Oregon
Kate Brown, Governor

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TO: Co-Chair Senator Steiner Hayward
Co-Chair Representative Rayfield
Human Services Subcommittee members

FR: Department of Human Services

RE: Child Welfare Day One Supplemental Quessions.

1. For those Alternative Response/Traditional Response assessments where families had high/moderate needs and accepted voluntary services, report the number/percent of children that had subsequent CPS reports, Founded reports, and removals into Foster Care.

   In a Differential Response county, if all children are safe, families with high-to-moderate needs are offered voluntary services. In FFY 2015 a total of 122 children were involved with families who accepted these services. Within the next 12-month period, DHS received subsequent CPS Reports of alleged maltreatment for 53 of these children (43 percent). Of those, 23 children (19%) had a founded CPS report and 8 children (7%) were removed.

   FFY 2015 Children Who Received Voluntary Paid Services Post-Assessment in a DR-County, and had subsequent CPS Reports, Founded CPS Reports and/or Foster Care Removal in the following 12-month period.

| | DR Admin Only Voluntary Services | Child Has a Subsequent Report | | Child Has a Subsequent Founded | | Child Has a Subsequent Removal | |
|---|---|---|---|---|---|---|---|
| | Count | Count | % | Count | % | Count | % |
| **Traditional Track** | 34 | 20 | 59% | 6 | 18% | 1 | 3% |
| **Alternative Track** | 84 | 33 | 39% | 17 | 20% | 7 | 8% |
| **Non-DR County** | 4 | 0 | 0% | 0 | 0% | 0 | 0% |
| **Total** | **122** | **53** | **43%** | **23** | **19%** | **8** | **7%** |

Note: the 4 Non-DR county cases likely started in a non-DR county and then moved to a DR county.

2. Please provide additional national data on DR and any other informative documents related to DR. (Note this is updated from the original day one question response.)

   Oregonians agree that children who stay safely at home with their families have the best chance to thrive. Children are safer and families stronger when DHS, communities and families work together to identify and provide for the families' needs as early as possible.

   Differential Response is a family centered approach for families struggling with issues of child abuse or neglect. Differential Response includes two tracks, an Alternative Response and a Traditional Response.

   In all counties in the state, whether they are practicing DR or not, when Child Welfare receives a report defined by law as child abuse or neglect and the report requires assessment by the department, a timeline of 24 hours or 5 days is assigned. In addition, all counties conduct comprehensive CPS assessments based on the Oregon Safety Model.

   In counties practicing DR, after the screener determines a report meets criteria for assignment, they then decide whether the report is assigned as either a Traditional or an Alternative Response. Child Welfare Screeners make the track assignment decision based on information received from the reporter, a review of the CPS history, and information from collateral sources. However, an Alternative Response is encouraged for most cases that do not allege severe harm. Approximately half of the assigned assessments in DR counties have been assigned Alternative Response and of those approximately 10-15% half switched to Traditional Response when needed.

   What's the same whether Alternative Response or Traditional Response?
   1. Safety, Permanency & Well-Being of Children
   2. Family focused
   3. Strengths based through engagement
   4. DHS, Community and Family Partnership
   5. Comprehensive CPS Assessment of reported concern
   6. Identification of moderate to high needs
   7. Assess family strengths and needs
   8. Provision of services post-CPS assessment after case is closed when 6 & 7 apply
   9. Unsafe children are protected through child welfare intervention

What are the differences between AR and TR assessments?

| Alternative Response | Traditional Response |
|---|---|
| Reports do not allege severe harm | Reports allege severe harm |
| Joint first contact with support person/community partner offered | |
| More often allows for pre-arranged contact with families | More often requires unannounced contact |
| No disposition | Disposition of founded, unfounded or unable to determine |
| No central registry entry | Central registry entry for founded disposition |

Alternative Response provides more opportunity to partner with families and community to solve family issues related to abuse and neglect. Removing dispositions and recognizing family as the experts of their own families are two parts of Alternative Response.

When child protection workers are assigned a case of abuse or neglect in the Alternative Response, they generally call ahead to set up a time to meet with the family to complete a comprehensive safety assessment to determine if the child is safe. The family will be asked if there are any people of support they would like to accompany the CPS worker on the first visit.

The Traditional Response is for the most serious reports of child abuse or neglect. These cases also receive a comprehensive safety assessment. A finding as to whether abuse or neglect occurred must be made.

Whether the assessment is Traditional or Alternative, when the child is determined to be safe and the family determined to have moderate to high needs, a service provider may also assess the family's strengths and needs in order to help the family determine what services and community connections may be helpful to them after the CPS assessment is closed. Moderate to High Needs means: The child/ren are safe but the family conditions, behaviors or circumstances are likely to have a negative impact (not judged to be severe) on the child's physical, sexual, or emotional/ behavioral development or functioning over the next year without intervention. And that short-term targeted services can reduce or eliminate the likelihood that negative impact will occur.

When a child is found to be unsafe in either response, DHS will work with families to protect children. Foster care is the last resort and is used only when attempts to keep children safe at home have been exhausted.

There are some optional components of the CPS assessment process in Differential Response.
They are:

- whether the family opts to have a support person at the first visit with family or beyond;
- whether the family opts to have a Family Strengths and Needs Assessment conducted with a community service provider when their children have been determined to be safe and their family has moderate to high needs; and
- whether the family, with safe children and moderate to high needs, wishes to be connected to services in the community either paid by child welfare or not.

For visual depictions of the differences and similarities between Alternative Response and Traditional Response CPS Assessments in Differential Response counties please go to:
http://www.oregon.gov/DHS/CHILDREN/DIFFERENTIAL-RESPONSE/Documents/Flowchart-Ar.pdf
http://www.oregon.gov/DHS/CHILDREN/DIFFERENTIAL-RESPONSE/Documents/Flowchart-Tr.pdf

In counties not practicing Differential Response, there is not the option to offer the Family Strengths and Needs Assessment or provide paid/contracted services to a family with a safe child and moderate to high needs after the CPS assessment is closed. In those counties, they may make referrals to non-contracted community services, but the CPS worker then closes the case because the children were determined to be safe therefore no safety threats for Child Welfare to continue to monitor and help manage.

