

IMPLEMENTING STRUCTURED DECISION MAKING
PROCEDURES IN CHILD WELFARE

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This article is based upon the
author's doctoral dissertation at the
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The author thanks Donald Brieland, Dean of the School of Social Work, University of Illinois at Chicago, and Jimmie H. Smith, Director of Staff Development, Central Baptist Children's Home/Family Services, for their comments on earlier versions of this article.

Paper presented at the
1st Annual National Symposium on Doctoral Research
and Social Work Practice
The Ohio State University
April 15-16, 1985

ABSTRACTImplementing Structured Decision Making
Procedures in Child Welfare

A descriptive study of the implementation of structured decision making procedures at child welfare intake revealed relationships between the degree to which the procedures were used and worker characteristics, client characteristics, and the agency service unit in which the decision was made.

Results of this study relate to the implementation of organizational innovations which limit worker autonomy and increase accountability. As such, they relate to current directions in the child welfare field and pose serious challenges to child welfare administration and practice.

Decision Making in Child Welfare

Decision making is central to child welfare. Child welfare workers must decide whether children have been abused or neglected, are in immediate danger, or must be removed from their home and placed in foster care. The study of decision making in child welfare began in the 1950s and continue today (Stein, Gambrell, and Wiltse, 1978; Stein and Rzepnicki, 1984). Results of these studies emphasize the fallibility of clinical judgment. With rare exception (Alter, 1985), studies indicate that professionals are able to agree on child welfare decisions only when children are clearly safe or clearly in physical danger (Craft, Epley, and Clarkson, 1980). Most families served by child welfare agencies present a mix of strengths and deficits, making predictions of safety difficult. With these most common cases, reliability of professional judgment is weakest (Craft, et al., 1980; DeLionardi, 1980).

Clinical theory, government policies, and agency procedures have not provided specific criteria for decision making (Knitzer, Allen, and McGowan, 1978). The lack of clear guidelines is blamed for inappropriate separation of children from their parents, procrastination, and failure to secure permanent homes for children. One proposed solution to problems in child welfare decision making has been the development of structured decision making procedures. Structured procedures direct data collection and use, require descriptive rather than inferential recording of information, and determine decision outcomes. Structured procedures restrict worker autonomy by requiring adherence to specific procedures and rules to make judgments. Research projects have demonstrated the effectiveness of structured procedures in securing permanent homes for children placed in foster care (Emlen, Lahti, Downs, McKay, and Downs, 1978; Stein, Gambrell, and Wiltse, 1978) and the efficiency of structured procedures at child welfare intake (Stein and Rzepnicki, 1984). However, the question remains whether structured decision making procedures will be implemented in practice.

Description of the Study

The purpose of this research was: 1) to describe the pattern of use of an innovative decision making model at child welfare intake, and 2) to generate hypotheses for future study. The study was a secondary analysis of data collected during an eight-month field test of structured decision making procedures conducted in six service units of three child welfare agencies: Illinois Department of Children and Family Services (IDCFS), Catholic Charities of Chicago (CC), and West Virginia Department of Welfare (WVDOW) (Stein and Rzepnicki, 1984). Protective service and voluntary child welfare service units were included in the IDCFS and WVDOW samples. Only protective service units were included in the Catholic Charities sample. The nine intake decisions studied are listed in Figure 1.

Workers were selected for the project in a non-random manner. The Catholic Charities workers and the DCFS protective service night shift workers volunteered for the project. All other workers were drafted by agency administration. Clients were randomly selected for the project and randomly assigned to experimental and comparison groups. ~~Use of procedures and the decision making process were measured by worker self-report for all intake decisions on behalf of each family served by experimental or comparison group workers.~~

Results of the parent study indicated that child welfare workers who used structured procedures made intake decisions in less time than their comparison group counterparts, with no increase in the recurrence of maltreatment. Seventy-five percent of IDCFS, 96% of

WVDOW, and 100% of Catholic Charities workers in experimental units were satisfied with the new decision, although testing of the structured procedures required considerable paperwork in addition to normal workloads.

