June 2010

Research and Evaluation Services Contract: Child Welfare Practice & Services

The Northeast and Caribbean Implementation Center (NCIC), in partnership with the Connecticut Department of Children and Families (DCF) seeks to contract with an established research organization for the purchase of research and evaluation services, in support of two key objectives:

> a) define and implement outcome and process measures for selected child welfare services as a precursor to their implementation in DCF's Programs and Services Data Collection and Reporting System; and
> b) design and implement a pragmatic evaluation of the new model for Child Welfare Supervision, a key component of DCF's Child Welfare Practice Model initiative and Program Improvement Plan. (See Appendix B for a description of the Practice Model.)

These services will be funded by contract with the Northeast and Caribbean Implementation Center at the University of Southern Maine's Muskie School of Public Service. CT DCF personnel will provide scope of work, guidance and assessment supervision. There will be a matrix reporting relationship to the Director of the DCF Office for Research and Evaluation, Hartford, CT and a TBN Practice Model Implementation project manager. NCIC will also play a role in the oversight of the work conducted for this project.

The Northeast and Caribbean Implementation Center (NCIC) is one of five Child Welfare Technical Assistance Implementation Centers established by the Children's Bureau in October 2008. The NCIC supports and facilitates communication and networking across public child welfare systems and provides resources to support intensive implementation projects that improve the quality and effectiveness of child welfare services for children, youth and families.

Scope of Work

A. <u>Programs and Services Data Collection and Reporting System</u>

DCF has recently implemented a client-level, web-based information system, the Programs and Services Data Collection and Reporting System, to collect process and outcomes data about clients enrolled in DCF contracted services. PSDCRS is operational for multiple Behavioral Health services/programs as of July 1, 2009 and several Child Welfare services/programs as of July 2010 for which program data modeling has been completed.

There are 4 additional Child Welfare programs identified for a January 2011 implementation. Completion of the work to support implementation will require collaboration with DCF program personnel, provider program personnel, the DCF PSDCRS contract manager, the PSDCRS

technology vendor and the NCIC State Liaison to develop conceptual and operationalized program models for selected child welfare services, including:

- Developing draft conceptual program models using logic model techniques
    - Incorporate Practice Model elements relating to program provision
    - Identify gaps, e.g. lack of proximate outcomes, lack of necessary curricula or resources with necessary training to achieve outcomes
- Conducting Review Sessions with all appropriate Stakeholders
- Reviewing data specifications for current PSDCRS programs, abiding by already-established measurement principles for common data items
- Developing operationalized program models with solutions to identified gaps, e.g. measurement instruments

B. Supervision Model Evaluation

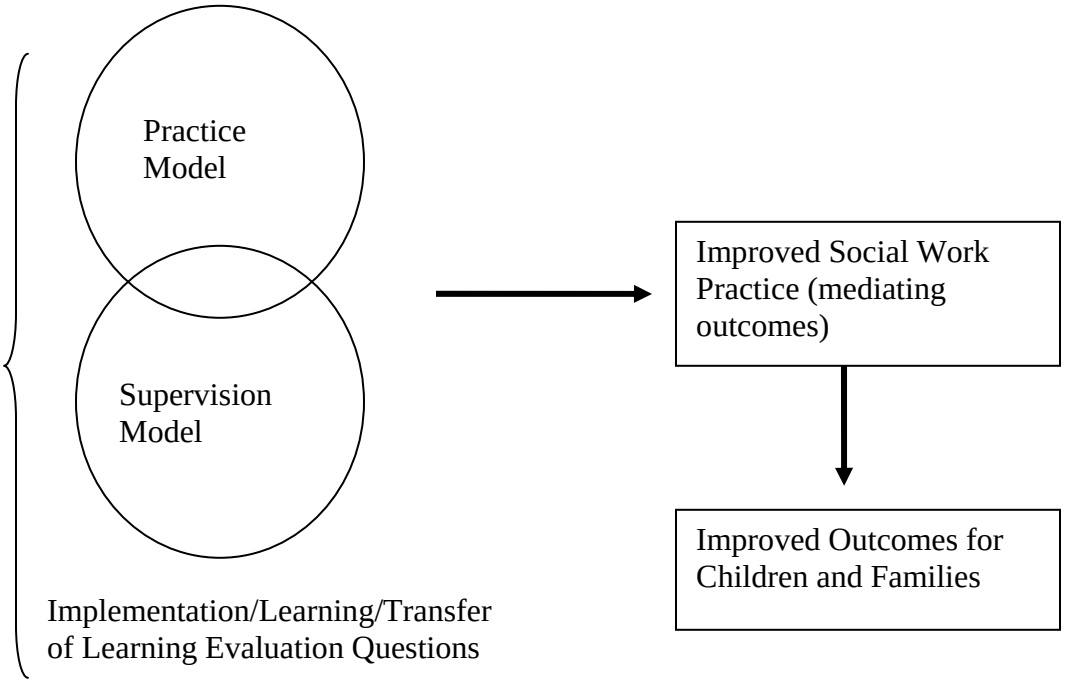
A key component of Connecticut's Program Improvement Plan (PIP) is the implementation of a comprehensive Practice Model (PM) covering all aspects of the delivery of social work services to children and families served by the child welfare system. Social Work Supervision practice is central to ensuring fidelity to the Practice Model. The Practice Model and Supervision Model (SM) will be implemented on a rolling basis with respect to time and geography, beginning with the Bridgeport Region. Therefore, the implementation strategy will allow comparison between PM/SM "treatment" and no-treatment sites (i.e. natural quasi-experiment).

