe?

When a jurisdiction implements an alternative CPS response, there are often concerns about whether or not children will still be safe. Most states (87%) implementing a differential response to child protection conduct some form of evaluation. There are several publications that subject this data to a meta-analysis. One such document is the *Implementation Resource Kit* published in 2014 by Casey Family Programs, which compiled and analyzed data collected from 16 jurisdictions in 14 states. Here is what they found:

Child Safety Impacts- Reduction in recidivism (re-referral rates)

36% better outcomes for DR (and statistically significant) using equivalent comparison groups

64% equivalent outcomes (non-significant)

0% worse outcomes

What these findings tell us is that children are no less safe from allegations of child abuse and neglect in a system using two or more response pathways. In fact, **there was not one study in which the safety outcomes were diminished**, there was a statistically significant improvement in more than one third of the cases. (Casey Family Programs, 2014) These findings are consistent not only in national data but also in evaluations conducted in Wisconsin.

There are many conclusions to draw from this data. Critically important is the evidence that a positive family experience isn't being recommended because it is nice or "family-friendly". Instead, a positive family experience is recommended because it leads to improved outcomes and more effective, sustainable interventions. If safety is maintained and the experience for families is better, why not utilize an engaged, collaborative approach with families? The families served through CPS and the children being protected through CPS intervention are our future. This perspective is in keeping with the mission, goals and values of DCF. It is also aligned with Wisconsin's Safety Model and Child Welfare Model for Practice.

When offered the opportunity to share comments about their experience, caregivers surveyed through the Wisconsin AR outcome evaluation revealed a common, positive theme from respondents in the AR pathway that CPS workers were helpful and respectful. Likewise, when given the opportunity to share their experience with the shift in practice implemented by the AR Pilot, workers and supervisors share feedback like this:

"When I think of Alternative Response and the transformation from where we were to where we are now as a team, I would say it is a dramatic difference. Some of our staff who are more seasoned and don't really want to get out of their comfort zone...to see them buy into it [an alternative CPS response] and feel the positive impacts on how they feel as professionals, but also for them to see the benefits for the families...it is powerful."

Fond Du Lac County supervisor recorded during the November 2017 AR Policy meeting

Even with the presence of the seven core elements details in figure 2 each implementation of an Alternative Response System is unique (Siegel, 2012).

Awareness of variation opens up new levels of understanding

It is helpful to understand the distinctions that describe a two-pathway system at the national level in order to provide context for outcome data, but that does not mean that these seven elements cannot be examined individually. The introduction of a

two-pathway system expands the intervention options available to CPS professionals when they are working with a family, but it does not provide guidance to direct the content or process of the intervention. That is the role of practice models, standards, and supervisory guidance. These seven elements were imagined and implemented in an attempt to evolve a complex system. They can be reimagined and deconstructed for the very same purpose. The introduction of a two-pathway approach to child protection and the seven elements used to describe it was a dramatic innovation. The conclusions reached by the Think Tank are equally innovative.

Evolving a transparent, thorough and equitable child protection response in Wisconsin

The Catalyst: Alternative Response was Transformational, and not just in the Pilot Counties.

The introduction and implementation of an alternative CPS response impacted the Wisconsin's child welfare system at many levels. This remarkable change in practice occurred the foundation of an intervention transformed from an investigation of maltreatment into a more global family assessment organized around the safety of the child and including the strengths and needs of the family. Wisconsin's AR pilot also provided the catalyst for a paradigm shift, as it necessitated a significant change in the typical way of thinking about or approaching work with families and introduced a different way of working with families where engagement, collaboration and enrollment of natural support systems is the focus.

The change begins when the very first connection is made between the family and Child Protection Services (CPS). There was an almost immediate shift in practice beginning with the way pilot agencies accepted reports of abuse or neglect into their system, especially in the questions they asked. The focus of the questions asked by intake expanded from a clear description of a specific incident to include information about parental protective capacity, hopes for the family's success as protective parents, and desired involvement of the reporter as a support person.

The morphing of a system does not happen all at once, and it took time for the shift to be noticed, named, and coached as additional pilot counties came on board. The changes at Access as pathway assignment decisions were made were the first nudge. It was subtle and significant, and the system as a whole began to respond. The image in figure 3 illustrates how once the change in practice expands out in increasingly complex ways to touch all aspects of the system charged with providing services and protection to children and families.

The counties piloting the project found that a shift in practice resulted in an array of desired outcomes for children, their families and the child welfare professionals serving them, similar to other pilot and statewide implementation results. Some examples of the outcomes include improvements in family and worker satisfaction with the delivery of child welfare services, reduced time between CPS reports, and

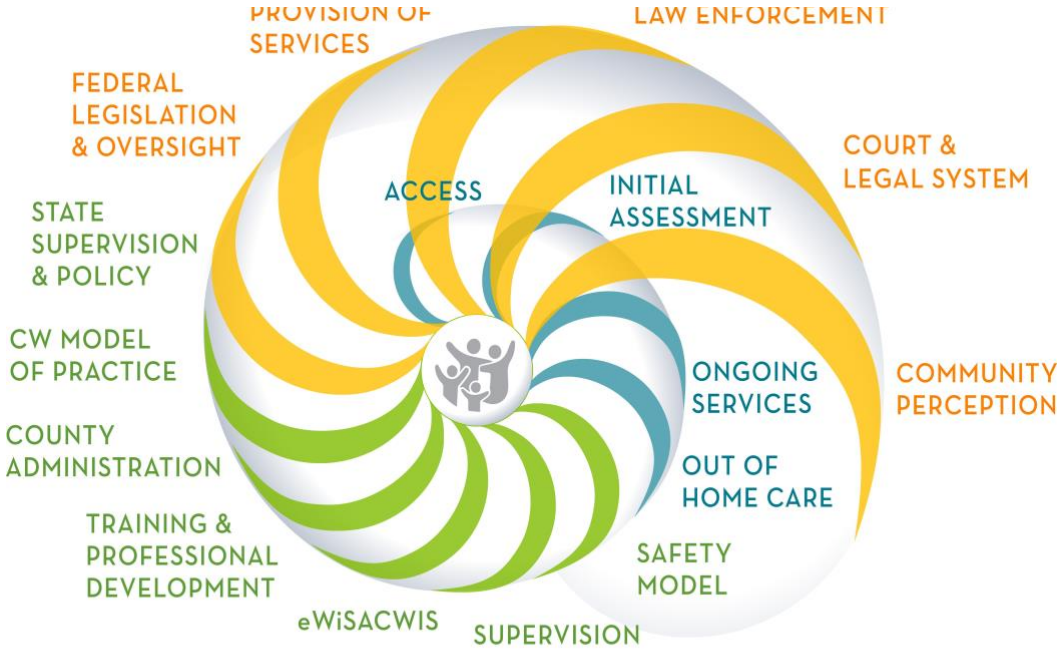


FIGURE 3 THE TRANSFORMATIONAL IMPACT OF THE AR PILOT

even retention improvements for staff employed in Alternative Response jurisdictions. In the Wisconsin study of Alternative Response, the changes weren't limited solely to families on the alternative CPS pathway. In fact, the introduction of engagement strategies of collaboration, family involvement, and enhancing supportive networks created a domino effect and influenced many other programs that were implemented during the pilot years.

How the Think Tank came to be

The Alternative Response Policy Think Tank was formed to advance collaborative thinking regarding the practice and system advances attained during the Alternative Response Pilot, and scale those advances state-wide. The intent of this report is to gather the reflections, best thinking and collective conclusions of the Think Tank for distribution to those interested in the findings and in order to support future decision-making regarding Wisconsin's child welfare services.

The Think Tank was asked to provide guidance and recommendations through the use of specialized knowledge and the activation of networks. They were charged with the task of turning this knowledge into actionable insights, from which they would

craft options for moving the lessons learned forward to enhance child welfare practice across the state.

This was no small task. Insight is not data or observations. It is akin to "apprehending the true nature of a thing"[4] and it takes a willingness to let go of preconceived ideas about what you will discover. Insight is the ability to look at your data holistically, discover the story or motivation behind what is observable, and use the ideas that emerge to gain an intuitive and robust understanding of what you are studying. (Dalton, 2017) The Think Tank's goals were to:

1. Identify the areas of progress made through the AR Pilot implementation
2. Distinguish the essential aspects of an alternative CPS response and how those intersect with the rest of the child and family serving system
3. Draft suggestions to improve the state-wide system, particularly recommendations on how to ameliorate areas where the system is not working well.

