



## Differential Response to Reports of Child Abuse and Neglect

A growing number of child welfare agencies are employing differential response (DR) in an effort to respond more flexibly to child abuse and neglect reports and to better meet individual family needs. In these systems, families with screened-in child maltreatment reports may receive either a traditional investigation or an alternative assessment response, depending on the type of allegation and other considerations. This issue brief provides an overview of DR in the United States and highlights lessons learned through research and implementation experiences.

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## Defining Differential Response

Differential response, also called “alternative response,” “multiple response,” or “dual track,” is a way of structuring child protective services (CPS) that allows for more than one method of initial response to reports of child abuse and neglect. DR emphasizes the importance of broadly assessing all families’ situations to identify and meet underlying needs. While definitions and approaches vary, DR responses typically fall into two major categories:

- **Investigation response (IR)** (also called the traditional response or high-risk assessment): These responses involve gathering forensic evidence and making a formal determination of whether child maltreatment has occurred or the child is at risk of abuse or neglect. In CPS systems with DR, IR is generally used for reports of the most severe types of maltreatment and those that may involve the legal and judicial systems.
- **Alternative response (AR)** (also called an assessment response or family assessment response):<sup>1</sup> These responses—usually applied in low- and moderate-risk cases—typically do not require a formal determination or substantiation of child abuse or neglect, and names are not entered into a central registry.

Both pathways generally encompass assessments of child safety and/or risk. A comprehensive family assessment focused on family’s strengths and needs is central to AR and may also be included with IR. Both pathways share many underlying principles and goals, including a focus on child safety, permanency, and well-being.

DR recognizes the benefit of responding differently to different types of reports. So, for example, referrals for inadequate supervision are handled differently from cases of severe physical harm or sexual abuse. Most child welfare systems that use DR allow for changes in the response track if information emerges that indicates a different type of response is needed to ensure child safety or to better respond to the family’s circumstances.

<sup>1</sup> In this publication, the terms alternative response (or pathway) and assessment response (or pathway) are used interchangeably.

In literature and practice, DR is described in various ways—as a restructuring of CPS, an approach, a practice, a systems reform effort, a policy orientation, and an organizational change. Given the diverse ways it has been defined and implemented across States and jurisdictions (see “Variations in Approaches” below), there is no single DR “model.” The highlight box summarizes core elements of DR as identified and explored in national surveys (Merkel-Holguin, Kaplan, & Kwak, 2006; National Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR], 2009).

### Core Elements in Differential Response

- Two or more discrete responses (pathways or tracks) for reports screened in and accepted for response by CPS
- Use of protocols and criteria to determine the response track, which consider the presence of imminent danger, assessment of risk, and other factors
- The ability to change track assignments over time
- Formalization of DR in statute, policy, or protocols
- For families on the assessment pathway:
  - Voluntary participation in services, as long as no safety concerns exist
  - No formal determination (substantiation) of whether maltreatment has occurred
  - No listing of caregivers’ names in a central registry

(Merkel-Holguin et al., 2006)

## Evolving Implementation of Differential Response

Over the past two decades, more than two-thirds of all States across the country have implemented or initiated plans for DR. Some jurisdictions are still in the early stages of planning or implementation with just a few DR sites, while others are expanding or institutionalizing DR statewide. This section briefly highlights some key influences driving implementation, presents a snapshot of the prevalence of current DR implementation and State laws enabling implementation, and describes some of the variations in approaches across jurisdictions.

### Key Influences in DR's Emergence and Expansion

The initial emergence of DR in the early 1990s and the subsequent growing interest over the following decades were rooted in concerns over traditional child welfare practices. Child protection was perceived both as being overly intrusive in family life (particularly for cases of neglect) and also as not doing enough to protect children and address underlying family problems (Schene, 2005). CPS workers faced seemingly conflicting objectives—to investigate and sanction perpetrators of maltreatment while also providing supportive services to families. DR evolved as a way to overcome perceived limitations in the traditional response system by recognizing that child maltreatment reports vary, and multiple pathways provide CPS with flexibility to meet differing family needs. Further, DR was intended to decrease the potentially adversarial nature of interactions between CPS and parents by conducting family assessments, connecting families to needed services, and eliminating the substantiation decision for AR families.