Here are some general national findings, which our evaluators believe it may be too early to be seeing some of these results in OR:

- Child safety not diminished
- Families & workers more satisfied
- Re-reports reduced over time
- Re-abuse reduced over time
- Foster care entry reduced over time
- Long term costs reduced

Why Oregon chose to invest in Differential Response:

- the recognition that more children in Oregon were coming into care and staying longer because of neglect; and

- The Governor's Task Force on Disproportionality in Child Welfare report prioritized Differential Response (DR) as a strategy and recommendation to move Oregon toward the safe and equitable reduction of children in foster care; and
- National findings showed DR to be a promising practice

In addition there are two attachments at the end of this document. One is an article from Merkel-Holquin Bross the second is a "Differential Response Kit."

Respectfully submitted,

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Editorial

# Commentary: Taking a deep breath before reflecting on differential response

Having taken time to slow up and reflect, we ask: "Why should there be a special section on **Differential Response (DR)** at this time?" DR is neither completely accepted nor completely rejected by the field of child protection, although there have been strong positions staked out. At present, DR is debated primarily in a limited number of countries, but the implications of the current DR efforts are likely to be of interest to other countries seeking to reform their child protection efforts. Finally, reviewing DR at this time offers an illustration of "policy science in action" and the difficulties inherent in conducting valid research on child protection services systems.

DR as a change to the existing Child Protective Services (CPS) system in the United States was conceptualized and introduced into State legislation in Florida and Missouri in 1993 (Merkel-Holguin, Kaplan, & Kwak, 2006). As the concept has moved to other states and nations, the original concept behind DR, i.e., to formalize at least two pathways that CPS agencies use to respond to allegations of child maltreatment, has been maintained, with some significant implementation adaptations in other countries. The approach from the beginning involved maintaining an *Investigation Response (IR)* and adding a formal *Alternative Response (AR).* The originators informally hypothesized that a DR-organized CPS system would allow the agency to respond to all cases in a more distinct and nuanced manner, based on such factors as the type of maltreatment, extent of harm, family characteristics, risk levels, and previous exposure to CPS.

There were explicit and implicit assumptions built into the innovation. These included (a) approaching a family with an *investigation* may not be the best way to build a working relationship with a family; (b) different kinds of cases are best served by different responses; and (c) it would be good to be able to offer needed services to families willing to accept them, setting aside the need to prove child maltreatment for cases that are deemed lower-risk. It remains to be seen to what extent these and other assumptions have been tested as part of DR-motivated innovations.

In 2008, the U.S. Children's Bureau funded the Quality Improvement Center on Differential Response (QIC-DR) with the purpose of evaluating DR as actually applied, identifying best practices related to this reform, and understanding replication issues. The QIC-DR (2014, pp. 12–13) defined the two pathways as:

Alternative Response, sometimes also called the family assessment response (FAR), incorporates the following considerations:

- Establishment of AR pathway is formalized in statute, policy, or protocols;
- New information that alters risk level of safety concerns can cause the initial AR pathway assignment to change to IR;
- Families assigned to AR can choose to receive IR;
- AR families can accept or refuse the offered services *if there are no safety concerns*;
- AR families are assessed with no formal determination of child maltreatment (no substantiation decision); and
- Since no determination of maltreatment is made, no one is named as a perpetrator, and no names are entered into the central registry for those individuals who are served through the AR pathway.

The IR pathway requires a formal investigation that includes the assessment of the allegation of child maltreatment and culminates in a finding, such as substantiated, indicated, or not substantiated. An integral part of IR is the identification of perpetrators of maltreatment. The names of these people are generally included in a central state registry.

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## Implementation and Evaluation Efforts

To date, there have been a number of efforts to implement and/or evaluate DR (QIC-DR, 2014), both within the United States and internationally. What confounds the discussion of DR are the numerous and varying definitions of DR across U.S. states, Canadian provinces, and other countries. At best, the use of the term DR has become a complex proposition, with many assumptions that can be either explicit or implicit. CPS agencies and community partners implementing DR in different parts of the world have diverse and fluctuating policies, procedures, target populations, legislative frameworks, workforce structures, and criteria based on initial risk levels for assignment to AR or IR. Variability, on the other hand, also allows for CPS agencies to be more responsive to local contexts.

Since 2000, in the United States, there have been different attempts by various research firms and academic institutions to determine whether and to what extent a two-pathway CPS system is helpful, harmful, or has no effect, in several main areas: child safety, quantity, timing and type of services, parental engagement, and costs. In other words, what effect does AR have on these outcomes? The most rigorous research efforts publicized to date in the United States consist of 10 evaluations, of which seven employed a randomized control trial design, and three used quasi-experimental designs. These are supplemented by a fairly large number of evaluation efforts in Australia and Canada, some of which are reported in this volume. The methodologies employed, and the characteristics of the jurisdictions where the studies of DR implementation have occurred, necessarily should impact both results and interpretations of findings. Dispassionate observers will also recognize that the lack of consistent definitions is an obstacle to implementation, interpretation, and comparison.

By providing a point in time for reflection, this Special Section presents an opportunity to examine DR from several vantage points, to consider what further evaluation efforts might be most helpful, and to provide a touchstone to spur additional and more sophisticated inquiry into this CPS reform effort. Reviewing different aspects of the phenomenon of DR at this time is also an opportunity to highlight how attempts at child welfare reform seem to quickly attract strong positions, for and against programmatic and systematic change. This is happening well before the development of a critical mass of evidence from what are necessarily prolonged attempts to define and work through the nature and meaning of innovations.