We can improve this system even more: The Think Tank had to define the box in order to think outside of it

At some point in the process it became clear that the Think Tank was operating with an unexamined assumption. That assumption was that the transformational growth spurred by the Alternative Response Pilot would be maintained and advanced through the statewide implementation of a two-pathway system. This would mean taking the AR Policy Addendum, with its codified permission to utilize an alternative CPS response, to all the other counties in Wisconsin.

Once that assumption surfaced the members of the Think Tank could entertain that possibility as only one option. At that point the quantity and quality of insights broadened and a reimagined one-pathway system emerged.

This was the Think Tank's paradigm shift

It was this change in perspective that was needed to take data, observations, and experiences and turn them into the insights and 5 Core Tenets in this report.

In Wisconsin, the investment in careful, collaborative thinking throughout the Alternative Response Pilot process, which was then examined critically through the Think Tank process, led to an innovative and comprehensive re- conceptualization of Child Protection Services for the state.

This is a vision that has demonstrated effectiveness within the pilot counties while maintaining alignment with the Wisconsin Safety Model and Child Welfare Model for Practice, and one that will be best served through a reimagined one-pathway system.

The one-pathway system we are advocating is evolved and optimized from its current iteration and realized through the full integration of the tenets created by the Think Tank.

Optimization is Key: Maintain and scale the advances made while fixing identified problems

The AR Pilot has led to many exciting advances in practice in Wisconsin and those that have been shown to have a transformative effect can be kept in place. For example, the elimination of or significant changes to the maltreatment determination in the two-pathway system changed the focus from the initial allegation to a comprehensive discovery of the family functioning.

A meaningful change to the maltreatment determination can be supported by other system improvements presented in this document and outlined in the 5 Core Tenets created by the Think Tank.

The opportunity also exists to reject or refute the elements that create confusion or get in the way of effective practice, such as using the word “voluntary” to describe services needed. Families must address safety issues. This is not voluntary, but it can be collaborative. The move away from this language creates a child protection response that is clear and precise about addressing safety issues.

Five Core Tenets for a Single Pathway CPS Response System

Tenet #1: All families deserve our highest level of service and support

It is our moral, ethical, and legal responsibility to provide every family that comes into the CPS system with the highest level of support and services required to establish safety and strengthen the resiliency of the family. A higher level of practice results in improved working relationships between family members, their support system and community, and the CPS professionals charged with assessing safety.

Identified Problems

A two-pathway system offers disparate and sometimes discriminatory experiences that push everyone into lower-level thinking and away from creativity and solutions. This system is inherently discriminatory and promotes bias; some families will get the best we have to offer, others will not (often because they are deemed "uncooperative").

Families that are less trusting of the CPS process, are reluctant to share information with the stranger investigating them, or who are intentional about deflecting testing or supports, for example, are more likely to be switched to an investigation pathway. (Wisconsin Alternative Response Evaluation Interim Report, 2019)

Regardless of the allegation type or initial pathway assignment, a family is more likely to be assigned a traditional response if they are perceived to be uncooperative. When this happens, CPS professionals and their supervisors predictably employ a more authoritative approach, moving away from efforts at engagement or family involvement in the safety planning process. The intervention is much more likely to become adversarial instead of collaborative. Qualitative and quantitative outcome data, as well as anecdotal information about the lived experience of families and the workforce, bear this out. (Wisconsin Alternative Response Evaluation Interim Report, 2019 and AR Policy Story Corp Project [Personal interviews November 2017).

Incident-Centered CPS Assessments

- Access and IA lay the foundation for assessing a child's vulnerability and the family's protective capacity accurately, driving the whole system. When Access and IA focus on data collection that confirms or refutes an allegation, the range of data collected about the family's needs is narrow.
- Determinations of substantiation or maltreatment determination push social workers into an adversarial relationship with "perpetrating" family members who are not likely to perceive them as helpful or supportive.

The Traditional One-Pathway System is Inherently Adversarial

In Wisconsin's traditional one-pathway system, process and perception are centered around an incident that prompted the CPS report. When a maltreatment allegation begins the assessment process and a determination of maltreatment concludes the assessment period, any information gathering and analysis is focused on if maltreatment occurred, and if so, by whom.

This incident focus steers the child welfare professional toward collecting data that will support the assignment of guilt and the naming of a maltreater. It also puts the family's focus on defending themselves against judgement, having their children taken away, or avoiding further involvement or legal charges. Incident focus automatically puts the family and the CPS system in opposition to one another.

Discoveries and advancements to integrate into the new single pathway system

When the CPS system seeks to understand each family in their complexity, it opens the door to a smoother process and more trust between everyone involved.

- Families report improved experiences on the AR pathway, feel more respected and involved, and have a better understanding of their rights and responsibilities.
- CPS workers have a better experience, greater job satisfaction, and appreciation for the opportunity to bring their best selves to each case. (Wisconsin Alternative Response Evaluation Interim Report, 2019)
- A shift away from incident focus in Access and IA reduces defensiveness and enhances the information gathered to include natural social support systems and existing protection from caregivers on which to build a more comprehensive assessment (AR Policy StoryCorps Project [Personal interviews] (2017, November).

Services do not create safety - relationships and learning do.

- When families have a more positive experience, they are more involved in creating sustainable safety plans.
- Often, CPS professionals are the primary service provider that a family will connect with; a relationship of collaboration is far more likely when the CPS professional isn't responsible for determining culpability.

This is an invitation for everyone to bring their best self forward.

One significant benefit of this shift in focus is the invitation for families and CPS professionals to bring their best selves forward. When they aren't worried about protecting themselves from culpability or being identified as a maltreater, the family can participate in the decision-making process about the everyday care, safety, and well-being of the children. Families in crisis aren't in the best position to self-advocate or to find solutions for long-standing problems.

Empowering the CPS professionals to be advocates eliminates the adversarial position that we have placed them in. This allows the social worker to act as a change agent and service advocate for that family, building a solid foundation of trust and collaboration.

Figure 4 A change in focus creates a paradigm shift

The focus drives the work.

The crux of the paradigm shift is where we put our focus. When we come into a family looking for evidence of culpability, we actually shift the focus away from the family and onto the child asking, "Who did this to you [child]?" The focus is on blame and naming a maltreater.

When we approach the family as the complex, multi-layered ecosystem that it is, we ask instead "What is happening within this family that might be dangerous to this child and how can we use what is working to make her safe?" Introducing this significant shift in focus causes the entire system to respond, and it plays out in the other four Core Tenets as well.

All families deserve our highest level of service and support. In order to achieve this standard, CPS professionals and the child welfare system have to change the dominant narrative applied to families and the role of the child protection system in the community.

THINK TANK RECOMMENDATIONS

The Think Tank committee makes the following recommendations to advance this tenet in Wisconsin:

1. **Redefine a one-pathway system** that is informed and shaped by the participatory and collaborative safety-assessment and planning efforts demonstrated by the Alternative Response pilot.
2. **Elevate the Wisconsin Safety Model** as a primary decision-making resource to prioritize meaningful family engagement in order to improve information gathering, assessment, safety decision-making, and planning.
3. **Realign the focus of the one-pathway system** to concentrate the assessment of safety on the child and on family needs for support and services rather than investigating specific incidents and assigning culpability.
4. **Fully implement all five core tenets** to provide a comprehensive response to child safety that improves the experience of all the people involved and eliminates disparate and discriminatory outcomes.

Tenet #2: Safety and well-being are possible through attention to both service and protection

While it is clear that both protection and services are critical outcomes for a CPS investigation, protection has historically been the driving focus. This emphasis places the CPS professional into a paternalistic role rather than a collaborative one. The CPS professional is then focused on determining what and whom we are protecting the child from, steering the investigation straight toward determining culpability and protection from a maltreater and away from collaboration with the caregivers to assess the child or family's need for services.