The NCIC is providing budgetary support to evaluate the Supervision Model.

The principal objective of this work will be to design and implement a meaningful and pragmatic evaluation of the Supervision Model with appropriate reference to the Practice Model, based on the high level causal model below (Figure 1). This work includes (but is not limited to):

- Developing an evaluation design based on available resources
- Identifying key respondents
- Developing evaluation instruments
- Determining instrument administration
- Determining data collection approach
- Analyzing data and summarizing findings

Figure 1



Qualifying Knowledge & Experience

NCIC and DCF are soliciting proposals from established research entities with access to necessary research infrastructures and resources. We will consider applications from individual researchers to the extent that such individuals can demonstrate such access, e.g. online university library holdings. Affiliation with an academic institution is allowed, but not required. The amount of the budget to be allocated to indirect costs is capped at 13.4%. Researchers with knowledge of child welfare systems and federal regulatory structures and measures are preferred. Researchers with program evaluation experience, particularly in the CT state government setting, are preferred. An approach wherein this work is conducted for an academic qualifications (e.g. dissertation) project, with demonstrated strong qualified faculty oversight, would be considered.

Available Resources

Budget

The allocated budget is up to $156,875 distributed across three years. This is inclusive of direct and indirect costs.

	Year 1	Year 2	Year 3	Total
Evaluation	31,375	62,750	62,750	156,875

DCF Research and Evaluation Support Structures

Practice Model information: Documents describing the Program Improvement Plan, and the Practice model are available. Information concerning the rollout of the PM will be made available. See **Appendix B** herein.

PSDCRS information: Meta-data documentation for programs that are already implemented on PSDCRS is available. This includes a full data dictionary and data definitions. These are available at: https://psdcrs.csando.net/live/Documentation.aspx

PSDCRS Program modeling resources and personnel: To support previous program implementations, DCF has created a "program modeling template". This is provided in **Appendix A**. Additionally "program lead" personnel with substantive knowledge of programs and responsibility for program oversight will be available and necessary to data definition activities.

CT DCF Supervisory Practice Model Implementation Project Logic Model (**Appendix D**): This Appendix is the logic model and shows some of the integration between the PSDCRS project and the Practice Model/Supervisory Model Initiatives. Refining the logic model as this work evolves is within the scope of this evaluation services contract.

DCF Research Support Resources: Staff within the Division of Planning and Best Practices can be made available to help support evaluation activities such as organizing focus groups, recruiting participants, formatting surveys.

Federal outcome measures modeled with DCF data using federal standards: To compare child and family outcomes in the treatment site compared to the no treatment/wait list site, already constructed measures used by the federal government are available. (Whether these measures will be integrated into the Supervision Model evaluation is TBD.)

DCF Institutional Review Board: DCF requires that studies involving human subjects - DCF staff and clients - are reviewed by its IRB. There is a standard application form and process available through DCF's public-facing Internet site.