Child welfare workers in experimental units were required to use the structured procedures for all intake decisions on project cases. Some workers used the procedures for all decisions; others never used the procedures; yet others applied the procedures to some, but not all, decisions. The study summarized in this article explored the relationships between the degree to which structured decision making procedures were used, worker characteristics, client characteristics, and the agency service unit in which the worker was employed.

Results

Worker Characteristics: The 31 workers ranged in age from 23 to 45 ($Md = 32$). Twenty-nine percent of the workers were male and 71% female. Experience in child welfare ranged from 3 months to 10 years ($Md = 3.25$ years). The median length of time in the current position was 10 months; the range, from less than one month to 4.5 years. Sixteen percent of the workers had Master's degrees and 45% indicated that their major academic discipline was social work. However, only 6% of the workers held Master's degrees in Social Work.

Fifty-eight percent of the workers had previous intake experience, 29% in-home service experience, and 42% experience in foster care. Thirteen percent reported adoption experience and 16% experience as a supervisor. Thirty-one percent of the workers reported that they had other types of child welfare experience. Seventy-four percent indicated that they had participated in in-service training on the topics of assessment or diagnosis, 81% on case planning, 42% on contracting, and 65% on methods of problem solving.

Relationships between use of procedures and worker characteristics are described in Table 1. Workers with Master's degrees were more likely to use the structured procedures than their peers who had Bachelor's degrees, Associate's degrees, or no degree. However, this finding should be viewed cautiously since only five of the 31 workers included in this analysis held Master's degrees. Academic discipline was not related to use of the procedures. The longer workers were employed in their current position the less likely they were to use the structured decision making procedures; however, total years of child welfare experience was unrelated to use of procedures. Males were more likely to use the procedures than females.

Correlations between types of training and experience and use of procedures are listed in Table 2. Workers who had foster care or adoption experience were more likely to use the procedures, but workers who had intake experience were less likely to use the procedures. Workers who had participated in training on assessment/diagnosis or contracting were more likely to use the procedures.

Client Characteristics: Sixty-two percent of the 208 families served by workers in experimental units were headed by single parents. Forty-five percent of mothers in these families were white, 47% black, and 8% Hispanic. Race of the father was reported for 85 families, 51% of whom were white, 34% black, and 15% Hispanic. Mean age of the mothers was 28.4 (153 cases reported). Mean age of the father was 34.6 (59 cases reported). Sixty percent of the 141 families for whom primary source of income was

reported were supported by some form of public aid and 30% were employed. The remaining ten percent received unemployment compensation, SSI, Social Security, or a pension.

The mean number of children in the 208 families studied was 2.4. They ranged from newborn to 18 years of age. The mean number of children identified as service recipients was 1.6 per family and the mean age of the youngest service recipient was 5.7 years.

Eighty-five percent of the cases were new, 15% active or reopened. Seventy-one percent were referred through a hotline, 29% by phone, mail, or walk-in. Forty percent of the families were referred by parents, relatives, friends, or acquaintances, 17% by medical personnel, the remainder by legal authorities, social service personnel, school or daycare personnel, and others. Forty-two percent of the 165 protective service cases were referred because of allegations of child abuse, while 58% were referred because of neglect. Forty-two percent of the 44 voluntary child welfare cases were referred because of parent-child conflict or child behavior problems, 17% because of parent behavior, 14% because of parent's inability to care for the children or a parental health problem, 6% due to child health, and 14% dependency and other reasons. Eight percent of the voluntary child welfare cases were initially referred because of an allegation of abuse or neglect.