The safety of children served in the child welfare system is enhanced when a collaborative approach is established from the start. This approach allows the family to be seen as an integral partner in making decisions about the safety of their child; including temporary placement decisions, recommendations for safety support network members, and creating a robust safety plan that is monitored by both the professionals and support network. When the conditions for full participation exist, parents and the child's support network can make changes in the everyday care of that child, maintaining consistent monitoring of safety and of the issues at hand.

Identified Problems

- Protection focus perpetuates the narrative that families are broken and incapable of keeping their children safe.
- The most dangerous situations thrive on secrecy. The focus on culpability aligns CPS, community and services against the families creating further isolation.
- This can push families away from the table while simultaneously diminishing the role of CPS (from comprehensive collaborative partner to a fact finder with limited focus)
- When families and their natural supports do not trust the child protection system to listen to them or include them in the assessment of and planning for the safety of their children, they become defensive and guarded, often labeled as uncooperative or resistant.
- The CPS professional who works with the family at IA is often the only professional service or support the family will receive. The quality and tone of that relationship is vital.
- System drivers such as documentation in eWiSACWIS, misalignment of language between Wisconsin's Safety Model and statutes, and overly prescriptive standards for interviewing are examples of how the current organizational structure is guiding practice in a direction that is not aligned with the goals of child welfare and protection.

Discoveries and advancements to integrate into the new single pathway system

The Wisconsin Safety Model supports a robust assessment of both the need for protection AND services

The Wisconsin Safety Model provides an effective structure in which to prioritize information gathering, family engagement and safety decision-making activities and focus them on providing a network of support and services that will address the protection of the children.

Focus on service increases information sharing and partnership

- The careful and thoughtful discussion about the best options for approaching a family are held at the point of Access when reports are screened in and assigned a pathway
- When the need for maltreatment or culpability determination is removed, it encourages both natural and professional supports to align with the family for the protection of the child.
- The workforce is also able to further integrate the components of Wisconsin's Safety Model at the time of entry into our CPS system. Present danger threats are no longer an afterthought at the end of the report, but instead put the focus and attention on the safety of the child.

Changes in the way CPS professionals viewed themselves and their role created a new narrative

- In AR, CPS professionals viewed themselves as part of the intervention rather than solely there to collect information and make a determination of culpability.
- When the focus is on both service and protection, it opens the possibility to more consistent safety planning, from intake through IA and into Ongoing Services.

THINK TANK RECOMMENDATIONS

1. Reorganize the current system to prioritize the assessment of child and family needs for support and services over investigating specific incidents and assigning culpability.
2. Develop supervisory guidance for the CPS Assessment professional on how to approach the family when making the initial contact.
3. Leverage communication, training, and resources to improve the rigorous application of the Wisconsin Safety Model. This will prioritize the use of Present Danger

4. Threats and Parental Protective Capacity for safety planning over and above the collection of data that focuses on confirming or denying the allegation.
5. The following are some specific examples of modifications that the Think Tank advises to support this type of reorganization. Additional specifics can be found in the memorandum in Appendix Two.

Reorganizing the eWiSACWIS template so that the documentation is weighted toward safety information rather than leading with maltreatment and the circumstances surrounding the maltreatment.

- Reordering the CPS Access Primary Access Report so that the first point of inquiry in the narrative is observable family conditions, not allegations of maltreatment. (In coordination with the Bureau of Performance Management to determine impact tools used for Access Case Record Review.)
- Inquiring from the beginning about parental protective capacity will focus everyone's attention on what is happening in the family, rather than the incident that got them involved with the agency.
- Aligning eWiSACWIS with the reorganized Access reporting process so that the decision of determining if this report qualifies for a CPS assessment is held until the end after collecting family needs.

Aligning language in the statutes with the Wisconsin Safety Model

- Introduce standardized language in Access to justify screening decisions, including the approach to information gathering at the initial face-to-face contact.

Tenet #3: Safety and well-being are achieved through collaboration and facilitation

Safety planning is a complex, dynamic and ideally collaborative child protection process that focuses on building safe practices and systems so that children remain in the care of their families. Everyone involved in the process must have the information and tools required to be successful and fully participate.

Effective collaboration requires that everyone understand their role, the role of others, the critical decision points, and the potential consequences of the decisions made. Whenever possible, maintaining children in their homes and communities leads to better well-being outcomes with no reduction in safety for the child.

Identified Problems

There is a common misperception that children are safer when we remove them from a dangerous home.

"We believe that we are taking children away from bad people and putting them with good people. That simply is not the case. Outcomes for children who linger in foster care are poor."

Kevin Campbell, founder of Family Finding

- The current child protection system is overly reliant on removing children from their families when there are identified danger threats in the home.
- Conversely, children may be maintained in their home with an inadequate safety plan due to lack of clarity on how to identify, utilize, and build parental protective capacity into a family-owned safety plan. An ideal plan is one that can be monitored and that offers structure to demonstrate protection over time.
- Families, community supports, professional partners, and even CPS professionals rarely have the information and tools needed to fully participate in a robust, individualized, comprehensive, and sustainable safety planning process.
- The community and professional partners often misunderstand the role of CPS and hold unrealistic and potentially harmful expectations regarding how the social worker should intervene.
- Child welfare agencies and CPS professionals are held accountable for the safety of the children that come to their attention. This creates a culture of risk-aversion in

- which there is an understandable desire to control as many factors as possible contributing to the often punitive nature of the CPS intervention.

Discoveries and advancements to integrate into the new single pathway system

Collaboration with families improves safety and well-being

Alternative Response research demonstrates that when the focus is on determining if services are needed and which ones need to be implemented,

- CPS professionals and families are more likely to work collaboratively together,
- families share more information with their CPS professionals,
- parents are more likely to follow the safety plans they collaboratively design with the CPS professional,
- and there are more options for building a natural social support network that can help the family long after the CPS agency is gone. (QIC-DR, 2014)
- What shows up in virtually every Differential Response study is that children are just as safe on an alternative CPS response.
- Entrance into kinship or foster care percentages remained stable after the implementation of a two-pathway system, meaning that children were coming into care just as often when safety concerns warranted their removal from their homes.
- What was different for children assigned to an alternative response pathway was that they typically stayed in care for shorter periods of time and came back home sooner than children removed on the traditional/investigative pathway.[9] They were also less likely to go back into care than children served through the traditional pathway. Child Welfare Information Gateway. (2014)

Collaboration leads to comprehensive assessments and robust, individualized safety plans

- The AR Pilot gave child welfare professionals explicit permission and tools to engage with families and shifted the focus from “what happened” to “what do you need.”
- The information gathered during the assessment period is more robust.
- Safety assessments that explore danger threats and protective factors provide everyone with the information needed to develop effective safety plans that include informed and defensible actions—particularly if removal or court involvement is indicated

- Addresses the misperception that children will be less safe and that the outcomes for children are better when we remove them from traumatic child abuse or neglectful situation.

Effective collaboration requires facilitation and well-equipped participants

- Collaboration means involving a network of support, including as many people services necessary to mitigate the identified safety concerns
- Everyone involved in the planning process must be informed about the safety threats and the presence of protective capacity that need to be addressed by the safety plan
- Naturally occurring support people provide critical insight into triggers and red flags, as well as examples of protective strategies that have worked in the past when they are viewed as critical partners in the process.
- The sense of belonging to the community and the development of a support system of people to whom the child is naturally connected is one of the resiliency factors known to have the most influence on a successful transition from childhood to adulthood. (Zimmerman M. A. (2013)
- Community partners such as the school systems, mental health, substance abuse treatment programs, law enforcement, and legal partners including district attorneys, court counsel and judges must be informed of changes in child protection system and offered information about how they can effectively partners with CPS professionals and families who were planning for safety concerns.

THINK TANK RECOMMENDATIONS

1. Through collaborative partnership, provide families with a structure to understand safety threats and to begin planning for safety for their child and better functioning for their family as a whole.
2. Help everyone involved in the child protection system to gain an understanding of two main safety planning components:
    a. The existing concerns and safety threats to their child as a result of their behaviors, and future risk of harm if nothing changes in the care of the children
    b. Enhancing or developing cognitive, emotional and behavioral protective capacity in parents so that they can seek out the support they need to effectively plan for and assure the safety of their children.