Application Process

Application Content:

Since this initiative is not funded through the State of Connecticut, Connecticut competitive RFP standards are not being required. Nevertheless we are seeking information as defined below in order to choose the best qualified applicant. The application narrative should be 8-10 pages. Appendices are allowed.

- Organizational Qualifications - identify access to research resources

- Key Personnel and their Qualifications

- High level workplan/timeline consistent with the project's needs. See the Year 1 timeline through September 2010 attached herein as **Appendix C**

- Proposed Budget and Budget Allocation (note a travel budget of ~$2,200 total is provided in a separate line item)

- Expected Challenges

Application Dates:

Non-binding Letter of Intent: June 25, 2010

Final Application Due: July 23, 2010

We anticipate making the contract selection by mid-August.

References:

Provide 3 reference letters related to previous research/evaluation projects. Referees should address the following:

- Nature of the evaluation project
- Scope of evaluation activities provided by the applicant (for example, did the applicant develop research collection instruments, conduct focus groups, transcribe focus group recordings etc)
- Timeframe over which the evaluation project was conducted
- Type of evaluation personnel brought to the project by the applicant and their roles (e.g. Research Assistants)

Submission Address:

Please address your letters of intent and applications to:

Joan E. Twiggs, PhD
Director, Office for Research and Evaluation
Bureau of Continuous Quality Improvement - 9th Floor
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Address your questions to Dr. Twiggs:
Email: jtwiggs@ct.gov
Phone: 860-560-5091

Appendix A: Program Modeling Template

Making Data Meaningful: Program Specification through Logic Modeling

- critical step to preparing for the PSDCRS (Programs and Services Data Collection and Reporting System)

Steps to Program Definition and Understanding

Phase 1: Program Definition/Specification

Step #	Program Dimension	Question	Your Thoughts
Step 1.0	Situation Statement/Problem Statement	What conditions are you trying to address?	
Step 2.0	Program Description	2.1-2.4	
Step 2.1	Program Population	Who do you serve? Examples: ■ DCF committed youth ages 14+ ■ Parents of children in DCF custody ■ Persons and Families identified through DRS	
Step 2.2	Program Activities	What do you do in the course of the program? Examples ■ 5 structured counseling/education sessions, 1 per month ■ Deliver training curriculum about budgeting	
Step 2.3	Program Outcomes	What benefits do participants	

Step #	Program Dimension	Question	Your Thoughts
	(conceptual level)	expect to receive as a result of program participation? Examples ■ Improve functioning ■ Reduce alcohol use ■ Improve parenting skills ■ Reduce stress ■ Improve budgeting skills	
Step 2.4	Program Theory	Connections between program activities and program outcomes - why do you think the activities will "produce" the outcomes	
Step 2.5	Program inputs	Confirm that adequate resources exist to implement the program as planned. For example, if an activity calls for budgeting classes, there must be resources such as curricula and program personnel with budgeting knowledge to deliver this activity.	

Phase 2: Evaluation Questions: Identify questions you wish to answer. Here are some questions that people often wish to ask. This is the first step to defining reports.

- How many clients did we serve in a given period?
    - How old, what ages, what races
- How many clients did we serve over time?
- How many clients completed the program; conversely how many failed to complete?
- How much of the program did the client receive (often referred to as dosage; example - of 10 classes, the client attended 5)
- Did clients experience improvement relative to outcomes?
    - Did some kinds of clients experience more improvement than others?

All of these questions are generally asked at various levels - all programs, each program/provider, sometimes by site within provider.

Phase 3: Indicators and Measures: Identify indicators for your program outcomes and other aspects of the program you wish to capture in the data system. (Evaluation Inputs).

Comment: Program personnel are likely to require help and support to complete this step. This is a step that can benefit in particular from research input/support.

This is the "how will you know" aspect and is key to ability to evaluate your program.