The 739 intake decisions made on behalf of the 208 project cases served in experimental units were included in this analysis. Use of the structured procedures was analyzed separately for each of nine intake decisions (see Table 3). The procedures were employed in 86% of the emergency response decisions applying to families in which the mother was non-white, as opposed to only 56% of these decisions for families in which the mother was white. The procedures were used in 93% of the decisions regarding whether a child could be safeguarded at home or should be taken into protective custody when no adult in the home was employed as compared to 71% when an adult was employed. Employment status was also related to the use of structured procedures in determining whether assistance was required with assessment or investigation. These procedures were used for all cases when no adult was employed compared to 57% of the cases when an adult was employed. The structured procedures were used in making 61% of the decisions regarding what specific problems would become the focus of service for two-parent families, but 83% of these decisions for single-parent families and others.

A small but statistically-significant relationship was observed between the age of the youngest child identified as a recipient of service and the use of structured procedures in deciding whether a child could be safeguarded at home or should be taken into protective custody. The younger the child, the more likely the procedures were used. No statistically-significant relationships were detected between the number of children in the family or the number of children identified as recipients of service and use of structured decision making procedures.

Relationships between use of procedures and case characteristics described in Table 4 indicate that the structured procedures were used to determine whether an emergency response was necessary for 82% of all new cases but only 40% of active or reopened cases. Method of referral was significantly related to use of procedures for the following decisions: specific problems, out-of-home placement, and determination of the service plan. If a referral was phoned in to the service unit, it was less likely that the procedures would be used than if the referral came through a hotline or if a client walked in. Neither the type of protective service allegation nor the reason for child welfare referral were associated with use of structured procedures (see Tables 5 and 6).

The Agency Service Unit was related to the use/non-use of structured decision making procedures (see Table 7). The highest percentage of use of procedures was displayed by WVDOW child welfare services (96%) and the lowest by IDCFS child welfare services (18%). The percentage of use of structured procedures for protective service cases ranged from 61% for the IDCFS followup team to 89% for Catholic Charities.

Summary of the Findings

Results of the analysis of the relationships between the use of structured decision making procedures, worker characteristics, and the agency service unit in which workers were employed indicate that:

- 1) Academic degree, training in assessment/diagnosis and contracting, experience in foster care and adoption were all positively associated with use of procedures.
- 2) Intake experience and length of time a worker was employed in the same position were inversely related to use of procedures.
- 3) Males used the procedures for a higher percentage of their intake decisions than did females.
- 4) Only 7% of the correlations between client/case characteristics and use of procedures were statistically significant. In addition, these statistically-significant relationships were not strong. However, the pattern of these relationships suggests that structured decision making procedures were more likely to be used when risk to the child was perceived to be great and strengths and resources of the family perceived to be limited.
- 5) Degree of use of structured decision making procedures was associated with the agency service unit in which the worker was employed.

In addition to these major findings of the study, further analysis revealed high correlations between independent variables (Gleeson, 1984). The longer workers were employed in the same position, the less likely they were to have Master's degrees, foster care experience, adoption experience, and training in contracting. Workers with Master's degrees were less likely to have had experience at intake. Single-parent families in the study were likely to receive their income from some source other than employment, were likely to be non-white, to have younger children identified as service recipients, and were less likely to have been referred by phone. Some worker, client, and case characteristics were associated with the agency service unit in which the worker was employed and the client served.

The correlations between independent variables indicate that the contributions which they make to explaining use of structured decision making procedures are not additive. However, the data did not permit analysis of the proportion of variance in use of procedures explained by each independent variable with all others statistically controlled.

Efficiency and Usefulness of the Model

The parent study (Stein and Rzepnicki, 1984) and this study tested the specific structured decision making model developed by Stein and Rzepnicki (1983). Therefore, the findings of these studies are applicable only to this model, when interpreted in the strictest sense. The reliability of this model of decision making was not compared with that used by workers in the comparison group. The field test did not demonstrate any difference between experimental and comparison groups with regard to decision outcomes, worker satisfaction, or recurrence of maltreatment at six-month follow-up. However, findings of the parent study suggest that this model reduces the amount of time workers spend in gathering data, thereby reducing total decision making time (Stein and Rzepnicki, 1984).