3. Continue to pursue community partnerships and educate the community about the role of CPS as well as the role others can play in safety planning.
4. Provide resources for local CPS agency directors, supervisors, and child welfare professionals to elevate the components of the Alternative Response approach that promote family and worker engagement.
5. Attend to organizational alignment through coordination efforts such as:
    a. Enhanced training and use of Supervising Safety to provide supervisors with the support they need to guide workers through the safety planning process with families.
    b. Coordination with local CPS agency directors to understand the nuances of a revised one pathway system.
    c. Coordination with local community partners including education, information sharing, and clarification of roles.
    d. Coordination with Family First Prevention Services Act legislation.

Tenet #4: Professional CPS response requires cultivation and expertise

A community can issue no greater obligation than the charge to protect its children. Inherent in this comes the authority to step into a family's life and determine whether or not they have sufficient capacity to keep their children safe and whether the child may remain in the home.

The best child protection work is a skillful and mindful balance of engagement, collaboration, and the use of authority that aligns the child's caregivers as critical partners. With this level of responsibility and accountability on the shoulders of CPS professionals, it is incumbent upon us to furnish those professionals with high-quality tools, support, and professional development that is commensurate and ensures the greatest likelihood of success in their endeavors.

Identified Problems

- The work of child protection is complex. The traditional one-pathway system does not provide adequate educational support and mentorship to the workforce.
- The current system has disempowered social workers by focusing their work on data collection rather than valuing them as safety experts—leading to checkbox social work.
- The role of CPS is often misunderstood and conflated with other roles such as law enforcement.
- Supervisors need clear avenues to support and develop critical thinking about safety decision making with their staff.
- Focus on protection over needs and services doesn't provide sufficient data to assess safety for each family.
- The current system doesn't account for the personal challenges faced by CPS professionals such as their own trauma history or secondary trauma experienced when addressing circumstances involving physical and sexual abuse or domestic violence.
- Inadequate training and guidance around cultural differences and implicit bias leads to disparate service provision.

The right skill focus creates more qualified CPS professionals

The skills required to deliver quality Child Protective Services are extensive and center around complex human interactions. The development and honing of these skills requires education and training, practice, support, humility, and a willingness to learn and grow. These skills include:

- Assessing and determining an unsafe situation
- Interviewing and developing relationships with people from very young to elderly

- Making critical decisions about a family's situation related to safety planning
- Setting boundaries and navigating situations that involve secrecy and manipulation
- Facilitating difficult conversations
- Displaying confidence and ease with intimate and personal topics
- Writing and organizational skills
- Knowledge of germane laws, statutes, and processes
- Ability to navigate family, community, and government systems
- Recognition of their own cultural context and how it impacts perception and interpersonal dynamics
- The ability to respond coherently and meaningfully when encountering cultural differences

The skill sets and areas of expertise that we require of CPS professionals warrants support, respect, encouragement, and the allocation of sufficient resources.

Discoveries and advancements to integrate into the new single pathway system

CPS Professionals deserve our highest level of investment and support

In many ways, this tenet mirrors the first one. It is essential that any system reforms account for the human beings that accomplish this difficult, skill-based work. In order to build skill, confidence, and longevity in the field CPS professionals require—and have a right to expect—the support of the system in which they work. This support is realized through training, leadership, and supervisory support. The organizational support must be sufficient to accommodate the paradigm shift necessary to move from primarily information-gathering to assessing and interpreting information in order to make sound, defensible safety decisions.

Predict and prepare for a paradigm shift

Shifting the focus and response of the current single pathway system will change the questions asked and the strategies applied. This shift requires professionals at all levels of the agency to examine underlying assumptions about families as partners and what constitutes a thorough and effective CPS assessment. This is uncomfortable. It is not uncommon for social workers learning this new type of assessment to feel like they've lost direction, tools, and authority. Workers may ask, "How do I conduct these interviews?" and more importantly, "Will the kids be safe?" Naming this predictable reaction before it happens allows the state's child welfare system and its local CPS agency administrators to prepare a response plan that fosters open dialog within and between the local CPS agencies and state leadership. The response plan can include an action learning cycle that fosters each agency's ownership of and accountability to it's implementation

process building on lessons learned from the AR pilot and employing the organizational effectiveness and continuous quality improvement (CQI) structures already in place.

Robust safety planning

Safety planning in the reimagined single pathway system will be robust enough to do two essential things: recognize individualized safety plans and address egregious circumstances.

Best practice has shown us for a long time that individualized planning specific to each family's situation yields the best results. To achieve this, CPS professionals require the structure and permission to do the following:

- move away from "cookie-cutter" plans with similar elements such as parenting classes, substance abuse treatment, or mental health services, and;
- move towards a family-driven that includes new behavioral rules for the care of the children and involves a network of naturally occurring supports.

There are always going circumstances that are difficult to address and present significant challenges to a CPS professional's ability to assess, plan for, or monitor safety regardless of pathway or jurisdiction. For example, situations where:

- there is a maltreater exercising coercive control, as in domestic violence or sexual abuse;
- there is a high level of secrecy and isolation often associated with significant substance misuse, and;
- there are mental health concerns with a primary caregiver, or the behavior of a child/youth is beyond the ability of a parent to control.

Recognizing the warning signs in these situations and discerning the best intervention is difficult.

Wisconsin's Safety Model has proven that it can support both of these vital functions and specific details about strengths and opportunities to improve this critical area of CPS practice can be found in that chapter. What is crucial in the context of this tenet is the foreknowledge that changes in these two aspects of the child protection system will necessitate a paradigm shift.

Cultural competence- implicit bias awareness and training

Professionalism in the field of child protection includes the ability to examine and develop insight around biases, cultural lenses, and trauma history so individuals can be as effective in their roles as possible. CPS is difficult, vulnerable work. To fulfill the promise of the Wisconsin Child Welfare Model for Practice, state and

local CPS agency leaders must provide training, leadership, supervisory support, and clear guidance in standards to the workforce.

Untangling the child protection function from the law enforcement function

When CPS professionals focus explicitly on building networks of support around children, connecting parents with services to address their challenges, and creating safety plans that focus on behavioral changes, then they clearly establish themselves as child safety experts. This allows the role of investigating criminal behavior that harms children and women (or victim parents) to reside more clearly with law enforcement and the court system. Social services, law enforcement, and the court system are inexorably tied to one another. Distinguishing functions and defining roles make it clearer where the expertise exists increases authority, credibility, and trust throughout the local CPS system.

THINK TANK RECOMMENDATIONS

1. Provide the structure needed to support a one-pathway system that embraces the principles and tools utilized in the AR Pilot through training and resources on all levels (statewide administrators, local CPS agency directors, program managers, quality assurance, supervisors, and child welfare professionals) to elevate the components of the approach exemplified in the AR Pilot.
2. Define CPS practice for the workforce, families, and our community partners—because if we don't define it for them, they will define it for themselves, and this can lead to misconceptions.
3. Child welfare professionals require ongoing support and training to increase their emotional intelligence, support them in managing personal and professional bias, and teach them to recognize and address secondary trauma.
4. Supervisors must support CPS professionals in developing skillful use of authority as well as family engagement--which means the supervisors need support in developing and mentoring those skills as well.
5. A move toward professionalizing CPS means forging a new level of partnership with law enforcement and the germane court system. Child protection professionals are experts in the assessment of safety threats and establishing collaborative partnerships with families to plan for the mitigation of those threats. This is best accomplished by distancing duties that involve uncovering criminal activity, determining culpability, and/or assigning maltreatment decisions.

Tenet #5 All case decisions are directed towards child and family safety

All allegations of child abuse and neglect that are screened in and accepted for a CPS response receive a safety decision at the end of the IA process; regardless of the assessment pathway there is always a determination made that a child is either safe or unsafe.