- How will you know if a person's budgeting skills have improved? Do you have an instrument or test to assess the client's budgeting knowledge that can be administered before and during/after the program to assess change and improvement?
- If you have an instrument in mind, is it proprietary, meaning that you/the provider must pay to use it?
- Will your indicators be based on self-report of the client? Example: What is your level of pain, thinking of a 10 being the worse possible pain? Is this a valid approach for your concept? For some concepts, it is the only valid approach, i.e. measuring a client's perception of being involved in treatment planning. If this is a perceptual measure, is it important to ask another party to provide their perceptions i.e. client/worker?
- If program personnel are expected to judge the client's improvement or knowledge on a particular topic, how will they know?

Phase 4 + : Data modeling Requires DCF analytic personnel and CS&O personnel. In Phase 4 we determine, among other matters, the data structure for the program: frequency of data collection; details of data collection. For example, some programs collect only summary information i.e. Client A attended 5 sessions. Other programs want to know which sessions were attended and when i.e. Session 1 on a certain date with a certain clinician. PSDCRS can accommodate both of these models.

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Appendix B: Practice Model - short version

MISSION AND GUIDING PRINCIPLES

The mission of the Department of Children and Families is to protect children, improve child and family well-being and support and preserve families. These efforts are accomplished by respecting and working within individual cultures and communities in Connecticut, and in partnership with others. **Guiding Principles**

Overarching Principle - Safety/Permanency/Well-Being: The Department of Children and Families (DCF) is committed to the support and care of all children, including those in need of protection, who require mental health or substance abuse services, and who come to the attention of the juvenile services system. In this context, DCF asserts that all children have a basic right to grow up in safe and nurturing environments and to live free from abuse and neglect. All children are entitled to enduring relationships that create a sense of family, stability and belonging.

- **Principle One - Families as Allies:** The integrity of families and each individual family member is respected, and the importance of the attachments between family members is accepted as critical. All families have strengths and the goal is to build on these strengths. Family involvement and self-determination in the planning and service delivery process is essential.

- **Principle Two – Cultural Competence:** The diversity of all people is recognized and appreciated and children and families are to be understood in the context of their own family rules, traditions, history and culture.

- **Principle Three – Partnerships:** Children and families are best served when they are part of and supported by their community. The Department is part of this community, works in association with community members, and is committed to its services being localized, accessible and individualized to meet the variety of children and families needs.

- **Principle Four – Organizational Commitment:** A successful organizational structure promotes effective communication, establishes clear directions, defines roles and responsibilities, values the input and professionalism of staff, creates a supportive, respectful and positive environment, and endorses continuous quality improvement and best practice.

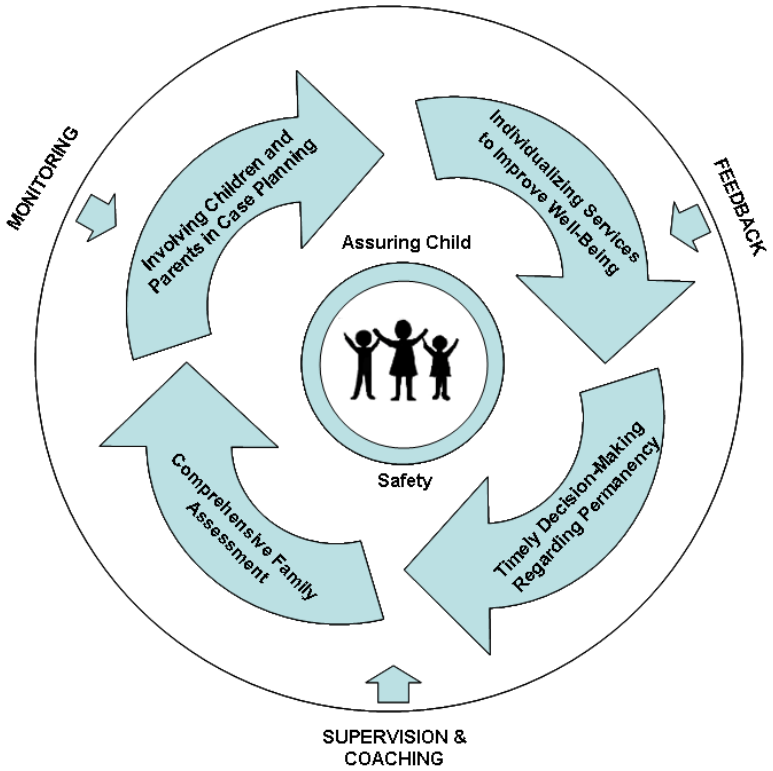
- **Principle Five – Work Force Development:** The work force is highly qualified, well trained and competent, and is provided with the skills necessary to engage, assess, and intervene to assist children and families achieve safety, permanence and well-being.