DR is no different in this sense than other systemic reforms which have generated great fear of unintended negative consequences for vulnerable children. As with the timelines embedded in the Adoptions and Safe Families Act or the emphasis on maintaining children with families of origin implicit in campaigns to reduce the foster care population, safety-focused advocates fear that an otherwise laudable innovation will inadvertently place more children at risk of serious harm. On the other side of that debate, advocates prioritizing permanency and family integrity fear that any innovation failing to embrace those values disrupts natural family functioning and unnecessarily traumatizes children, often in ways that disproportionally impact already disadvantaged populations. It is rare for child welfare reforms to be quietly implemented and tested in highly reliable ways before policy conclusions for and against are solidified. There are still many unanswered questions and more open, reflective, fact-focused and carefully reasoned analyses are needed. With multiple definitions, widely varying local systems, and research that is still necessarily constrained by the need to carry out field tests in the "real world" of complex emotional and political agendas, much will always be needed to gain adequate understanding of the variables that correlate with increased or decreased child and family safety and well-being.

### *Separating Claims and Data from Both Pros and Cons*

One challenge for evaluating DR dispassionately is to consider how the assumptions favoring or disfavoring DR have sometimes changed over the course of DR implementation. For example, as the number of public child welfare agencies implementing DR expands and evaluation results emerge, so do the reasons for implementing this CPS reform. As with many innovations in child welfare, headlines and proclamations may misinterpret, overly simplify, or inflate what is claimed as achieved or even possible and simultaneously might avoid nuance and qualification in the name of promise. One jurisdiction's promising research findings from implementing DR may become the expectation for the next community, even if the implementation structures and underlying cultures and conditions are significantly different.

As one example, it is possible to note a few of the many technical reports, manuals, and newspaper stories that highlight or even "headline" claims about DR. When such highlights are noted we try to provide the possible origins of the particular assumption or claim that is highlighted and point out the questions that we believe then become important for the child welfare field to answer in the years to come. Among these headlines are

*DR Allows for More Functional Non-Adversarial Relationships Between CPS Workers and AR Families*. Some questions have emerged from this statement: Do families experience IR as adversarial, and if so, then under what conditions, and to what extent does this affect case outcomes; and what are the ways caseworkers can engage with families to decrease emotions of hostility and/or resistance? On the AR pathway, do casework assessment practices always reflect strengths-based, solution-focused practices that are increasingly embedded into both child welfare responses? If consistently reflected in practice, do these assessments work to reduce animosity? If a state changes the language of its practices from *investigation* to *assessment* does that help change the culture of worker belief and parental perception? The literature has detailed the inherent tension between caseworkers' dual roles of helping and policing/investigating (Drews 1980; Dumbrill, 2006). Various research studies have captured clients' perspectives about their involvement (voluntary and involuntary) with CPS, with some of those emotions noted as fear, anger, and shame (Buckley, Carr, & Whelan, 2011; Dale, 2004; Diorio, 1992).

*DR Results in Caseworkers Being Better Able to Engage AR families*. This statement gives the impression that family systems are necessarily engaged in the AR pathway, which may or may not be accurate. Parents and/or caregivers, along with their children, are part of the initial CPS intake and assessment process, but it is unclear whether the term *family engagement* has been inadvertently inserted for what is more accurately described as *parent engagement*. Independent of this statement's validity, the emerging questions are: what are the active ingredients to the AR caseworker-parent relationship that results in better engagement? Are there innovative participatory practices that accompany the AR pathway that caseworkers are using to engage parents/caregivers and perhaps the broader family system? If so, what is their nature, and under what conditions are they most successful? Again, which of these approaches could and should be tried by IR workers?

Dumbrill (2006) concluded from his qualitative study that the separation of casework and coercion is difficult if not unlikely, from a CPS client perspective, even in DR-organized CPS systems. In AR, child welfare agencies have adopted new engagement strategies and techniques, and the substantiation decision has been eliminated. Although many have hypothesized this to be one of the largest barriers to engagement, does this change alone overcome parents' initial reactions to being involuntarily involved in what is perceived as an intrusive government agency with significant power to impact family life?

The implementation of DR has illuminated the engagement construct as being critical to the CPS paradigm, but it has also begged the question of what engagement means. Is engagement most closely tied to notions of positive emotional responses, partnership, collaboration, or even compliance? Can the DR research be used to more fully explore concepts of engagement? Fuller, Paceley, Schreiber, and Jones (2015) note that CPS parents (both AR and IR) perceived that a positive and emotionally supportive relationship with their caseworker was most helpful to them. Merkel-Holguin, Hollinshead, Hahn, Casillas, and Fluke (2014), also in this issue, were able to isolate factors that influence parents' emotional responses to CPS. However, it is unclear whether these measures alone led to a greater proclivity to engage. It does seems valuable that parents had lower reports of worry if they received AR, had higher ratings on the casework scale, and experienced only one face-to-face contact (vs. two or more) with the caseworker. This of course assumes that only one contact was sufficient for assessment or intervention. Although this Special Section contributes some new knowledge to this complex proposition, unpacking the concept of engagement will require concerted efforts in the years to come.

*DR-organized CPS systems result in more families receiving services, especially material or economic hardship services for AR families, who are deemed low-to-moderate risk*. The hypothesis is that by serving and meeting the needs of low-to moderate-risk families through AR, children in these families are less likely to be maltreated, and accordingly these families are less likely to be re-reported to CPS in the future. There is an assumption that most families who are reported to CPS, whether they receive AR or IR, have some needs, which informal or formal services might address. Dependent on jurisdiction, this assumption may be interpreted as only AR families need to receive more services. What DR may have done, however, is shine the light on the dearth of services that caseworkers can access to meet CPS families' needs, independent of whether they are designated AR or IR.

With the implementation of DR, caseworkers have reported unearthing new community resources, understanding better how to access other government benefits, and helping parents navigate complex systems to gain needed resources. Such activities should benefit both AR and IR families (Murphy et al., 2012; Winokur et al., 2012). This was not originally identified as a purpose of DR, but if confirmed, it would seem to be worthy of study as a good result even if some other promises of DR are not confirmed. Cameron and Freymond (2015) the significance of accessible service delivery models on client willingness to ask for help, creation of constructive relationships, and access to services.