The relative efficiency of this model makes it an important decision making tool. The emphasis on reporting suspected cases of abuse and neglect has resulted in growing protective service caseloads nationwide without proportionate increases in the number of staff to conduct investigations. Procedures which reduce the time workers spend in decision making activities without increasing danger to children allow workers and agencies to better handle these ever-increasing demands and devote more time to provision of services.

The findings of the current study further describe the usefulness of these procedures. The evaluation literature describes the false conclusions which may be made when a new method is tested and implementation of the independent variable is not monitored (Charters and Jones, 1974). It is axiomatic to state that the benefits of any new practice method are lost if the methods are not used. This study identified some obstacles to use of this model of decision making and situations in which the procedures would likely be used. The few relationships observed between client/case characteristics and use of procedures suggest that the structured decision making procedures are applicable to a wide range of client and case situations. Obstacles to use of these procedures appear to be primarily in the realm of worker and the agency service unit in which the worker is employed.

The structured decision making procedures were used more frequently when a worker was new on the job, did not have previous intake experience, when the case was unfamiliar, and when the client situation was viewed as being of greater risk to the child. These results suggest that the procedures are useful as an initial training and orientation document for the new direct service worker, a reference manual for the seasoned worker, and a clear guideline to all workers facing high-risk decisions.

Broader Implications

The generalizability of these findings is limited by the fact that only one structured model of decision making was tested. In addition, only three agencies and six service units were included in the study. The sample of workers was small, was not randomly selected, and workers reported their own decision making behavior. Also, the problem of "consistent availability" of data common to secondary analyses (Shyne, 1975) may have distorted the representativeness of client characteristics. However, the purposes of this study were to describe the pattern of use of an innovative decision making model and to generate hypotheses for further study. This first purpose was accomplished. The second can be accomplished by comparing the structured decision making procedures tested here to current directions in the child welfare field.

The structured decision making procedures developed by Stein and Rzepnicki may be described as an innovative practice method which defines and structures the tasks of child

welfare workers, restricts autonomous judgment, and makes actions of workers more visible, thereby making workers more accountable. As such, they parallel current directions in child welfare. The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) mandates written case plans, clear case goals and objectives with timelines for accomplishment, and third-party case reviews for all cases served in substitute care for six months or longer. The increasing role of the courts in child welfare requires workers to make descriptive and behaviorally-specific presentations of their cases verbally and in writing. The Children's Rights movement and the statement of children's rights in the Constitution further suggest that the actions of child welfare workers on behalf of clients will have to be approved by or defended in court (Stein, 1981). These systemic reforms continue to increase worker accountability, reduce autonomy in worker decision making, and will continue to require innovations in practice which assist workers in functioning within this less autonomous, more visible and accountable system. Therefore, it is important to identify obstacles to implementation of these innovations and factors which may facilitate their implementation.

Results of this study suggest several hypotheses for future study of implementation of innovations of the type described above. These hypotheses are discussed in the remainder of this article.

Hypothesis 1: The more familiar workers are with their job and the longer they are employed in the same position, the less likely they may be to implement innovations which structure the decision making process. It may be that workers who have been doing the same job for some time have no need to improve their decision making. However, the literature in child welfare provides no evidence that decision making efficiency or effectiveness improve with experience. It may be that reluctance to implement a new practice model reflects resistance to change rather than no need to improve.

Innovations which are mandated by organizations have high costs to seasoned workers. Familiarity with a way of working increases one's confidence that decisions are made "correct." Being open to a new way of doing things leaves one questioning whether former methods were less effective or efficient. This experience may shake long-time employees' confidence and cause them to lose power associated with their positions as resident experts. Conversely, new employees with no previous experience in the job to be performed may welcome introduction of a practice model which clearly defines and structures their tasks.

Hypothesis 2: Higher education, as well as a variety of experience and in-service training, may be associated with a higher degree of implementation of innovation. Workers with advanced degrees, more training, or a variety of experience may be more open to learning and change. They may have had their convictions and skills questioned in the past and learned to integrate new information and skills with those previously acquired. Successful adaptation to change in the past may have bolstered their confidence and reduced their fear of change. Workers exposed to a variety of work and learning experiences may also be more cognizant of the need to develop, test, and improve practice methods.