A second force coinciding with the emergence of DR was the growing recognition of the importance of family engagement.<sup>2</sup> DR approaches demonstrate shared values with family engagement practices (Christenson, Curran, DeCook, Maloney, & Merkel-Holguin, 2008; Lohrbach et al., 2005). They operate on the assumption

<sup>2</sup> For more information on family engagement, see <https://www.childwelfare.gov/famcentered/engaging/>.

that strong partnerships with parents will increasingly motivate families to use services, and such services will better fit assessed needs. It is important to note that, as part of best practice efforts, child welfare agencies across the nation are integrating family engagement and strengths-based approaches into their everyday practice. In those jurisdictions, there may be less distinction between IR and AR pathways.

Another impetus in the adoption of DR has been an enhanced focus in child welfare on accountability and outcomes. The Federal Children's Bureau's Child and Family Services Reviews (CFSRs)<sup>3</sup> and the Bureau's attention to continuous quality improvement (CQI)<sup>4</sup> have heightened awareness of State performance in achieving outcomes. States have included DR as a strategy in their Program Improvement Plans (PIPs) to improve safety and well-being outcomes and also have integrated DR as a strategic component of their CQI and title IV-E waiver efforts.

The 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA; P.L. 111-320) represents another catalyst for DR expansion. CAPTA now requires State plans and assurances to describe laws, policies, or programs reflecting DR in screening and assessment, including "triage procedures for the appropriate referral of a child not at risk of imminent harm to a community organization or voluntary preventive service." CAPTA also requires States to submit data in their annual reports that specify the number of families that receive DR as a preventative service.<sup>5</sup> Neither the CAPTA legislation nor the related Information Memorandum (ACYF-CB-IM-11 02)<sup>6</sup> provide a formal definition of DR and, as such, leave room for interpretation and tailoring to local needs.

<sup>3</sup> For more information on CFSRs, see <https://www.childwelfare.gov/management/reform/cfsr/>.

<sup>4</sup> For more information on CQI, see <http://www.acf.hhs.gov/programs/cb/resource/im1207>.

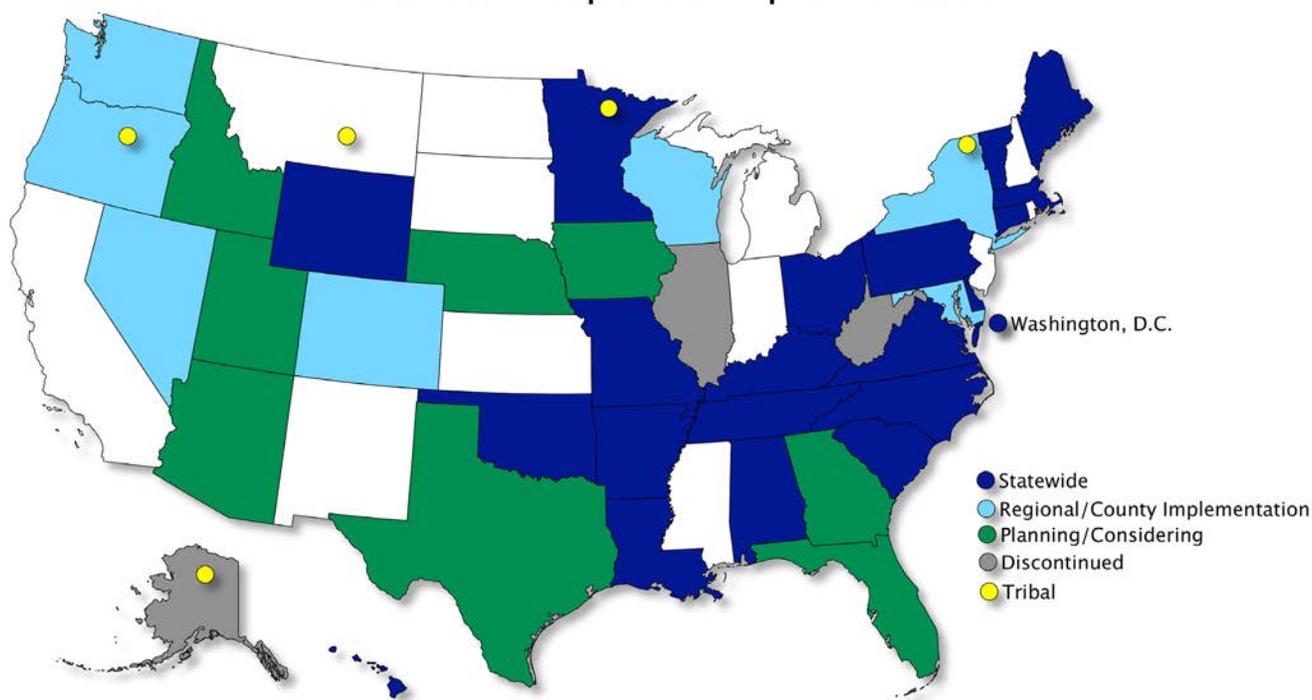
<sup>5</sup> For the full CAPTA legislation, see <http://www.acf.hhs.gov/programs/cb/resource/capta2010>.