On the other hand, what is the evidence of any CPS agency providing an improved or disproportionate share of services and resources to low-to-moderate risk AR families at the expense of IR families? Alternatively, what is the evidence that caseworkers have increased the service pool that can be accessed for all CPS families? Separately, what services, if any, provided through IR or AR, are considered most helpful by parents? Will the helpfulness of those services result in behavior or attitudinal changes of the caregivers, and is such change enduring or transitory?

An examination of how much and to whom agency services are provided under a DR system, as compared to a "standard" approach, usually obscures the question of whether the same "services pie" is being divided differently, or whether a larger "services pie" is being obtained to implement DR. The fact that some agencies implementing DR received additional funding for AR families (e.g., Ohio Round 2 counties [Murphy et al., 2012; Winokur et al., 2012]) might allow an inference to be drawn that DR inherently yields more service dollars (i.e., a larger "services pie"). Additional funding to implement innovations rarely continues. Thus, depending on ongoing additional funding is a potentially damaging implication unless thoroughly justified, because it is also possible that a decrease in "founded cases of child maltreatment" will do more than affect the epidemiological analysis of child abuse and neglect trends. It ignores the possibility that once fewer cases are founded, legislatures will appropriate less money on the basis that there is always need for human services but limited revenues justify only services to address actual child maltreatment or to prove its prevention.

*AR is Voluntary and Provides Families with More Control of Decisions About Their Lives*. The idea that AR is voluntary is a misrepresentation of its implementation in most CPS systems in the United States, which may not be the case in other countries, such as Australia. Lonne, Brown, Wagner, and Gillespie (2015) describe the implementation of differential response in Australia, where early services are voluntarily provided to families, some with highly complex needs. Voluntariness means that families, without consequence, can elect to partake in whatever the agency is offering, from the initial and ongoing assessments to services. Because most families in the United States who receive AR are the subject of screened-in, accepted

child maltreatment reports, the child protection agency, at a minimum, must conduct some form of assessment for such factors as safety, risk, danger, harm, strengths, and protective factors. AR families cannot forego this initial assessment: a refusal results in the case being switched to IR. The next decision point where voluntariness is tested is at service provision. If CPS agencies believe a service is necessary to shore up children's safety or for some other reason, then families cannot decline its' receipt. Although structurally having a way to reassign cases or transfer them between the AR and IR pathways is intuitive and logical, does it also escalate the possibility of coercion that systems have over families under both models?

*AR Reduces the Investigatory Nature of CPS and Reduces the Workload of the Judiciary*. As Janczewski found and reported in this issue, U.S. counties implementing DR did in fact have lower investigation and substantiation rates, but higher substantiation rates among investigation cases. Using a different methodology, Harries, Thorpe, Cant, and Bilson (2015) also concluded that the number of child protection investigations in Australia could be substantially lessened without compromising the child welfare system's capacity to prevent harm. This leads us to ask: Does a two-pathway system create a self-fulfilling prophecy (i.e., IR cases are deemed more serious so they are investigated as more serious and AR workers view AR cases as less risky and so assess less intensely)?

The notion in DR-organized CPS systems is that the forensic response will be reserved for cases of sufficiently serious harm. In essence, this would allow for investigative caseworkers to apply specific skills to families who require significant precision and attention. This may also allow CPS caseworkers to more effectively partner with police and other community partners in conducting investigations. It might also translate into the courts seeing the same or lesser number of families, and allow the courts time to concentrate on the most serious, egregious cases of maltreatment. However, could the DR system also result in IR caseworkers' workloads being comparatively more strenuous, stressful, and trauma-inducing if the children and families with whom they exclusively work have more entrenched issues and more severe abuse and neglect histories without the *leaving effects* of working with healthier families?

*DR Results in More Comprehensive Assessments of Families Coming to the Attention of CPS*. This might be related to the assumption that caseworkers spend more time, albeit still a limited amount of time, with AR families than IR families. This might be true, but does not necessarily result in a fuller and more accurate portrait of what brought the family to the attention of CPS. A more in-depth exploration of how assessment and investigation processes change through the implementation of DR is warranted, including how the assessment processes vary for IR and AR families. If different assessment processes are used, do they result in sufficiently substantial information about children and families to match services to their needs? Waldfogel (2000) noted that in a DR paradigm, CPS systems would need to improve screening and assessment functions to better decipher risk levels so that those families deemed at higher risk for maltreatment are served through IR. Some CPS agencies implementing DR have created enhanced screening protocols and mechanisms in an effort to improve initial screening and pathway assignment decisions (Winokur, Ellis, Drury, & Rogers, 2014).

It was noted earlier in this Commentary that the information gathered by CPS hotlines and the criteria identified by state policies are assumed to be sufficient in assigning families to IR or AR. The work with DR should not obscure the difficulty created by the absence of a "science of triage" that would improve resource allocation irrespective of the CPS system employed. This leads to the obvious need for research to anchor CPS with a replicable, reliable, objective, and validated means of determining, for example, who gets AR or IR. Germane to this topic, Jones (2015) found that children of color (or non-White children) were less likely to be assigned to AR, when controlling for poverty and other risk factors.

*In DR-CPS Systems, AR Families are As Safe or Safer Than IR Families*. This headline stems from the Minnesota and Ohio random control studies (Loman and Siegel, 2004; Loman, 2010). Loman et al. found reductions in subsequent screened-in reports of child maltreatment for AR families, compared to AR-eligible families who received IR. Since that time, however, descriptive statistics from DR evaluations in New York (Ruppel, 2011), Colorado (Winokur et al., 2014), and Ohio (Murphy et al., 2012) show no difference in this indicator between AR and IR families. In Illinois, the reverse from the Minnesota and Ohio studies was found with AR families being more likely than IR families to have a screened-in re-referral. In this issue, two articles (Loman & Siegel, 2014; Winokur et al., 2014) tackle this statement, providing more sophisticated analyses for a challenging question.