Hypothesis 3: Innovations which structure the tasks of child welfare workers and limit their autonomous judgment may be more likely to be implemented when the risk to the child is perceived to be great and when the strengths and resources of the client are perceived to be limited. Workers tended to use the procedures to determine whether children could be safeguarded at home more often if the children were younger and, therefore, less able to protect themselves. Single-parenthood, unemployment, and being a non-white mother were associated with more frequent use of the procedures for some decisions. Unemployment and

single-parenthood may be viewed by workers as indications of a lack of resources, thereby indicating less ability to cope with stress. The vulnerabilities of non-white female single parents in this society may also be interpreted as high risk factors.

Perhaps the more strengths and resources workers perceive a family to have, the less fearful they are that a decision could result in harm to the child, hence the greater confidence they have in their own expertise. They may be more likely to rely on structured decision making procedures in situations perceived as higher risk. Also, if workers are less sure of themselves and the decision is perceived to be high risk, using structured procedures which have been adopted by the agency protects workers from liability.

Hypothesis 4: The agency and service unit in which an innovation is introduced may be related to the degree to which it is implemented. The number of organizations and agency service units included in this study was small and specific characteristics of these organizations were not systematically measured. Therefore, one can only speculate why workers at IDCFS used the procedures less often than the staff at the other two agencies, or why the WVDOW voluntary child welfare services unit used the procedures for a higher percentage of decisions than all other units, while IDCFS voluntary child welfare services used them the least. However, one might suggest from other findings in this study that some agency characteristics related to implementation of innovation may include policies and practices related to employee selection and mobility, staff training programs, and support of the innovation by supervisors and peers in the agency service unit.

Results of this study suggest that organizations which hire workers with Master's degrees at the direct service level, provide in-service training, and promote job mobility (within or outside of the organization) may demonstrate a higher degree of implementation of innovation than those which hire workers with Bachelor's degrees or no degree, provide little training, and encourage longevity in the same position. While high turnover rates may be an obstacle to continuity of service and rapid achievement of permanent homes for children (Gruber, 1976; Shapiro, 1976), very low turnover rates may be associated with failure to implement innovation. Perhaps there is some ideal moderate length of time in direct service positions which optimally facilitates continuity of service, achievement of permanency for children, and implementation of innovation in child welfare.

Conclusion

The study described here suggests that the structured decision making model developed by Stein and Rzepnicki provides a useful and efficient orientation and training document for new intake workers and a reference guide for all workers making high-risk intake decisions. The study also poses hypotheses regarding implementation of innovations which structure worker activity and increase worker accountability. Directions in the field suggest that child welfare agencies and workers will continue to be faced with innovations of this type. Adaptability to change will be a key ingredient for the successful child welfare agencies and workers of the future.

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FIGURE I

CLINICAL INTAKE DECISIONS

PHASE I: RECEPTION

IS AN EMERGENCY RESPONSE NECESSARY?^a

IS ASSISTANCE REQUIRED WITH THE PROCESS
OF ASSESSMENT/INVESTIGATION?^b

PHASE II: INVESTIGATION AND PROBLEM ASSESSMENT

IS THE CHILD IN IMMEDIATE DANGER?

SHOULD THE CHILD BE LEFT IN HIS OWN HOME
OR TAKEN INTO PROTECTIVE CUSTODY?

IS THERE CREDIBLE EVIDENCE THAT ABUSE OR
NEGLECT HAS OCCURRED OR THAT THE
CHILD IS AT RISK OF EITHER?

IS IT NECESSARY TO PETITION THE COURT?^b

WHAT ARE THE SPECIFIC PROBLEMS FOR WHICH
THE FAMILY WILL RECEIVE SERVICE?^b

IS OUT-OF-HOME PLACEMENT NECESSARY?^b

PHASE III: SERVICE PLANNING

WHAT IS THE APPROPRIATE SERVICE PLAN?^b

^aDoes the situation warrant a more immediate response than the response time required by law?