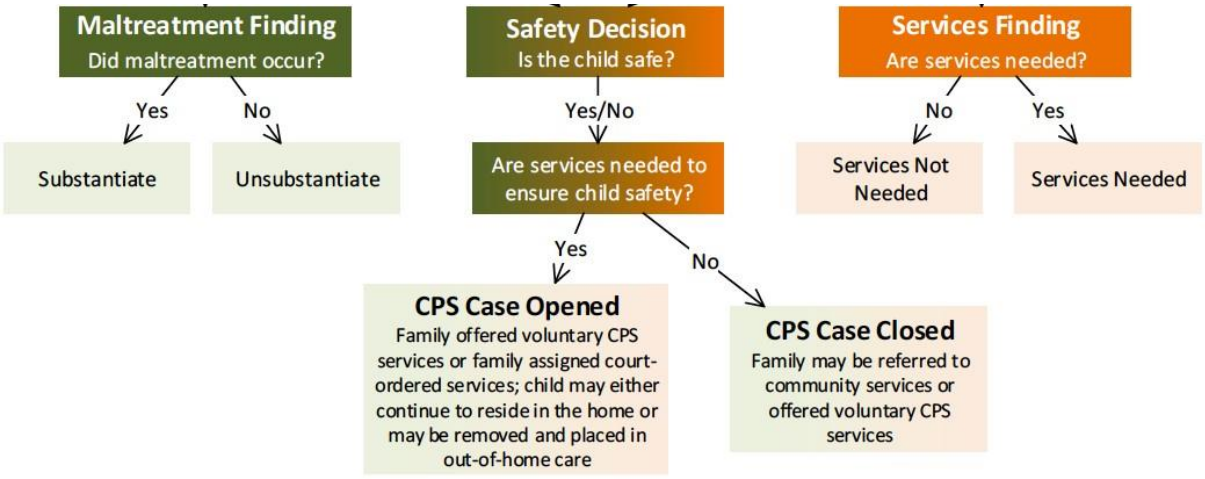
When the decision is reached that a child is unsafe, it is the role of the CPS system to intervene at the level required to establish and maintain safety. This is the decision point that determines whether we need to stay involved and why.

When circumstances within a family rise to the level that it becomes necessary to file a CHIPS (Child in Need of Protection or Services) petition with the court, it is important that the judicial authorities have the most accurate and comprehensive information available. This allows attorneys to give their clients sound advice and judges to ascertain if there is basis to grant the petition. This comes with a set of challenges due to a variety of systemic factors.

Identified Problems

- To communicate information effectively and to convey meaning, a term like substantiation needs to be applied consistently.
- There is broad variance between counties around the application of the substantiation finding. This creates a situation where two families with similar circumstances who come to the attention of CPS may have very different experiences depending on the county in which they reside.
- There is additional variance in the significance judicial authorities such as corporation counsel or district attorneys place on a substantiation.
- In some counties, it is hard to get a CHIPS petition through the court if there is no substantiation finding, even if the safety decision is that the child is unsafe, while other local court systems have successfully worked with families in the alternative CPS response pathway where no substantiation exists.
- This inconsistency means that a substantiation determination actually does little to communicate clear, actionable information to the judicial system.

The difference is in the finding.



In a two-pathway system, the traditional maltreatment determination remains in place on the investigatory track, while within the alternative CPS response the finding is either services needed or not needed. If the goal of CPS is to make a thorough assessment of a family situation to determine if a child is in need of protection or services and that is accomplished via the safety decision, what is the purpose of a maltreatment finding?

Broadly speaking it is used to fill three functions:

1. To communicate information to judicial authorities within the local court system;
2. To protect children both in the family and the public who might be harmed by a maltreater of abuse or neglect, and;
3. To hold an individual who is guilty of abuse or neglect of a child accountable.

The problem is- the maltreatment determination doesn't do any of these things effectively or equitably.

Communicating critical information to the court system

All screened-in reports of child abuse or neglect involving a caregiver result in a safety decision. The addition of a maltreatment finding is not necessary to provide protection or services, or to establish safety. The comprehensive information gathered in IA and the analysis of available protective capacity to mitigate identified danger threats is more relevant to establish legal basis for a CHIPS petition.

Individual accountability protects children in the family and in the community

The types of abuse that are most harmful to children such as sexual abuse are also the circumstances when substantiated maltreatment findings are most likely to be appealed and overturned

based on the state's initial analysis of CPS appeals data. Keeping the focus on the experience and safety of the child and the caregiver's ability to protect and safely care for the child(ren) produces stronger safety plans that directly address the behavior of the maltreater. These decisions and actions related to child safety and caregiver ability to protect and safely care for the child(ren) are not predicated upon and may not even be related to the maltreatment/ maltreater determination.

THINK TANK RECOMMENDATIONS

The Think Tank asks the CPS system to reimagine the utilization of case decisions as being primarily for the child. This will serve as a means of validating an experience in the child's life and establishing our presence with the family while there are unmitigated safety threats. This can be accomplished by:

1. Replicating the gains of the AR pilot in a one-pathway system by making changes in the current case decision structure when it comes to the safety findings;
2. Recognize the state and national findings from alternative response implementation that consistently indicate children are equally safe on both pathways, eliminating or substantially changing the maltreatment finding, and aligning practice more closely with Wisconsin's Child Welfare Model for Practice, and;
3. Establish the professionalization of child welfare by clearly aligning the role of CPS professionals on identifying, assessing, responding to child abuse and neglect, and planning for safety.

CPS professionals are the appointed experts on child safety, the gatekeepers between what they determine are the protection and services needed for the well-being of the children and the larger system created to enact those judgments.

The recommendation is to establish a single-pathway system that:

1. Encourages, teaches, and requires these professionals to broadly assess the overall functioning of the family and bring that quality information forward to the court.
2. Makes room for partners in the legal and law enforcement arenas to focus fully on their area of expertise, responsibility, and authority
3. Recognizes that while maltreatment determinations may be required by statutes (s. 48.981(3)(c)4), the utility of the determination has little to do with protecting children, assuring accountability, or persecuting wrongdoing.

The Five Core Tenets represent the effort to synthesis the lessons learned over the ten-year pilot process and turn them into actionable insights. In addition, the Think Tank synthesized much of what has been learned over this same period of time about the Wisconsin Safety Model.

Wisconsin's Safety Model and Child Welfare Model for Practice

The Wisconsin Safety Model

A comprehensive solution that supports critical decision making

Wisconsin's Safety Model proved itself to be healthy and flexible enough to sustain rigorous CPS practice through both the traditional and alternative CPS responses.

> A child is determined to be safe not because there are no danger threats but because the "family has sufficient protective capacities to protect the child and manage the threat."

Safety decisions were equally valid in both pathways and were in no way diminished by the differences in the two approaches. The key assertions we are making with this conclusion are:

- Counties had the opportunity to apply Wisconsin's Safety Model without the allegations driving the assessment and the need to establish a maltreatment determination at the close of the IA. The model contained all the key elements required for both pathways to be successful at establishing child safety.
- Safety is established by using the parental protective capacity (PPC), natural supports, and professional and community services to mitigate danger threats. CPS professionals emphasized these elements earlier in their contact with the family when using the AR pathway.
- Strengthening Wisconsin's Safety Model to assess PPC capacity earlier in the life of a case puts the model in the forefront and gives the child welfare workforce explicit permission to engage and partner with families.
- The AR Pilot demonstrated that the Wisconsin Safety Model applied in a reimagined single pathway system has all the pieces needed to create the desired shift in practice. It also revealed areas that need to be added, clarified, or strengthened. These include improving the continuity between IA and Ongoing Services, strengthening the guidance for safety planning, and determining how the system will define and respond to risk.

Give the Wisconsin Safety Model Top Billing

In the traditional investigative CPS response, the information-gathering at Access and during IA is driven by a maltreatment allegation at the front end and a

substantiation decision at the point of case disposition. As a result, the emphasis is on the investigation of an allegation, making a family assessment and the application of the Wisconsin Safety Model secondary.

The standard for information gathering outlined in the Wisconsin Safety Model is the same on either track; the difference is the focus on the past allegation versus future safety. There was never a different expectation regarding what information needed to be collected. What the AR Policy Addendum did was allow CPS professionals to collect information in different ways and to work collaboratively with families. When working with families in an investigatory pathway, CPS professionals are given implicit permission to not engage with families and to be the sole decision-maker. It is counter-intuitive, but we actually push ourselves into a weaker position by overusing authority because we create a battle of wills between the family and the professional--and thus create a lack of trust. By balancing the skillful application of statutory authority with a more prominent use of engagement strategies, CPS professionals are able to gather more robust information about families.