Most CPS researchers probably accept that although re-referrals and re-reports are generally accepted indicators of child safety in CPS, they also are imprecise measures. Published evidence, with the exception of Illinois, shows that AR families are either less likely to be re-referred to CPS than are IR families or are re-referred at the same rates. This may imply that AR families are as safe as IR families given current information, again acknowledging that this was not found to be true in a very large state (Illinois). How can the next generation of research be structured to provide more convincing child safety data? Can research help us understand different outcomes to date, and what factors in the AR pathway, engagement techniques and services provided, might be contributing as mediators to these attaining these varied outcomes? Pending more sophisticated analyses, any headlines risk presenting premature conclusions and overgeneralizations.

*DR Reduces the Number of Children in Foster Care*. More recently, in 2012 and 2013, newspaper articles and technical reports have correlated implementing DR with decreasing the number of children in foster care. Longer-term analyses of the Minnesota and Ohio DR data sets have fueled this claim (Loman & Siegel, 2004; Loman & Siegel, 2013; Loman & Siegel, 2014). However, as noted by the QIC-DR (2014, p. 123), "the implementation of AR did not appear to impact—positively or negatively—the entry of children into foster care" in any of the later three sites studied. Such a result is also suggested by Winokur et al. (2014). Given that the lower entry rates into foster care were not replicated in the most recent studies, that most States reserve the AR pathway for what they initially classify as low to moderate risk cases, and that this population of AR children is predictably less likely than their IR counterparts to be placed outside the home, this

lower-out-of-home-placement outcome might not be tied to the implementation of DR. Perhaps the decrease in foster care admissions in the United States is the result of other child welfare policies, practices, and system changes occurring more globally. This would align with observations by Janczewski (2014), who found that although there were significant reductions in removal rates associated with DR implementation, the AR or IR pathway was not a variable in creating that reduction.

*DR Reduces the Costs of Child Welfare Systems*. It appears that, increasingly, DR is being described as a way to reduce or reallocate child welfare system costs, particularly as it is being implemented as a core component of a number of States' Title IV-E waiver demonstration projects. Previous evaluations of DR in Minnesota and Ohio, however, have shown that initially, AR actually costs more than IR. This finding likely correlates to two factors: caseworkers spent more time with AR families than IR families; and child welfare agencies leveraged more flexible dollars to meet AR family needs than those that were available for IR families. When AR and IR families are tracked over time, the converse occurs, with IR costing more than AR (Loman & Siegel, 2004; Loman & Siegel, 2013). This is likely because in the Minnesota and Ohio studies, there was a greater likelihood of IR families being re-reported to CPS and having children enter foster care than AR families. Two QIC-DR local evaluations also demonstrated that over-time IR cases cost more than AR cases (QIC-DR, 2014).

*AR is An Evidence-Based Practice*. AR has been deemed as a promising practice with a high level of interest for the child welfare field by the California Evidence-Based Clearinghouse for Child Welfare (2014) based on the research evidence reviewed (albeit incomplete). Neither AR nor IR are standard, manualized interventions or practices. The variability of what constitutes AR—at the level of a family, caseworker, or government at the local, state, and national level—makes this presently not feasible. The implementation of AR modifies the CPS system, which likely also impacts the delivery of IR. So the question that emerges is whether any system level policy modification can be viewed as evidence-based or whether this is reserved for specific interventions? Therefore, we believe that at best, DR can be classified as being an evidence-informed system change.

## Summary

Although there are certainly limitations to each and every research and evaluation project in child welfare, as with other fields of study, understanding DR as a CPS reform has been fostered through many thoughtful and rigorous studies that have employed random control trial evaluation designs. For each assumption addressed in this commentary, we have raised a few questions. For all interested in CPS reform, other questions arise because child protection and child welfare professionals are trying to encourage more scientific ways of thinking as a means of engendering improvements:

1. Has the research on DR spotlighted the inadequacy of CPS interventions, either AR or IR? A high percentage of CPS responses are short-term. Is it reasonable to expect significant differences between AR and IR families and improvements in the CPS population, given that families often present with problems characterized as intractable but the intensity of the CPS response, coupled with limited service availability and accessibility, may not be sufficient to meet family needs?
2. Has the DR research, which has mainly focused on AR families, also highlighted the glaring absence of quality research in what is effective in producing positive outcomes for families that receive traditional child abuse and neglect investigations?
3. Does the implementation of DR move the CPS field ahead in terms of making better triage decisions, identifying especially those that require CPS involvement as compared to those who will benefit from but might not absolutely need intervention? Is 'triage' an *explicit* assumption of the DR innovation? Is it an *implicit* assumption of DR, however defined? If triage is not part of the research, does the ability of child protection to respond both differentially and also correctly to cases needing most, some, or no attention remain unknown? Until there is a reliable and valid way for determining for which families services are most urgently needed, are many reforms in CPS at risk of not producing the outcomes desired?
4. Are there other unintended consequences of either accepting or rejecting DR that might not have been considered?

Our current perspective is to state the obvious and point out that rarely are scientifically or "evidence-based" changes in practice achieved or discredited in a decade or two, much more a scant few years. Breathing deeply from time to time, and even pausing for reflection once in awhile, are useful habits for taking on long-range and difficult human endeavors.