<sup>6</sup> The Information Memorandum is available from <http://www.acf.hhs.gov/programs/cb/resource/im1102>.

## Statewide and Regional/County Implementation of Differential Response

Since 1993–94, when Florida and Missouri first passed legislation and piloted DR approaches, implementation of DR has expanded across the nation. As of September 2014, the National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR) reported that 20 States and the District of Columbia had statewide DR programs,<sup>7</sup> another 7 States had regional or county implementation of DR,<sup>8</sup> and at least 8 States were in various stages of actively planning DR initiatives<sup>9</sup> (Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, 2014). Several Tribes or Tribal consortia also have piloted and practiced DR. A few States discontinued earlier pilot or demonstration initiatives, and some of those same States are planning subsequent implementation of DR programs.<sup>10</sup> A snapshot of 2014 DR implementation is illustrated in the map below.

### Differential Response Implementation



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THE KEMPE CENTER FOR THE PREVENTION AND  
TREATMENT OF CHILD ABUSE AND NEGLECT



Map used with permission from the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect. Updated September 2, 2014.

<sup>7</sup> Statewide DR programs in 2014 included AL, AR, CT, DE, HI, KY, LA, MA, ME, MN, MO, NC, OH, OK, PA, SC, TN, VA, VT, and WY.

<sup>8</sup> Regional or county DR programs in 2014 included CO, NV, NY, MD, OR, WA, and WI.

<sup>9</sup> States in planning stages in 2014 included AZ, FL, GA, IA, ID, NE, TX, and UT.

<sup>10</sup> States that had initiated and discontinued DR programs included AK, AZ, FL, IL, TX, WA, WV; States that were planning subsequent implementation included AZ, FL, TX, and WA.

## State Laws

State laws can require or enable the use of DR. As of February 2013, 21 States<sup>11</sup> and the District of Columbia had statutes that authorized the use of DR in responding to child abuse and neglect reports (Child Welfare Information Gateway, 2013). Statutory provisions related to DR differ from State to State and may include language related to the nature and scope of an investigation and assessment track, service provision, exclusion from the central registry of families assigned to the assessment pathway, pathway reassignment, and coordination with law enforcement (QIC-DR, 2010). Some statutes also specify the development of demonstration programs and/or evaluations of the approach.<sup>12</sup>

## Variations in Approaches Across Jurisdictions

While child welfare systems that integrate DR tend to share basic characteristics (i.e., the use of multiple tracks, family-centered approaches, and community-oriented perspectives), DR in one jurisdiction may look very different from DR in another jurisdiction. DR approaches vary in system components, structure, and decision-making processes (Casey Family Programs, 2014; Casey Family Programs, 2012; QIC-DR, 2011; QIC-DR, 2009), including:

- **Number of tracks or paths of response.** While initially child welfare systems included only two DR tracks, over time, some States (e.g., Hawaii, Minnesota, and Tennessee) recognized the value of additional tracks. A 2011 survey indicated that at least 14 States (or jurisdictions within those States) had implemented a third track that provides services or community resource referrals to families who do not meet CPS intake criteria and would otherwise be screened out

<sup>11</sup> DR State statutes have been enacted in AZ, CO, CT, DE, IL, KY, LA, MD, MN, MO, NV, NY, NC, OH, OK, TX, VT, VA, WA, WI, and WY.

<sup>12</sup> For more detailed information on related legislation, see *Differential Response in Child Protective Services: An Analysis of State Legislative Provisions* on the National Conference of State Legislatures website at <http://www.ncsl.org/issues-research/human-services/state-legislation-differential-response.aspx>.

entirely from services (Morley & Kaplan, 2011).<sup>13</sup> Other States (e.g., Kentucky) have incorporated as many as four tracks, including one for law enforcement response when the alleged perpetrator is not the caretaker. Olmsted County, MN, includes a specialized pathway tailored for families dealing with domestic violence (a separate assessment is conducted with the adult who was harmed and children.)