In the re-imagined single pathway system proposed by the Think Tank, the Wisconsin Safety Model would drive the process. In all cases, the model directs CPS professionals to identify danger threats. The model also provides guidance about how to mitigate danger threats whenever possible through discovery and strengthening of parental protective capacity. This is how safety is established.

The introduction of the AR pathway resulted in a more robust realization of the safety model by emphasizing comprehensive information gathering that improved the ability of the CPS professional responsible for IA to assess the family situation including strengths, needs, and existing protective capacity.

Safety Planning and Ongoing Services

The WI Safety Model includes information about the assessment of PPC in Ongoing Services, but the ongoing case management workforce has not received the support necessary to incorporate parental protective capacity into their practice. The AR Pilot gave counties an opportunity to have a different awareness of protective capacity throughout the system beginning at Access and throughout IA with the types and scope of questions asked to guide IA pathway assignment, IA CPS professionals approached families using more sophisticated engagement strategies. In a single IA pathway system that maintains these positive changes into and through ongoing case management services, all casework interventions would include a balanced assessment of overall family functioning.

The need to ensure children are safe and whenever possible maintained in their homes is non-negotiable. How needs and danger threats are addressed can and must be negotiated as part of a collaborative safety-planning process with the family. Ideally, safety plans and case plans are co-created with families instead of

being “done” to them. This means that information-gathering and decision-making is a shared responsibility between CPS and the family, and the limits and expectations about how decisions will be made is openly discussed throughout the CPS intervention.

This is done by engaging families through relationship-building and the skillful use of authority. It is not a “feel good” approach, it is a rigorous and detailed exploration that allows the CPS professional to partner with families and establish common goals concerning child safety, well-being, and permanency. Engagement and collaboration with families during IA lays a foundation for Ongoing Services to build upon.

CPS professionals Ongoing Services can then use the information gathered during the IA process and build on the relationship already developed with the family to tailor continued in-home or permanency plans that build on strengths and protective capacities and meet the family’s needs.

Child Safety Comes First

The assessment of child safety is always paramount, but the change in focus from investigating an allegation to assessing family strengths and needs relative to child safety does more than improve family engagement--it strengthens safety planning. Classroom and web-based training, technical assistance, webinars, conferences, and other professional development opportunities offer new tools and strategies for working collaboratively with families.

The AR Policy Addendum gave CPS professionals permission to work with families in a different way. The change in policy removed the bookends of allegation and substantiation and thereby shifted the perception of CPS away from adversary and towards partner. Information gathered in IA within an alternative CPS response points to services that are needed and allows the CPS professional to put those in place as quickly as possible.

Family engagement leads to better information and safety decisions. If a child is unsafe, they are unsafe in either pathway. While all of this is true, it doesn’t address those situations where, in addition to lack of cooperation, there may be significant danger threats present in a family.

This Think Tank recommends that DCF closely examine family situations currently handled through an investigation and determine what CPS professionals need to know or be able to do to effectively assess family functioning and create meaningful safety plans in those circumstances. For example, in cases of denied child abuse, safety can be achieved without an admission of wrongdoing because the focus is on a change in behavior or the care of the child instead of with compliance with services. Pushing for admission puts our focus on culpability, which often distracts from creating and executing an effective safety plan. On the other hand, there is a need for

stronger guidance, even for the addition of a new danger threat definition that addresses situations where there is a maltreater exercising coercion, power and control, and/or there are high levels of secrecy or family isolation.

The Wisconsin Safety Model has all the elements necessary but there needs to be an increased focus on critical thinking about safety planning centered on the care and protection of the child. That includes safety networks, the protective parents, holding a perpetuating caregiver accountable for their decisions, and providing information about agency bottom lines so that what is required to ensure safety is achieved is understood by everyone.

Clarify how the child welfare system will attend to 'risk'

Risk exists on a continuum and can present to the child welfare system in multiple ways. First, at the front end of the child welfare system via the receipt of an Access report. In these cases, if there is not maltreatment or threatened maltreatment to a child, the case is screened-out. Local CPS agencies do have the ability to serve families with risk, identified as service needs, through a Services Report. However, this varies greatly from county to county and is not required in standards.

Next, risk can present at the conclusion of the IA. In these cases, there is an allegation of maltreatment or threatened maltreatment that gave CPS the authority to screen-in the report and assess the family. During the IA, sufficient information was gathered, and the safety assessment concluded with no identified danger threats; however, information does support risk that, if unattended, could result in the development of danger threats in the future. Options for these cases are less clear and CPS professionals are often frustrated because they do not have a clear avenue to provide services or protection

Currently, the Wisconsin Safety Model does not attend to risk, nor does our child welfare system use formal risk assessments. As a result, many CPS professionals confuse risk and safety (danger threats). Furthermore, they do not know what to do with risk cases that do not have identified danger threats.

We have learned that counties used AR pathway as a way to address risk with families during the IA because AR gave them the authority to knock on the family's door and engage with them in a different, more collaborative way. Consequently, if you create healthier family engagement, you are more likely to learn things about the dynamics that suggest higher risk. Uncovering more information about risk may force a danger threat when there isn't one there because CPS professionals feel an obligation to continue serving the family. Clarifying how risk is addressed within the Wisconsin Safety Model structure could eliminate this 'false positive' by providing more legitimate options for service and support to the family.

THINK TANK RECOMMENDATIONS

1. Incorporate information gathering and assessment of parental protective capacities into Access and IA, as well as into Ongoing Services.
2. Assess parental protective capacities during the IA process and incorporate information about diminished and enhanced protective capacities into the initial safety assessment. This will better position professionals to collaborate with the family and quickly develop goals and case plans centered around behavioral change and the elimination of danger threats. It also will provide a more grounded and consistent experience for families, which creates trust and a more positive worker/family relationship.
3. Define the role of Ongoing Services regarding continued engagement and information gathering with families and implement the changes in the Ongoing Services Standards where necessary in order to promote the same level of engagement.
4. Develop a robust safety assessment and safety plan that includes the assessment of parental protective capacities from the IA to support case planning in Ongoing Services.
5. Consult with child safety experts to determine what existing tools are available to provide clear structure to the safety planning process.

Organizational alignment:

1. Make changes to eWiSACWIS to give priority to documenting information related to the safety assessment and safety decision-making by:
    a. Modifying the Safety Assessment and Safety Analysis and Plan documents to support information-gathering and decision-making that includes the assessment of PPC.
    b. Modify the Safety Assessment Safety Analysis and Plan documents to better support documentation regarding how CPS professionals in Ongoing Services can work with families to enhance PPC to support changes that eliminate danger threats.
2. Remove language about “Parental Protective Capacities” from the Access report and replace with language about “family strengths and stressors.”
3. Assess where documentation of PPC should be added in the eWiSACWIS case record to support information gathering and case decision-making.

The Wisconsin Child Welfare Model for Practice

The GPS for System Reform

The Child Welfare Model for Practice was developed by Wisconsin's County Human Services Association to guide and support the entire service array, from Access and IA into Ongoing Services, Permanency Planning, and Reunification.

The Child Welfare Model for Practice and the elements it includes developed as a direct result of the dedication the Bureau of Safety and Well-Being (BSWB) and the pilot counties have demonstrated during the implementation of the AR Pilot and other important initiatives. The devotion to open communication between the state and implementing counties set the stage for success, and it can be utilized as a guidance system for reforms suggested by the Think Tank as well as other elements of the state's strategic planning efforts to better serve children in their family homes.

Key assertions for this conclusion:

- The workforce increased their skills and knowledge through the implementation of an alternative CPS response because it required them to rethink the approach taken with families and to include comprehensive information gathering about both danger and protective capacity. The Child Welfare Model for Practice provides a map to similar opportunities for growth that are offered statewide.
- When there is an unsafe finding that is not accompanied by a substantiation or a CHIPS petition, it can be tough to serve the family in Ongoing Services. This is an area where whole system perspective will help strengthen the way in which we assert the jurisdiction to serve and protect children and families; even where there isn't the presence of court authority.
- The move to an expanded skillset and the paradigm shift required to navigate the system changes led to a higher level of collaboration with Wisconsin Child Welfare Professional Development System. This collaboration needs to continue in order to scale a reimagined single pathway system statewide.
- System change is easier to accomplish when there is an established standard to provide guidance and to act as a checks and balance, thus allowing leaders to assess recommendations for change against the Child Welfare Model for Practice and ask, "Is this action in alignment with the standards we have set for ourselves?."
- In order to fulfill the promise of the Think Tank recommendations and the Model for Practice state leaders have a responsibility to the counties to commit to organizational alignment so that the system is able to support the work CPS professionals are being asked to do.