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# The Differential Response (DR) Implementation Resource Kit:

A Resource for Jurisdictions Considering or Planning for DR

Updated—May 2014

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## Introduction



## Resource Kit Sections

# Introduction

The Differential Response (DR) Implementation Resource Kit is a resource for child welfare jurisdictions that are interested in ways that others have approached Differential Response implementation. The Resource Kit provides readers with information on the various ways that jurisdictions have conducted their implementation processes, including the basic design features for DR implementation, and sections organized around the following topics:

- Policy
- Practice
- Implementation Processes
- Communications
- Evaluation

Casey Family Programs is the nation's largest operating foundation focused entirely on foster care and improving the child welfare system. Founded in 1966, Casey's mission is to provide and improve ─ and ultimately prevent the need for ─ foster care in the United States. We are committed to our 2020 Strategy—a goal to safely reduce the number of children in foster care and improve the lives of those who remain in care. As a national foundation, we believe we can achieve our 2020 strategy by investing in three primary areas:

- Direct Practice
- Strategic Consulting
- Public Policy

The Differential Response Implementation Resource Kit is not a statement of Casey Family Programs' position regarding Differential Response. The Resource Kit was created in order to share knowledge of how jurisdictions have implemented DR.

Available on a web-based platform, and in a traditional PDF format, the Resource Kit provides extensive information on the DR implementation processes of jurisdictions across the United States. Each of the five sections includes a matrix of survey items asked of 16 jurisdictions with currently operational DR systems. Each section also includes a narrative analysis of the matrix, as well as an electronic web folder, which includes documents that are either publicly available or were shared by the surveyed jurisdictions for public use. Some sections include additional tools or resources that can assist jurisdictions with their planning processes, such as the DR Legislative Language Matrix (in the Policy Section) and the Communications Materials Matrix (in the Communications Section).

## Differential Response in Child Welfare

Per Federal mandate, traditional Child Protective Services (CPS) systems treat all screened-in reports of child abuse and neglect in a "one size fits all" approach, requiring a forensically-focused investigation to determine whether or not the maltreatment occurred, regardless of the severity of the allegation or the strengths and needs of the family. For low to moderate risk cases, investigations may not be appropriate,[1] because by their very nature, they are narrowly focused, and may not be able to identify broader issues occurring in the home that may impact

[1] See P. 9 of Merkel-Holguin, L., Kaplan, C., and Kwak, A. (2006). *National Study on Differential Response in Child Welfare.* Englewood, CO: American Humane Association and Child Welfare League of America. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/Documents/Research_eval%20tab/pc-2006-national-study-differential-response.pdf

child safety.[2] As a result, investigations can miss opportunities for helping families to prevent issues in the future.

By contrast, Differential Response (DR), also referred to as 'alternative response,' 'multiple response,' or 'dual-track,' provides child welfare agencies with a response continuum, including ways of responding that are proportionate to the severity of alleged child maltreatment and the family's level of need. DR separates out reports of abuse and neglect into risk categories; high-risk cases are served with a traditional investigative pathway, while lower- to middle-risk cases are served by an alternative family assessment pathway, and sometimes a community services pathway is also offered for cases that would otherwise be screened-out. Family assessments allow workers to engage families as partners by allowing them to identify their own strengths and needs, and connecting them to appropriate services and resources available in the community.

Expanded ways of responding to reports can allow for more individualized treatment, better matching the intensity and type of services to family needs. According to the research, systems function well when a robust set of family support services is available in the community, where the economic, health, mental health and other needs of these families that brought them to the attention of child welfare can be addressed. In order to be responsive to child safety needs, DR systems provide workers with the flexibility to switch the family's track to a traditional investigative response (TR), when new information comes to light that reveals the presence of safety threats in the home. The evidence base for DR has demonstrated improvements in family engagement, worker satisfaction, and community satisfaction and cooperation, while maintaining child safety (with the exception of Illinois' evaluation)[3].[i] DR has also shown reduced foster care entry rates, which have contributed to some cost savings over time.[ii]

In describing how DR works, Minnesota created a simple formula: A + B = C, where (A) involves approaching a family in a respectful, strengths-based way consistent with family-centered practice, (B) involves providing services and assistance, often of a basic kind, that fit the needs and circumstances of the family, and (C) is the outcome, the results desired by the family and agency: reducing future risks to the child, enhancing child and family well-being,

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[2] As cited from Siegel and Loman, 1997 (p. 214-215, and Table 5.3 on p. 93), Siegel (2012) notes that: "A particular reported allegation about a family was generally not predictive of what kind of allegation would be made in subsequent reports that might be received. Take, for example, reports in which one of the allegations was educational neglect. If the initial report (which brought the family into our study) involved educational neglect you might suspect that subsequent reports involving these families might also involve educational neglect. They did, but only 25 percent of the time. Subsequent reports on these families were more likely to involve other accusations and not include educational neglect 75 percent of the time. In fact, 81 percent of second and third reports that involved educational neglect concerned families whose initial report did not include this problem. This same pattern, or perhaps better lack of pattern, was found irrespective of the initial allegations contained in a maltreatment report, whether the report involved sexual abuse or physical abuse or lack of supervision or medical neglect. This indicated that the particular allegations in the report were often just the tip of the iceberg, what was observed by the reporter, but that there were other issues hidden from view (P. 14)." See:

- Siegel, G.L. & Loman, L.A. (1997). *Missouri Family Assessment and Response Demonstration: Final evaluation report*, p. 195. St. Louis: Institute of Applied Research. Available at: http://www.iarstl.org/papers/MO FAR Final Report-for website.pdf
- Siegel, G.L. (2012). *Lessons from the Beginning of Differential Response: Why it Works and When it Doesn't*. St. Louis: Institute of Applied Research. Available at: http://www.iarstl.org/papers/DRLessons.pdf

[3] Note that the recent DR evaluation from Illinois found that families initially assigned to the DR track had a higher re-referral rate than those assigned to the investigative track, and this difference was statistically significant. This was the first evaluation to show worse child safety outcomes for families assigned to the DR track since DR systems were first evaluated using large datasets and rigorous methods with Missouri's evaluation from 1997. For more information about the findings from Illinois, see: Fuller, Tamara, Nieto, Martin, and Zhang, Saijun (2013). *Differential Response in Illinois: Final Evaluation Report.* Urbana, IL: Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Available here: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/QIC-DR/Documents/Illinois%20DR%20final%20report%20January%202014.pdf

and strengthening the family's ability to take care of itself.[iii] For jurisdictions that were able to provide additional resources to support the implementation of DR, and to meet the service needs of additional families under DR, those jurisdictions were able to produce relatively large improvements in family outcomes, as well as cost savings under DR. For more information on evaluation findings see the Evaluation Section.