- **Criteria for pathway assignments.** States have different eligibility criteria based on legislation or agency policies for determining pathway assignments. In general, criteria are related to immediate safety concerns, risk, and the nature of the maltreatment. Some jurisdictions have additional criteria related to the type of maltreatment, previous reports of child abuse or neglect, age of the alleged victim, the relationship of the alleged perpetrator to the victim, domestic violence in the home, caregiver substance use, and other factors. A jurisdiction's criteria likely affect the proportion of screened-in reports that are assigned to an AR track.
- **Who makes the pathway decision.** Typically, the selection of a response track is made immediately after the report is accepted or screened in. In some jurisdictions, a hotline worker, caseworker, and/or supervisor make the pathway assignment. Other jurisdictions in Hawaii, Minnesota, North Carolina, and elsewhere rely on a group process. In a number of States, such as Minnesota, Colorado, and Ohio, assignments are made by a group of cross-functional staff at the county level—including a supervisor, intake worker, assessment workers, investigative workers, and/or ongoing workers.
- **Assessment processes and timeframes.** Assessment processes, service planning approaches, and timeframes for implementation can vary across jurisdictions and within a jurisdiction across tracks.

<sup>13</sup> For more information on responses to nonscreened-in reports, see *Formal Public Child Welfare Responses to Screened-Out Reports of Alleged Maltreatment* at [http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/General%20Resources/docs/issue-3\\_10-31-11.pdf](http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/General%20Resources/docs/issue-3_10-31-11.pdf).

- **Ongoing child welfare involvement/privatization of services.** Approaches vary in the extent that private community agencies serve families. In some jurisdictions, all assessments and services are provided by child welfare staff. In other jurisdictions, they are provided exclusively through contracts with external service providers, or there is a combined approach. For example, during the period that Illinois implemented DR, a paired team of a DR specialist from the child welfare agency and a Strengthening and Supporting Families (SSF) caseworker from a private agency jointly conducted the family assessment and, if there were no immediate safety concerns, the SSF worker continued to work with the family to provide services (Fuller, Nieto, Zhang, 2013). Nevada is atypical in that a private community-based agency (Family Resource Center) conducts all assessment and case management functions for families on the assessment pathway (Siegel, Filonow, & Loman, 2010).
- **Funding for services.** Some States and jurisdictions have leveraged supplemental funding to provide services, particularly for families on an assessment path during pilot phases. Funding sources include foundation grants; Federal funding (through title IV-B Promoting Safe and Stable Families, CAPTA, title IV-E demonstration waivers, QIC-DR grants, Social Services Block Grants, and Temporary Assistance to Needy Families [TANF]); and State and county funding streams.

## Experiences in the Field

Like the DR components and processes, experiences in the field have varied from jurisdiction to jurisdiction. This section describes selected issues related to critical stages of DR implementation—the decision to implement, planning and early implementation, and ongoing systems change and evolution.

### Decision to Implement

States and jurisdictions make the decision to implement DR for a variety of reasons. Motivations often reflect the desire for what is believed to be (1) a less adversarial way

to meet children and family needs and (2) improvement in child welfare outcomes. In an online survey, a majority of States indicated that their current DR was introduced as part of system reform efforts. Others noted that DR was connected to reactions to a crisis, changes in leadership, and legislative mandates (QIC-DR, 2009). In many States, the call for implementation has come from State leadership—the Governor’s office, a high level commission on child abuse and neglect, a State legislative committee, or an oversight group. Several States have integrated implementation of DR into larger or parallel reform efforts—such as family engagement and systems of care in North Carolina or a new practice model and a statewide effort to address disproportionate representation in Colorado.

### Missouri: Breaking New Ground

In 1994, the Missouri State Legislature spearheaded the DR movement by mandating a demonstration of a DR approach to child abuse and neglect reports. In pilot counties, less severe incidents were forwarded to a family assessment response, which did not require substantiation but rather determinations of ‘services needed’ or ‘not needed.’ A significant result was the development of partnerships between child welfare workers and community resources to meet identified service needs. An impact analysis showed that families most helped were those who lived in poverty who received basic services that they may not have received under a traditional approach (Siegel, 2012a).<sup>14</sup>

<sup>14</sup> For more information on Missouri’s DR experience, visit the Institute of Applied Research website at <http://www.iarstl.org/>.