AN INTEGRATED PRACTICE MODEL

The goal of the practice model is to provide a framework regarding how the agency as a whole will work internally and partner with families, service providers, and other stakeholders in child welfare services. It connects the mission and guiding principles to daily practice. At its core, the model is the description of what we do, how we do it, why we do it and what outcomes we hope to achieve for children and families. Connecticut's Practice Model has six components:

- Assuring Child Safety
- Assessing Strengths and Needs of Family Members
- Involving Children & Families in Case Planning and Decision-Making
- Timely & Appropriate Decision-Making Regarding Permanency
- Individualizing Services
- Monitoring

The diagram below illustrates the interrelationships among the six components. None are designed to operate independently of the others and together, they comprise an integrated approach to serving children and families in a holistic, family-centered manner.
As illustrated in the graphic, all the agency's interventions revolve around the family, which is at the core of the model. At its most fundamental level, the practice model is concerned with assuring child safety. The activities that comprise the other components are designed to protect the child and support the family's capacity to care for the child safely and appropriately, while also meeting the child's needs for permanency, stability, and well being.



The next four components of the model represent the day-to-day interventions with children and families that define a family-centered approach and address their specific needs with the appropriate services. Although these interventions might appear to be linear in function, i.e., moving from assessment to involving families in decision making, providing individualized services, and then making timely appropriate decisions, they are actually circular and closely interrelated.

Comprehensive assessments of the strengths and needs of all relevant family members is a necessary step in developing appropriate goals, plans, and interventions. The assessment is also necessary in order to identify services that are appropriately matched to the family members' strengths and needs. Accurate assessments cannot be completed most often, however, without the active **involvement of family members** whose needs are being assessed, since we must assume that family members know their circumstances better than anyone else. Further, simply completing an assessment of strengths and needs is futile unless that information is then used to inform case planning activities.

Involving children and parents in decision making about how best to use the information from assessments is central to developing goals and strategies that family members can commit to and assume responsibility for achieving. Although involving parents and children can occur through a variety of settings and approaches, the constant here is consistently providing the family with the opportunity to identify their needs, determine their goals, request services, and evaluate their progress, and using their information to guide planning activities. This occurs and re-occurs over the life of the case. The assessment should guide the development of case plans and activities, and the family's involvement in both assessing and planning are important practices in ensuring accuracy and relevance.

When family members are actively involved in decision making and case planning activities, the likelihood is increased that the **services will be individualized** to meet their unique strengths and needs. Through their involvement in decision making and the agency's willingness to bring them to the planning table, family members can identify those services that can best help them to achieve their goals, rather than being reliant upon someone else to make decisions for them. Further, without having completed an accurate assessment of strengths and needs, matching services to what a family actually needs is very difficult and may result in families being offered what is available rather than what they need. Either completing assessments without using the information to guide decision regarding services, or attempting to provide services without the benefit of an assessment are both likely to be unsuccessful and ineffective in supporting families to care safely for their children.

When strengths and needs have been correctly evaluated and identified, family members have provided meaningful input into the plans to which they are accountable, and when services have been tailored to their individualized needs, agencies are better situated to make **timely and appropriate decisions** regarding the outcomes of the agency's involvement with families, for example, permanency decisions, case closure decisions, decisions to re-evaluate or re-configure services, and so forth. This ability stands in contrast to decision-making that is based on the family's disengagement, the lack of measurable improvements resulting from mismatched services, or simply the passage of time without reaching designated goals. When all of the necessary supports have been provided appropriately and timely, the agency can accurately evaluate the family's ability to care for its children and work with the family to make informed decisions that will affect its future.

Back to the cyclical nature of these components, the comprehensive assessment process occurs throughout the life of the agency's work with children and families, and is not a singular event at the start of casework activity. Assessment informs timely decision making and the effectiveness of services. Similarly, the family's involvement does not simply occur when an initial case plan is developed, but in initial assessments and re-assessments, when important decisions are made, and throughout service provision.