Lessons from the AR Pilot

- Refocus the CPS workforce on skill development for both engaging families and asserting knowledge, trustworthiness, and authority
- Standards, statutes, and the Wisconsin Safety Model have the pieces neccesary for promoting family engagement while maintaining authority, but CPS professionals need the tools, permission, supervision, agency buy-in, and alignment so that they can be successful.
- The AR Pilot showed that CPS professionals were able to successfully engage and empower families to collaborate on solutions for providing safety and managing their responsibilities. Supervisory guidance and agency leadership are critical in order to support the workforce through the shift.

Improve the connection between IA and Ongoing Services

When CPS professionals are working with a family and there is an unsafe finding, it is our responsibility to respond. The focus on service provision within an alternative CPS pathway allows workers to address concerns early in the intervention. Both the CPS professional and the family are identifying needs to be addressed through support and services throughout the assessment period.

However, there are always going to be situations in which families need more time and resources than can be provided during the IA period. Whether there is court involvement or not, if we have identified that a family needs support and services, we are obligated to remain involved until safety has been established.

Currently, there is very little structure that outlines ideal actions and responsibilities once a family transfers to ongoing services. The case plan documentation and process doesn't link well from IA to Ongoing where there are different documentation requirements and focus in each area of practice, making the transfer disjointed and difficult to coordinate--particularly with a family where services are the primary focus.

This challenge needs to be addressed, beginning with the recognition that when families are transferred into Ongoing Services, those professionals need the same level of guidance, structure, timeline parameters, and opportunities for skill development that were provided to Access and IA through the AR pilot.

These added supports will strengthen the ability of professionals providing ongoing case management services in every stage of the system to address the continuous assessment of safety, as well as provide rigorous planning to make the changes needed in the everyday care of the children.

Ideas for advancement in Ongoing Services

1. Incorporate parental protective capacities into information gathering, safety assessment decision-making, and in case planning.
2. Clarify the purpose of PPC at Access, IA, and Ongoing.
3. Gather information to understand how PPC and other models of practice such as Signs of Safety incorporate family strengths into rigorous safety planning.
4. Incorporate and clarify information about the utilization of PPC into standards for Access, IA, Ongoing Services, and other safety intervention responsibilities.
5. Make changes to eWiSACWIS to support the identification and documentation of PPC.
6. Re-evaluate/establish the role the court system plays in the CPS helping process.

Utilizing the kind of collaborative approach described above is less court dependent but does not mean that court involvement is eliminated, so we also have to attend to collaboration with the legal system. One of the predictors for pathway switching in the AR Pilot was a perceived lack of cooperation on the part of the family. The ability to maintain engagement and transparency with families comes in part through the knowledge that we always maintain our statutory authority. We are responsible as a system to address issues of child safety with or without a substantiation. This is where it is critically important to assert our own area of expertise which is child safety.

Even extremely skilled workers will encounter families that refuse to participate voluntarily, but we still have statutory authority and mandate to address conditions that are causing a child to be unsafe. No matter where it occurs in the life of the case, if we are unable to facilitate the level of behavioral change needed to establish safety, we are obligated to draw on other parts of the system--specifically the court.

Safety decisions are separate from a finding of maltreatment or substantiation. Once they have exhausted options for leveraging engagement with their skillful use of authority, CPS professionals may require a CHIPS petition to increase the ability to compel cooperation. The child protection system holds expertise on child safety, and the court holds expertise on due process. There may need to be a change in case type definitions as well in the maltreatment determination to establish a consistent and clear conduit between the two.

Alignment within the organizational systems

Child Protective Services is a complex system, and within that system, there are many forces that drive the work; often invisibly. Wherever possible, operations, procedures,

and structures should be aligned with and pointing in the direction of the values and goals of the organization as stated in the Child Welfare Model for Practice

This alignment and guidance create explicit and implicit expectations for high-quality performance. This includes attention to big details such as analyzing workloads in order to allocate resources effectively and looking at what we are measuring to ensure continuous quality improvement. It also includes attention to the smaller details such as the order and prominence that is given to a particular type of information in our documentation, or the language we are using to describe that information.

The following are examples of the systemic alignment needed to achieve desired performance and outcomes:

Our Focus and Language Drive Our Work

One of the outcomes from the AR Pilot that is difficult to measure but critical to its success is the change in how CPS professionals talk about and think about the families with whom they are working. The lexicon throughout the system should be clear and consistent so that when terms are used it is clear what is meant throughout our own system, as well as with our professional partners and family members.

The focus also needs to move from a myopic, protection-heavy approach. It is vital to establish a more encompassing approach that helps CPS professionals understand the possibility of establishing safety when we prioritize service without shirking protection.

Prior to the impact seen in the AR pilot, the focus on protection has been an invisible driver that can get in the way of determining if there is a danger threat--and how it can be mitigated through strengthened PPC and services. In a reimagined single-pathway system, the language and guidance will have to be clear throughout the process.

Some specific opportunities to improve clarity include:

1. Refine and connect language between statutes and standards regarding child safety in order to support how CPS professionals serve families. This would happen at the conclusion of the IA and during Ongoing Services, with or without formal court orders.
2. Align the language in the Safety Intervention Standards to clearly put the focus on safety and not on an incident.
3. Eliminate or further delineate use of Service Reports and increase clarity and confidence to screen out CPS reports where there is no maltreatment involved.

Operations and Procedures

When the system is out of alignment everyone is swimming upstream; it is hard to make progress and advances made are impossible to sustain. DCF and local CPS agencies have to resource priority areas, especially related to human capacity. The requirements set out in a reimagined single pathway system must be humanly possible and flexible to align with local CPS agency resources. The state system must hold reasonable expectations of what the individuals and local CPS agency jurisdictions can accomplish, considering caseloads, county size, and availability of local resources.

What we measure matters, and the data CPS professionals and local CPS agencies are held accountable to drive the focus of their work. We can't determine the quality of work if we don't accurately track the professional workload and the time CPS professionals have with each family. One theme that appeared consistently throughout the Think Tank work was the need to reduce redundancies and inefficiencies to streamline the CPS casework process. This would optimize the workload and allow more time to engage and work with families. Additionally, these changes will help to mitigate worker burnout, and improve the quality of their interactions with families

Some specific recommendations to increase alignment:

Standards need to reflect the guidance in the Wisconsin Safety Model and fully detail the priorities of the Child Welfare Model for Practice.

1. Revise standards to limit prescriptive language as follows:
    a. Eliminate the perception that the order of interview in standards is more than a guideline, it is seen as a directive in an investigatory response.
    b. The order in which eWiSACWIS is prompting the documentation of information is driving practice; order the primary access report differently.
    c. Revise and update response time categories to catch up with evolved thinking about likely and impending danger.
2. Continuous quality improvement and alignment of standards, policy guidance, and job aides. These should all align and support the operation of the Model for Practice. Match the language in all materials with values that provide clear guidance without being prescriptive.

FINAL THOUGHTS FROM THE THINK TANK

Attention to The Phasing Out of the Alternative Response Pilot

Careful attention must also be paid to how the AR policy is phased out, and how both the simplicity and the complexity of system reform is communicated. This Think Tank conclusion is going to surprise, as well as disappoint many counties, both those that are already implementing AR and those that hoped to do so. To mitigate any confusion in the transition, responsibilities must include:

- Clearly communicating how the Think Tank arrived at its conclusion.
- Clearly communicating the benefits and positive impact the optimized system will have on families and CPS workers.
- Acknowledgement of the need to support the counties in the transition away from AR and and return to a reimagined single pathway IA approach.
- Continue to model open communication and parallel process with counties by both providing guidance and receiving feedback when planning the best way to implement the transition from AR to a reimagined single pathway IA approach.
- Engagement with all the key stakeholders in participatory discussions about how to engage and scale the tenets towards statewide reform

A Reimagined Single-Pathway Response Requires Transformation

Transformation Requires a Catalyst for Change

Transformation occurs when an experience, a new level of insight or an incongruous interpretation of information causes us to reexamine our beliefs or frames of reference. Transformation initiates changes in our thoughts, feelings, decision-making and behaviors or actions; it is uncomfortable. Neither individuals nor systems experience a transformational shift without a catalyst.