### Planning and Early Implementation

As with any system reform effort, introducing DR and changing traditional processes can be complex and challenging. Some common barriers to DR implementation include insufficient financial and staff

resources, inconsistent application of assessment and casework protocols and tools, lack of community capacity for service provision, and stakeholder concerns that not conducting investigations will compromise child safety (QIC-DR, 2011).

A review of diverse jurisdictions' DR experiences (Casey Family Programs, 2012) points to several important activities for successful planning and early implementation of DR, including:

- **Initiating a philosophical shift** from incident-based responses towards a more holistic, family-centered service orientation, which can require significant changes in practice as well as organizational culture
- **Gaining buy-in** from key stakeholders and strategic allies (community and Tribal leaders, legislators, judges, caseworkers, family members, community service providers, law enforcement officers, etc.) and, in the process, anticipating and alleviating concerns (such as concerns over safety and extra workload)
- **Drawing on peer expertise** and capitalizing on the lessons learned in experienced jurisdictions through peer-to-peer coaching, shadowing, training, and technical assistance
- **Ensuring comprehensive service availability** and strengthening community relationships to meet family needs

Differential response involves significant practice changes for workers. Some changes result from the introduction of a new response pathway, for example, there may be new assessment procedures and changes in required timeframes. These changes also may trigger modifications in data systems to support and evaluate the new approach. Moreover, AR workers may need to rely on different skills and strategies to engage families, build partnership relationships, and conduct family assessments. DR sites should carefully consider workload and caseload issues, as well as the skills needed to handle AR (Brown, Cox, & Mahoney, 2012). The practice changes also create needs for training, supervision, and ongoing support to help staff transition to new practices.

## St. Regis Mohawk Tribe: Aligning Values

In rural upstate New York, the St. Regis Mohawk Tribe turned to DR in 2009 to provide more inclusive and respectful responses when working with Tribal families. The Tribe was particularly interested in addressing growing trends of multiple reports for the same families in the areas of educational neglect, inadequate guardianship, and lack of supervision. A DR approach appealed to the Tribe because of the respectful ways in which families are engaged and offered choices on services, as well as the emphasis on support from extended family and kin (QIC-DR, 2012).<sup>15</sup>

<sup>15</sup> For more information on Tribal implementation of DR, see <http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/General%20Resources/docs/tribal-symposium-summary.pdf>.

## Ongoing Systems Change and Evolution of DR

Over time, DR child welfare systems change and evolve. Many States (e.g., Colorado, Minnesota, Missouri, Nevada, North Carolina, and Ohio) have begun implementation with a pilot test in one or more counties and an accompanying evaluation. In several of these States, early experiences have then led to further DR expansion and statewide rollout. Building from early experiences, many jurisdictions continue to modify the practices, processes, and structures of their DR approach (e.g., adding additional tracks).

## Ohio: From Pilot to Statewide Rollout

Initiated by the State's Supreme Court, Ohio began an 18-month pilot program with 10 counties in 2008. The pilot's experimental evaluation found that child safety was not compromised and there was a reduction, albeit modest, in re-referrals among AR families. In addition, there was evidence of greater family involvement in decision-making, more services provided, and high degrees of worker and family satisfaction (Loman, Filonow, & Siegel, 2010). Based on the success of their pilot, Ohio progressed with a phased rollout of additional counties. Ohio's DR expansion reflected a developmental process in which new counties were provided extensive training and peer-to-peer support and benefited from earlier lessons learned (Carpenter, 2012).<sup>16</sup> In addition, the introduction of DR affected practices in both the AR and IR pathways, and subsequent training helped institutionalize the systems change (Murphy, Newton-Curtis, & Kimmich, 2014).

<sup>16</sup> For more information on Ohio's DR experience, listen to the topical centennial webinar, *Who Should Our Clients Be? Differential Response and the Provision of Services to Voluntary Clients*, available from <http://cb100.acf.hhs.gov/webinars>.

Several States (including Alaska, Arizona, Florida, Illinois, Texas, Washington, and West Virginia) made decisions to discontinue DR after pilot programs. Reasons for discontinuation included barriers related to resource limitations, inconsistent DR implementation, changes in leadership, changes in agency focus, and the absence of champions (Casey Family Programs, 2012; Merkel-Holguin et al., 2006; QIC-DR, 2009). In some instances, suspension of DR also was influenced by concerns over child safety among stakeholder groups. (As discussed below, however, evaluation findings have not validated

such concerns.) Several States that at one point discontinued DR later began to plan new DR initiatives, demonstrating a common "fits and starts" pattern of systems improvement (Casey Family Programs, 2012).