^bThese decisions apply to voluntary child welfare services as well as child protective services.

TABLE 1

Correlations Between Worker Characteristics^a and
Proportion of Decisions for which Experimental
Procedures were Used^b

Worker Characteristics	Gamma	N
Gender (male = 1; female = 2)	-.38*	31
Age	.10	29
Degree	.62*	31
Discipline (social work = 1; others = 0)	.03	29
Experience in Child Welfare	-.21	28
Time in Current Position	-.64*	31

^aGender and discipline were measured as dichotomies.
All other characteristics were treated as ordinal variables.

^bProportion of decisions for which the procedures were used was
measured as follows: 1 = never used the procedures; 2 = 1-69% use;
3 = 70-99% use; 4 = 100% use.

$p < .01$, two-tailed

TABLE 2
Correlations Between Types of Child Welfare Experience,
Types of In-Service Training, and Proportion of
Decisions for which the Procedures were Used^a

TYPES OF CHILD WELFARE EXPERIENCE	(N = 31) GAMMA
Intake	-.60*
In-home Services	.15
Foster Care	.40*
Adoption	.59*
Supervision	.24
Other	.18
TYPES OF IN-SERVICE TRAINING	
Assessment/Diagnosis	.46*
Case Planning	-.15
Contracting	.50*
Methods of Problem Solving	-.04

^aTypes of experience and training were measured as separate dichotomous variables (yes = 1; no = 0).

The proportion of decisions for which procedures were used was measured as described in TABLE 1.

* $p < .01$, two-tailed

TABLE 3

Correlations^a Between Family Characteristics and
the Use of Experimental Procedures by
Type of Decision

	<u>ER</u>	<u>AR</u>	<u>ID</u>	<u>SH</u>	<u>CE</u>	<u>PC</u>	<u>PR</u>	<u>PL</u>	<u>SP</u>
FAMILY STRUCTURE (2-Parent Families=1; Others = 0)	(56) -.09	(29) -.02	(106) -.11	(111) -.12	(114) .04	(88) -.17	(83) -.24*	(95) -.14	(97) -.06
EMPLOYMENT STATUS ^b (Employed = 1; Unemployed = 0)	(41) -.13	(19) -.57*	(79) -.11	(79) -.29*	(81) .04	(62) .04	(64) -.05	(68) -.04	(48) -.13
RACE OF MOTHER (White = 1; Other = 0)	(54) -.34*	(24) -.15	(102) -.14	(103) -.09	(105) -.17	(70) -.07	(73) -.18	(84) -.11	(51) -.17
RACE OF FATHER ^b (White = 1; Other = 0)	(16) -.33	(14) -.45	(40) -.23	(39) -.17	(41) -.19	(42) .14	(29) -.03	(41) .17	(19) .17
AGE OF MOTHER ^b	(48) -.22	(21) .05	(88) -.16	(88) -.05	(87) .08	(63) .05	(66) -.09	(75) -.05	(49) -.05
AGE OF FATHER ^b	(12) -.41	(13) -.41	(30) -.19	(31) .05	(31) -.17	(30) -.03	(23) .31	(29) .02	(16) .17
NUMBER OF CHILDREN	(56) -.01	(29) .17	(106) .00	(111) -.09	(114) -.02	(88) -.02	(83) -.01	(95) .07	(57) .20
NUMBER OF CHILDREN IDENTIFIED AS SERVICE RECIPIENTS	(55) -.17	(29) .00	(106) .12	(111) -.05	(114) .07	(88) .03	(83) .08	(95) .14	(57) .13
AGE OF YOUNGEST SERVICE RECIPIENT	(55) -.15	(29) -.10	(105) -.13	(110) -.19*	(113) -.08	(88) -.02	(82) -.07	(94) -.16	(57) .04

NOTE: ER = emergency response; AR = assistance required; ID = immediate danger;
SH = safeguard at home; CE = credible evidence; PC = petition the court;
PR = specific problems; PL = placement necessary; SP = appropriate service plan.