## National Overview of DR Implementation

It is important to note that DR systems vary widely across jurisdictions, and have important differences in terms of their structure, level of implementation, practice features between tracks, and available resources. At the time of publication, the current national landscape of DR implementation is rapidly growing (see the National Overview Map, below). DR is operational in 22 states, at a state or county-level (CO, CT, DC, HI, IA, KY, LA, ME, MD, MA, MN, MO, NV, NY, NC, OH, OK, TN, VT, VA, WA, WI). Similar front-end system reforms, which do not quite meet the full AHA/CWLA (2006) definition for DR, are currently operational in 8 additional states (CA, NJ, NM, ND, PA, SC, SD, WY).[4] DR has been discontinued in 6 states (AK, AZ, FL, IL, TX, WV),[5] but note that 4 of these are currently in planning stages of reinstating DR. Twelve states are currently considering DR implementation, or are in the early stages of planning (AK, AR, AZ, DE, FL, GA, ID, NE, OR, PR, TX, UT).

In September 2011, the U.S. Congress passed the Child and Family Services Improvement and Innovation Act, which allows a maximum of 30 states to conduct 5-year Waiver demonstration projects. These demonstration projects allow child welfare agencies to retain any funds they save from reducing the number of children in foster care (as opposed to the current funding structure of Title IV-E of the Social Security Act, which requires agencies to return savings back to the federal government).[6] DR has been an important system reform that has been included in several states' Waiver demonstration projects.

## Process of Gathering Information

The Resource Kit Team surveyed a total of 16 jurisdictions across the United States. These jurisdictions were included in this project because they currently have an operational DR system, and they agreed to speak with our team. The choice of these jurisdictions was not intended to serve as an endorsement of the "best" DR jurisdictions, but instead to identify jurisdictions from various social and political environments that have implemented DR in diverse ways. Jurisdictions were first contacted to participate in the Resource Kit project through Casey Family Programs' Strategic Consultants, who work directly with jurisdictional leadership in 49 U.S. states, and additional territories. Jurisdictions identified a lead contact (or sometimes several) from the child welfare agency, who typically was the DR manager and provided oversight during the DR implementation process. Information was collected through phone conversations and email requests, including a 25-item survey (which comprise the column variables for the 5 Section Matrices).

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[4] See the AHA/CWLA definition of DR on Pages 10-11 of: Merkel-Holguin, L., Kaplan, C., and Kwak, A. (2006). *National Study on Differential Response in Child Welfare*. Englewood, CO: American Humane Association and Child Welfare League of America. Available at: http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential-response.pdf

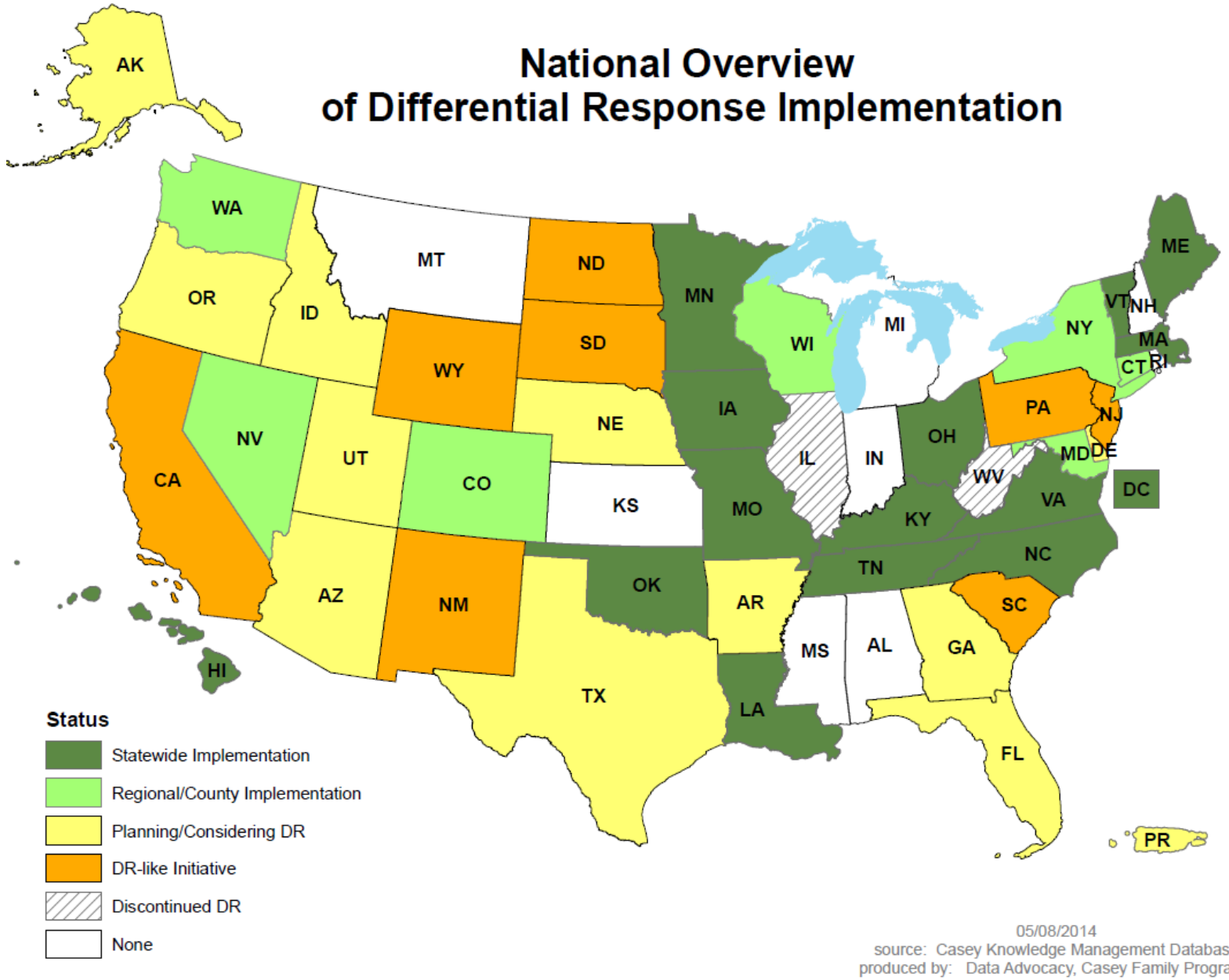
[5] For a discussion on why states have discontinued DR, see Page 12 of: Casey Family Programs (2012). *Comparison of Experiences in Differential Response (DR) Implementation: 10 Child Welfare Jurisdictions implementing DR*. Seattle, WA: Casey Family Programs. Available at: http://www.casey.org/resources/publications/DifferentialResponseReport.htm