## National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR)

In 2009, the QIC-DR, supported by the Children's Bureau, funded three demonstration sites—the State of Illinois and county consortiums in Colorado and Ohio—to implement and evaluate DR. The evaluations studied families who met AR eligibility criteria and compared families who were randomly assigned to AR and IR to answer the following questions:

- Are children whose families participate in AR as safe as or safer than children whose families participate in IR?
- How is the AR pathway different from the IR pathway in terms of family engagement, caseworker practice, and services provided?
- What are the cost and funding implications to the child welfare agency of the implementation and maintenance of a DR approach?

For more information and evaluation reports, visit <http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/QIC-DR/Pages/QIC-DR.aspx>.

## Evaluation Findings

Evaluations of DR have been completed in at least 20 States (or counties within States),<sup>17</sup> and additional ones are underway. The Children's Bureau's QIC-DR conducted a literature review in 2011 that examined existing evaluation findings<sup>18</sup> and supported evaluations in three States along with cross-site analyses (see highlight box), finalized in 2014. While many DR evaluations generally have demonstrated positive outcomes, overall results have been mixed. Selected findings from multiple DR evaluations are presented below as they relate to three evaluation components—process, outcomes, and cost. Emphasis is placed on findings from experimental studies or those with a random control trial design.

### Process Findings

Process evaluations examine DR implementation, assess stakeholder attitudes, and identify variables that might affect DR's impact. Selected findings from process evaluations fall into the following topic areas:

**Fidelity.** Many process evaluations examine whether DR is being implemented as intended. Some States have identified problems with fidelity and inconsistent practices, particularly early multisite initiatives (Casey Family Programs, 2012). A cross-site analysis of QIC-DR sites (Brown, Merkel-Holguin, & Hahn, 2012) found support for fidelity to core components, although intentional variations in implementation existed across jurisdictions.

**Family satisfaction.** On client satisfaction surveys in 13 jurisdictions prior to 2011, AR parents reported having more positive responses to CPS than their IR counterparts (QIC-DR, 2011). Experimental evaluations in Ohio, Minnesota, and New York found that AR parents were more satisfied with their interactions with

caseworkers and were more likely to feel respected and treated fairly. They also were more likely to participate in decision-making processes (Brown, Merkel-Holguin, & Rohm, 2012). In the 2014 QIC-DR cross-site evaluation, Illinois AR parents were likewise significantly more satisfied with the treatment by and help received from the caseworker than were the IR parents. In Ohio and Colorado, however, there were no statistical differences between parents on these indicators. In Colorado and Illinois, AR parents were statistically more likely to report that they would be willing to call the caseworker in the future if the family needed help (QIC-DR, 2014).

**Family cooperation.** In some DR studies (e.g., Minnesota, Ohio), workers reported that AR parents were more cooperative and willing to accept services (Loman et al., 2010; Loman & Siegel, 2005). To the contrary, in the QIC-DR cross-site evaluation, caseworkers in all three study sites rated the IR parents as having more positive engagement attributes (such as being cooperative, receptive to help, and engaged) at their first meetings as compared with AR parents. Study authors theorized that caseworkers working with these two groups may have different paradigms for viewing engagement (QIC-DR, 2014).

**Worker satisfaction.** In several studies, workers generally favored the AR approach to working with families (QIC-DR, 2011). In the early Ohio evaluation, for example, almost 40 percent of workers reported that DR had made it more likely that they would stay in the field of child welfare (Loman et al., 2010). The more recent Ohio evaluation found that while AR workers were five times more likely than IR workers to say that they intended to remain in this field of work because of DR implementation, there were no significant differences in overall satisfaction with their current child welfare job (Murphy, Newton-Curtis, & Kimmich, 2013). Across many sites, worker buy-in was not always instantaneous; as is typical in systems change, many agencies have encountered resistance among workers to the introduction of DR.

<sup>17</sup> States (or counties within States) that have conducted DR evaluations include AK, AZ, CA, CO, FL, IL, KY, LA, MN, MO, NV, NJ, NY, NC, OH, TN, TX, VA, WA, and WV.

<sup>18</sup> For additional information on evaluation methodologies and findings, see the QIC-DR's literature review, available from [http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/QIC-DR\\_Lit\\_Review%20version%20%202.pdf](http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/QIC-DR_Lit_Review%20version%20%202.pdf).