At the outer circle of the practice model, **monitoring** is the component that provides feedback, support, and reinforcement of the practices that the agency has identified as important. Encompassing routine supervision as well as more formal quality assurance activities, monitoring promotes fidelity to the principles of the practice model, helps staff and providers continually make the connections between values and interventions, evaluates the effectiveness of interventions and systemic supports, and provides the basis, when needed, to make systemic changes and strengthen practice. Implementing the practice model without a strong reinforcement process that is based on constructive feedback and interaction with all levels of the service delivery system increases the risk that the components will become perfunctory and ineffective. Implementing the practice model as we have defined it, will be a process of skill development and capacity building over time. An effective monitoring system will inform that process and help to keep it moving in the desired direction.

PRACTICE MODEL COMPONENTS & PRACTICE PRINCIPLES

Assuring Child Safety

Safety and risk-related interventions are designed to help children remain safely at home whenever possible and appropriate. Assuring child safety begins with the first report to DCF that someone believes a child is being maltreated and continues for the following activities: Initiating investigations of maltreatment; initial safety and risk assessment; ongoing safety and risk assessment; developing a case plan; when children are in placement; reunification and case closure. Safety and risk interventions cross CW, JS, and BH. They are applicable for all children within a home, not only for a child for whom a report of maltreatment has been received.

Practice Principles: Safety and risk assessment practice guides casework activities with regard to safety, permanency, and well-being; Safety and risk assessments are used to develop case plans and inform service delivery; Safety and risk assessment occurs throughout the life of a case; Family centered practice principles apply to safety and risk interventions; Safety and risk are addressed within the cultural background of children and families being served.

Assessing Strengths and Needs of Family Members

Comprehensive Family Assessment is the ongoing and continuous process for gathering, organizing, and analyzing information for the purpose of informed decision making and service planning concerning the safety, permanency, and well-being of children, youth, and families. Beyond an assessment of risks, safety and the circumstances leading to agency involvement, the CFA includes a broader focus of the strengths and needs of all individual family members along with underlying conditions affecting the family. Collaboration with key professionals throughout the process is critical.

Practice Principles: All families have unique strengths & needs; families are participants in identifying their strengths & needs and in requesting services; assessment includes strengths & needs regarding safety, permanency, and well-being; assessment addresses underlying conditions in addition to presenting issues; all relevant family members' strengths and needs should be assessed; assessment information is used to guide case planning and decision making; families are best understood in the context of their culture; early identification of concerns that can lead to emotional or behavioral disturbance is prioritized in assessments; assessments should be multidisciplinary.

Involving Children &Families in Case Planning and Decision-Making

This component includes active involvement of age-appropriate children/families/youth in identifying their unique strengths/needs/service requests and in developing plans to address their needs, establish and attain their goals, and maintaining safe and appropriate relationships within families while children are in foster care. It includes all relevant family members, whether in the household or not, preparing them for and supporting their participation in meetings, reviews, and other forums that affect them. It also includes using information from safety and risk assessments and comprehensive strengths/needs assessments to determine negotiable and non-negotiable aspects of case planning, casework activity, and levels of family involvement.

Practice Principles: Parents, age-appropriate children, and youth are actively involved in developing or modifying all plans that pertain to them; Parents who do not reside in the home of the children are involved in developing and modifying plans that pertain to their children whenever it is safe and appropriate to do so; When safe and appropriate, parents are involved in the care of their children in foster care and in their children's activities; Safety of children is not compromised through involving children and parents in case planning and decision making.

Timely & Appropriate Decision-Making Regarding Permanency

Every child is entitled to a safe and permanent home. In order to assure this, decisions should be made in a timely manner and must be based on information gathered from comprehensive strengths and needs assessments, reflect the developmental needs of the child and the cognitive abilities of the parents, and reflect the child's sense of time and needs for family and other connections. Decisions should be made with parental and age-appropriate child input. Major decision points should address initial safety and risk concerns, appropriate placement decisions, establishment and review of permanency goals, linking services to needs, and case closure.