Family structure, employment status, and race were measured as dichotomies.
All other family characteristics were measured as interval variables.

^aPearson's r was used to compute correlations when the independent variable was interval.
Phi was used to compute correlations for the remaining variables. Use was coded 1 and
non-use 0. The numbers in parentheses indicate the number of cases included in each
analysis.

^bThe reader is cautioned in making interpretations because of the high percentage of
missing data on these variables.

* $p < .05$, two-tailed

TABLE 4
Correlations Between Case Characteristics and
the Use of Procedures by Type of Decision

	<u>ER</u>	<u>AR</u>	<u>ID</u>	<u>SH</u>	<u>CE</u>	<u>PC</u>	<u>PR</u>	<u>PL</u>	<u>SP</u>
STATUS (new = 1; active or reopened = 0)	(55) .37**	(28) .30	(104) .14	(109) .17	(112) .17	(87) .01	(82) .15	(94) .03	(56) .09
METHOD OF REFERRAL (phone = 1; other = 0)	(55) -.06	(29) -.01	(105) .05	(110) -.01	(114) .10	(88) .01	(82) -.26*	(94) -.25*	(57) -.30*
REFERRAL SOURCE PARENT/RELATIVE (1) VS. OTHERS (0)	(56) -.05	(29) .21	(106) .02	(111) .00	(114) .14	(88) .05	(83) .13	(95) -.04	(57) .11
FRIEND/NEIGHBOR/ ACQUAINTANCE (1) OTHERS (0)	(56) .12	(29) -.20	(106) .13	(111) -.07	(114) .03	(88) .01	(83) .15	(95) .09	(57) -.06

NOTE: Case characteristics and use of procedures were measured as dichotomies (Use = 1; Non-use = 0). Phi was used to calculate all correlations. The numbers in parentheses indicate the number of cases included in each analysis.

^aThe reader is cautioned in making interpretations here because of the high percentage of missing data regarding whether a home visit was made for IDCFS CWS cases.

* $p < .05$, Fisher's Exact Test, two-tailed

** $p < .01$, Fisher's Exact Test, two-tailed

TABLE 5

Correlations Between Type of Allegation and the Use
of Experimental Decision Making Procedures for
Each Protective Service Intake Decision

	Phi	N
Emergency Response	-.01	56
Immediate Danger	-.12	105
Safeguard at Home	-.17	110
Assistance Required	-.12	19
Petition the Court	-.14	57
Credible Evidence	-.06	113
Specific Problems	-.04	54
Out-of-Home Placement	-.24	62
Service Plan	.16	37

NOTE: Type of allegation was measured as abuse = 1; neglect = 0.
Use of procedures was measured as a dichotomy (use = 1;
non-use = 0).

TABLE 6

Correlations Between Type of Allegation and the Use
of Experimental Procedures for Each Voluntary
Child Welfare Intake Decision

	<u>Phi</u>	N
Assistance Required	.32	6
Petition the Court	.25	24
Specific Problems	.00	20
Out-of-Home Placement	.23	26
Service Plan	.32	14

^aReason for Referral was coded as follows:

1 = child-parent conflict or child behavior problem;

0 = other reasons. Use of procedures = 1; non-use = 0.

TABLE 7
Percentage of Use of Experimental
Decision Making Procedures for All
Decisions Combined by Service Unit

<u>Service Units</u>						
IDCFS PS INTAKE	IDCFS PS TEAM	CC PS	WVDOW PS	IDCFS CWS	WVDOW CWS	TOTALS
%	%	%	%	%	%	%
(N = 143)	(N = 90)	(N = 305)	(N = 82)	(N = 71)	(N = 48)	(N = 739)
77	61	89	78	18	96	76

NOTE: Use of procedures was measured as a dichotomy (use = 1; non-use = 0).

The N in parentheses indicates the number of decisions made.
 Chi -square (5) = 177.36, $p < .001$, Lambda = .25, Cramer's
 V = .49.