## Outcomes

Outcome evaluations have assessed the impact of DR on various child and family outcomes and services:

**Child safety.** Collective evaluation results suggest that child safety has not been compromised where DR has been implemented (QIC-DR, 2011; QIC-DR, 2014). Early studies revealed that children in AR cases were less likely or as likely as children in IR cases to be the subject of a subsequent report or investigation (Center for Child and Family Policy, 2009; Loman et al., 2010; Shusterman, Hollinshead, Fluke, & Yuan, 2005; Siegel et al., 2010; Siegel & Loman, 2006). This finding was maintained even when comparable lower-risk families were randomly assigned to tracks, as in Minnesota and the early Ohio evaluation. While reductions in re-reports tended to be modest, they were statistically significant (Loman et al., 2010; Loman & Siegel, 2005). The 2014 QIC-DR cross-site evaluation found that in Colorado and Ohio, AR families were less likely to be re-referred to CPS than IR families, whereas in Illinois, the AR families were more likely to be re-referred. In all three sites, the longer families received services, the more likely that there would be a re-referral (QIC-DR, 2014). Additional analyses conducted in Illinois explored the effects among different groups of AR families and found that families that were switched to IR (but were still considered AR families in the safety analysis) had significantly higher risk of re-reports and substantiation than families that initially received an investigation. Families that withdrew from DR services had significantly higher risk of re-reports but not of substantiation (Fuller, Nieto, & Zhang, 2013).

**Subsequent out-of-home placement.** Minnesota, Missouri, and the early Ohio evaluations demonstrated modest reductions in child removal for families on an assessment pathway (Brown et al., 2012). Following families for 3½ years, Minnesota found that fewer children in AR families were placed in out-of-home care (17 percent) as compared with children in control families that received investigations (19 percent) (Siegel & Loman, 2006). In the QIC-DR cross-site evaluation,

DR implementation did not appear to affect entry into out-of-home care, either positively or negatively. Less than 5 percent of children from AR families and likewise from the control group of IR families were removed at any time during the year study period (QIC-DR, 2014.) A follow-up study in Ohio that extended the study period to 4 or 5 years found that out-of-home placements were significantly lower for AR families as compared to control families (Loman & Siegel, 2014).

**Service delivery.** Several early evaluations found that AR children and families received more services and received them earlier than did IR children and families (QIC-DR, 2011). Studies found that when compared with families who were randomly assigned to receive an investigation, AR families tended to receive more concrete material assistance, such as support for housing costs, food, transportation, and clothing, as well as help with job training and child care (Brown et al., 2012). The QIC-DR cross-site evaluation found that across all three study sites, a statistically significant higher proportion of AR families in comparison to IR families received at least one service. As with other studies, AR families were more likely to receive services to meet material needs. Only in one site (Illinois) was there a significant difference in terms of AR families receiving services more quickly than IR families. Nevertheless, the vast majority of families in the study did not receive any services (QIC-DR, 2014).

## Cost Analyses

Cost studies suggest that DR may be cost effective over the long term. Minnesota's cost study found that costs of AR in the early stages of a case (including direct service costs and costs associated with worker time) were greater than costs of a traditional CPS intervention. However, costs for case management and other services were lower through two follow-up periods. Savings achieved later more than offset the early investment costs (Siegel, 2012b).

Results from the QIC-DR sites have been somewhat similar. A 2013 study using a small sample of data from

two of Ohio's counties found that overall costs were slightly less for the AR families compared with costs for IR families (Murphy, Newton-Curtis, & Kimmich, 2013). The QIC-DR cross-site examined initial case costs plus 1 year's follow-up costs incurred in Colorado and Illinois. In Colorado, average AR cases were slightly more expensive than IR cases (overall mean of \$1,212 versus \$954, respectively), but the differences were not statistically significant (Winokur et al., 2014). In Illinois, there were significant differences—AR cases cost on average substantially less than IR cases (\$725 versus \$2,738, respectively) (Fuller, Nieto, & Zhang, 2014). Across sites, evaluators noted that out-of-home placements, while infrequent, contributed to higher costs.