Practice Principles: Decisions about initial goals are made in collaboration with children/youth/parents on a timely basis; The family's progress is monitored regularly in order to make timely decisions with regard to changing or continuing goals and services, or to take other actions to assure the safety, permanency and well-being of children; Information from all available sources (child/youth, family, extended family, formal and informal supports) will be used to assure any placement is the most appropriate for the child in order to assure timely permanency.

Individualizing Services

Children and families are treated as partners to ensure joint decision making about which services can best meet their needs, how those services are delivered, who delivers the services and when they are delivered. Case plans include tailored services to meet the child/family's specific needs. Services are designed and delivered to meet the unique needs of the children and families served and not selected from a standard menu of services that may or may not match their needs. Systems of Care principles are central in emphasizing services that are comprehensive, incorporating a broad array of services and supports that are individualized to meet the specific needs of the children and families and provided in the least restrictive setting appropriate for the child and family.

Practice Principles: System of Care principles guide casework activity in individualizing services. Services are designed and delivered pursuant to a careful assessment of the children's and parent's needs; Services and supports are individualized to meet the unique needs of the children and parents; children and families are treated as partners to assure joint decision making.

Monitoring

Monitoring includes supervisory and administrative oversight and coaching of staff, in addition to quality improvement activities that support and reinforce the practice model components. It includes reviewing for the quality and substance of the components of the model and providing prompt and appropriate feedback to staff in order to reinforce quality work and correct practices that are inconsistent with the model. It includes clear communication on expectations and the use of monitoring to keep the practice model in focus and avoid shifting of practice in other directions. It includes the use of qualitative and quantitative information to evaluate practices and outcomes. It includes avoiding duplicated oversight efforts in favor of complementary roles for front-line supervision, administrative oversight, quality improvement activities, and ACR roles and responsibilities.

Practice Principles: Monitoring should reinforce desirable practice. Feedback from monitoring at case, unit, office, and statewide levels helps to reinforce practice. Monitoring should be outcome based. Monitoring should occur with sufficient frequency to become integrated into daily work activities. Monitoring should occur at all levels, from the individual case to the system and administration level.

Appendix C

Year One Milestone Plan

Critical Assumptions:

1. All resources available as planned.
2. DCF Executive Team approves PM products as planned.
3. Key personnel remain at DCF.

Month	Milestone	Project Dimension Emphasis	Responsible parties (organizational)	Responsible parties (persons)
May 2010	Agreement between NCIC and DCF finalized	PSDCRS & PM	DCF & NCIC	Twiggs & Muniz
June 2010	Project Manager Hired	PSDCRS & PM	DCF & NCIC	Twiggs & Muniz
June 2010	Evaluation services contract finalized	PSDCRS & PM	ORE with NCIC Support	Twiggs
June 2010	Training modules developed	PM	DPBP & Training Acad.	Muniz & Hill-Lilly
June 2010	Practice Guides finalized for Social Workers and Supervisors	PM	DPBP with NCIC support	Muniz, TBD Project Manager
July 2010	Revised Detailed Work Plan for overall 3-Year Implementation Project Developed	PSDCRS & PM	DCF	TBD Project Manager
July 2010	2010 Programs - Implemented in PSDCRS	PSDCRS	ORE	Twiggs
July 2010	Begin Preparation for PM implementation in Region I	PM	DPBP with NCIC Support	Muniz, TBD Project Manager
July 2010	Identify Practice Coaches	PM	DPBP with NCIC Support	Muniz, TBD Project Manager
August 2010	2011 Programs - Draft conceptual logic models and evaluation questions	PSDCRS	ORE with NCIC Support	Evaluator

Month	Milestone	Project Dimension Emphasis	Responsible parties (organizational)	Responsible parties (persons)
August 2010	Draft evaluation plan (for integrated project)	PSDCRS & PM	ORE with NCIC support	Evaluator
August 2010	IRB Application submitted and approved	PSDCRS & PM	ORE & DPBP	Evaluator
September 2010	Finalize evaluation plan	PSDCRS & PM	ORE with NCIC support	Evaluator
September 2010	Pre-Test instruments administered in Region I	PM	ORE & DPBP	Evaluator
September 2010	2011 Programs - Final Data Dictionaries completed	PSDCRS	ORE	Evaluator

APPENDIX D: Connecticut DCF Supervisory Practice Model Implementation Project Logic Model
April 2010