We have examined and illustrated the impacts of implementing an alternative CPS response and the positive effects that result. This starts by shifting our assessment of families and the safety of their children from an incident focus to a more comprehensive look at functioning. It is a change that is transformative.

Transformation occurs in response to a stimulus

In this report we outlined the key changes that have occurred and offered examples of changes that are recommended in all of the areas. Reimagining the current system as a single pathway must include a significant change to the structure of the whole. If you approach the changes a little at a time without enacting a substantial element to force people and agencies to examine current practices, the significance will be diminished.

The AR Pilot has been the impetus for a transformational shift in thinking about child protection and we will explore in detail some of the often- surprising ways this influences the system. But if Wisconsin wants to replicate and sustain the important gains described here, we have to set the context of what causes transformation.

Transformation requires a catalyst for change- the Wisconsin Safety Model and Child Welfare Model for Practice will hold the transformation, but the transformation will not come without a significant challenge to current practice

It is not enough to pay lip service to the advances made by the AR Pilot and expect those changes to translate into a reimagined single-pathway system without significant alterations within the system. Without the concept of evolution and optimization, nothing will change, and the system will settle back into business as usual.

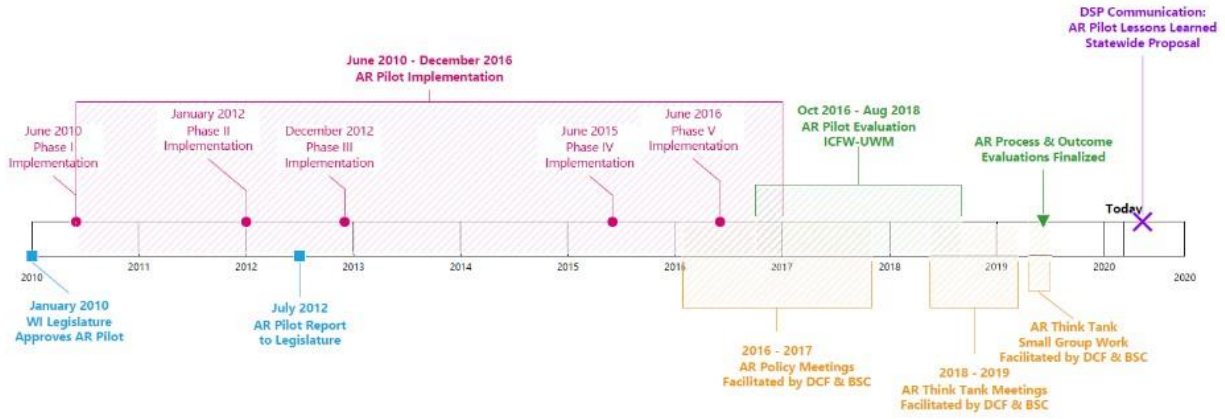
The innovative conclusion reached by the Think Tank

The overarching conclusion of this entire report is the determination that Wisconsin's families will be best served through a reimagined single pathway CPS response**.** The culmination of the deep research of the Think Tank has shown that, rather than adopting Alternative Response as it has been constructed in other state projects, the way to scale a just, equitable, transparent and compassionate CPS response statewide is to create a system that is unique and innovative. This is achieved by incorporating the key advancements from the AR Pilot into a restructured, reimagined, single-IA response within the state's CPS system.

ABOUT THE THINK TANK

The Think Tank was formed in early 2018 and concluded in late 2019. The meetings over this period used the critical thinking and planning that AR pilot counties have already accomplished and elevated it to the next level by including research and evaluation, training and safety model expertise, CQI, and consultants in the discussion.

Members of the AR Think Tank collaborated to think deeply about the cultural, practice, and policy changes that resulted from the AR pilot in the 22 counties that implemented the program. The Think Tank was facilitated by Blue Spiral Consulting (BSC), who were uniquely positioned to support the process due to years of experience with child welfare in jurisdictions across the country, intense involvement in Wisconsin's AR pilot project, and a deep background in designing and facilitating group processes.



Acknowledgments

Blue Spiral Consulting would like to thank the individuals who contributed their time, energy, ideas, knowledge, experience, passion, and creativity to the think tank process. It was challenging and frustrating at times but your commitment to the families and communities of Wisconsin and the CPS professionals from the local CPS agencies who serve them never wavered. It was a privilege to facilitate this process with you.

This group made every effort to further and honor the innovative and courageous work of all the counties who expressed their readiness to pilot AR in their communities. The CPS professionals, supervisors, managers and directors that took up the challenge and not only rethought their approach to partnering with families to improve child safety but also invested their time and energy to attend

training, webinars, AR Policy meetings, and conferences. We hope you see your contributions reflected in this document.

Finally, the Think Tank Committee would like to join Blue Spiral Consulting to thank all the hard-working, deep thinking social workers, supervisors, county, and state staff who are dedicated to making life better for families. The AR Pilot was codified in 2010 as a result of a push by county directors to strengthen CPS practice, , increase family engagement, improve child and family outcomes, and decrease out of home care. Leading up to that decision and continuing today, innovative work is occurring all over the state within the pilot program and other initiatives. The work of the AR Policy Think Tank would not be possible without the commitment to growth and the advances made in social work practice across the state. The following individuals, in their respective roles at that time, comprised the Think Tank:

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Appendix One: References

AR Policy Storycorp Project [Personal interviews conducted with frontline and supervisory staff]. (2017, November).

Child Protective Services Alternative Response Pilot Program, WI State Legislature § Addendum to the Child Protective Services Access and Initial Assessment Standards: Program Requirements and Guidelines (2010).

Child Welfare Information Gateway. (2014). Differential response to reports of child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Casey Family Programs. (2014). The differential response (DR) implementation resource kit: A resource for jurisdictions considering or planning for DR. Retrieved from the Kempe Center website: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/ pediatrics/subs/can/DR/Documents/Differential%20Response%20%28DR%29%20Implementation%20 Resource%20Kit--May%202014%5B1%5D.pdf

Dalton, J. (2017, July 02). What Is Insight? The 5 Principles of Insight Definition. Retrieved August 31, 2020, from https://thrivethinking.com/2016/03/28/what-is-insight-definition/

Differential Response Approach in Child Protective Services: An Analysis of State Legislative Provisions. Prepared by the National Quality Improvement Center on Differential Response in Child Protection Services for The National Conference of State Legislatures, 2015.

Guterman, K., Solarte, K., & Myslewicz, M. (2014). The Differential Response Resource Kit: A resource for jurisdictions considering or planning for DR (Rep.). Casey Family Programs.

National Quality Improvement Center on Differential Response in Child Protective Services. (2014). Final report: QIC-DR cross-site evaluation. Available from:

www.differentialresponseqic.org.

Siegel, G. L., Ph.D. (2012). *Lessons from the Beginning of Differential Response: Why it Works and When it Doesn't*. Manuscript submitted for publication, Institute of Applied Research, St Louis, Missouri.

University of Wisconsin, Milwaukee Helen Bader School of Social Welfare Institute for Child and Family Well-Being (2019) *Wisconsin Alternative Response Evaluation Interim Report*

University of Wisconsin, Milwaukee Helen Bader School of Social Welfare Institute for Child and Family Well-Being (2019) *Wisconsin Alternative Response Evaluation Outcome Report*

Zimmerman M. A. (2013). Resiliency theory: a strengths-based approach to research and practice for adolescent health. *Health education & behavior : the official publication of the Society for Public Health Education*, *40*(4), 381–383. https://doi.org/10.1177/1090198113493782

Appendix Two: Memorandum from the Think Tank workgroups