## Lessons Learned

Evaluation and practice experiences across varied jurisdictions point to several important lessons learned. New jurisdictions starting out as well as those moving forward with DR implementation may benefit from the following recommendations:

- **Take time to plan and prepare.** Setting the foundation for DR requires time and effort to enable necessary shifts in philosophy, structure, organizational culture, and practice. Necessary activities may include conducting outreach and education, obtaining stakeholder input and buy-in, facilitating legislative changes, developing protocols and guidelines, adapting staff responsibilities, training and building capacity among staff, planning for evaluation, making data system modifications, and instituting other changes to align systems with practices. Be mindful that other parts of the child welfare system will need to change either before DR can be implemented or in response to it.
- **Foster stakeholder buy-in.** Buy-in and endorsement by key stakeholders can facilitate implementation and sustainability of DR and may also mitigate resistance. Some sites have found it necessary to reaffirm DR's commitment to safety and frame the new pathways as an add-on and not a replacement of traditional investigation (Casey Family Programs, 2012).
- **Encourage peer-to-peer learning.** Contact with State and local agencies that have experience with DR has helped other agencies to replicate promising strategies or avoid pitfalls. Many jurisdictions have benefited from shadowing opportunities between a new site and a more experienced site and also from peer networking mechanisms.
- **Incorporate training and ongoing staff development opportunities.** The early experiences of the QIC-DR sites pointed to the need for training all staff (IR and AR workers) to help promote a shared understanding of DR. They also highlighted the importance of coaching and development activities for supervisors who play an important role in supporting new practices and may need to oversee functions with which they themselves have little experience (QIC-DR, 2012; Brown et al., 2012).
- **Pay attention to workload impact.** Administrators need to carefully consider how DR will affect workload and caseload management in both the short-term, while supervisors and workers are experiencing learning curves, and also over the long-term as practices become more established (Brown et al., 2012). Administrators must also be sensitive to potential inequities (or perceived inequities) in the caseloads and workloads of workers on different DR tracks and staff responses to them (e.g., resentment, push back).
- **Convey support and value for the entire child protection structure and not just new pathways.** One unintended consequence of DR restructuring and the promotion of an assessment pathway is the potential to send negative messages that leave investigative workers feeling devalued (Carpenter, 2012). Investigations remain a critical response for moderate- and high-risk child protection cases, and that message must be communicated broadly and routinely.
- **Be aware that the introduction of DR may lead to systems changes beyond the AR pathway.** The QIC-DR evaluators noted that in two of the three sites, the entire child protection system was affected by the

introduction of the new pathway (Murphy, Newton-Curtis & Kimmich, 2013; Winokur et al., 2014; QIC-DR, 2014). Changes such as new screening procedures, family engagement activities, revised family service plan documents, and team case consultation processes were introduced throughout the agency and benefited families on both the AR and IR pathways. Over time the two pathways evolved so that they were both different from traditional child protection responses but not necessarily that different from each other.

- **Ensure service availability and strengthen community relationships.** DR implementation has been a catalyst for conversations about which families who encounter child welfare are provided services, particularly given limited resource availability. A few DR evaluations showed that AR families received more services and/or received them more quickly than those randomly assigned to an IR pathway. One of the other results of DR implementation appears to be workers' enhanced knowledge of and orientation toward accessing services for *all* families (Lisa Merkel-Holguin, personal communication, August 26, 2013). Successful implementation of all child protection responses requires that the child welfare agency can tap into a robust array of community services that support families (Casey Family Programs, 2014). Many agencies have found it helpful to work with community partners to identify and secure services from public and private agencies and help develop additional services as needed.
- **Recognize that implementation of DR is a developmental process.** Expansion of DR is not always linear—to the contrary, often implementation of system change will start and stop, sometimes experiencing setbacks before advancing forward (Casey Family Programs, 2012). Lessons learned through evaluation, particularly when evaluation is incorporated early into implementation, can be valuable in shaping ongoing development.

## Conclusion

The expansion and enhancement of DR efforts represents significant child welfare reform. Child protection systems

have been adapted to meet varying family circumstances with distinct responses. Moreover, DR supports agencies in adopting approaches that maintain a dual focus on keeping children safe and responding to families' broad-based needs. In general, evaluations demonstrate that children are at least as safe in AR cases as in traditional IR cases, parents are engaging in services, and families, caseworkers, and administrators are supportive of DR.

State and county experiences with DR also point to systemwide changes in attitudes, policies, and practices—evident among both AR and IR pathways. These shifts may result from the infusion of DR principles and procedures throughout child welfare agencies and also from parallel reform efforts in areas such as family engagement and solution-focused assessment. With increasing numbers of States and jurisdictions turning to DR, new variations are likely to emerge. At the same time, given the ongoing trends, the distinctions between alternative and investigative responses may continue to lessen.

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