[6] For more information on the Administration for Children, Youth, and Families, Title IV-E waiver process, see: http://www.acf.hhs.gov/programs/cb/programs/child-welfare-waivers

The Resource Kit Team also gathered documents that could be helpful for planning jurisdictions, and organized those documents within a set of electronic folders that encompass the Resource Kit Document Library.[7] Jurisdictions shared these documents with the Resource Kit Team for public use, or they were gathered from public websites. The folders are organized according to the structure of the Resource Kit and its 5 sections, and include the following types of documents: policy manuals, decision trees, assessment tools, training curricula, implementation plans, communication plans, communication materials, and evaluations (among others).

When available, the Resource Kit Team gathered information from online searches of publicly available literature and documents in advance of the phone conversation, to minimize the amount of information requested directly from the jurisdiction. As a result, the information contained in the Resource Kit Section matrices was primarily gathered from the jurisdictional contact, but was also supplemented with information from the research literature and agency websites. Whenever a source of information was not the jurisdictional contact, it is cited accordingly.

[7] The Resource Kit Document Library can be accessed here: https://drive.google.com/folderview?id=0B26M5TMdNUWNTnFTNHhIVU1nOVE&usp=sharing


National Overview
of Differential Response Implementation
AK
WA
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CA
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WY
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WV
GA
FL
SC
NC
VA
PA
NY
MD
DE
NJ
DC
ME
VT
NH
MA
CT
RI
HI
PR
Status
Statewide Implementation
Regional/County Implementation
Planning/Considering DR
DR-like Initiative
Discontinued DR
None
05/08/2014
source: Casey Knowledge Management Database
produced by: Data Advocacy, Casey Family Programs

# Basic Design Features of Differential Response

The Basic Design Features Matrix summarizes information that we learned from jurisdictions about the basic design features of DR that may be important for successful implementation outcomes. The design features (which are the column variables) were identified by participants through their anecdotal experience as the more important design components of their implementation planning process. The design features identified here cannot be determined to have a cause-effect relationship to better outcomes, but jurisdictions have emphasized the importance of these design features to their own success. The basic design features include:

- Strong legislation
- Less restrictive assignment criteria for the Differential Response (DR) pathway
- Use of a structured tool for pathway assignment
- All workers trained in DR
- Use of a coaching model
- DR families have full access to services available under Traditional Response (TR)
- Flexible funds available to meet family service needs
- Staged implementation process
- Utilization of extensive technical assistance
- Dedicated staff to manage DR implementation
- Strong communication strategy

The Basic Design Features Matrix includes a coding system to visually summarize the information learned in matrices throughout the Resource Kit.

## Code Key:

### Strong Legislation

Legislation was scored based on each jurisdiction's inclusion of four key elements in their legislation: (1) Strong definition of differential response; (2) Description of the community's role and service provision within the DR system; (3) Description of when a case should switch tracks from the DR track to a traditional response, and vice versa; (4) Guidance around the determination of abuse/neglect, and the handling of DR cases in a central registry.

| | |
|---|---|
| • 3-4 key elements | * |
| • 2 key elements | + |
| • 0-1 key elements | - |

### Less Restrictive Assignment Criteria for the DR pathway

From the Pathway Assignment Criteria Matrix, among the Family Risk/ Environmental Factors (Table 2) and Parental Factors (Table 3), what percent of cases are mandatory investigations? Note that Table 1: Severe Harm allegations are excluded from this analysis, as DR was not intended to address such allegations.

| | |
|---|---|
| • Less than 30% | * |
| • Between 31% and 50% | + |
| • Above 51% | - |

### Used Structured Tool for Pathway Assignment

| | |
|---|---|
| • Yes | + |
| • No | - |

### All Workers Trained in DR

| | |
|---|---|
| • Yes | + |
| • No | - |

### Used a Coaching Model

| | |
|---|---|
| • Yes | + |
| • No | - |

### DR Families Have Full Access to Services Available under TR

| | |
|---|---|
| • Yes | + |
| • No | - |

### Flexible Funds Available to Meet Family Service Needs

Flexible funds can be used to provide a robust set of family support services from the community, where the economic, health, mental health and other needs of these families that brought them to the attention of child welfare can be addressed.

| | |
|---|---|
| • Yes | + |
| • No | - |

### Staged Implementation Process

| | |
|---|---|
| • Yes | + |
| • No | - |

### Utilized Extensive TA

Utilized multiple sources of TA (when available), i.e. used TA beyond internal sources only.

| | |
|---|---|
| • Yes | + |
| • No | - |

## Dedicated staff to manage DR implementation

| | |
|---|---|
| • Dedicated staff position was created to manage the DR program and implementation process | * |
| • Primary staff who focused on DR implementation, but had other assigned responsibilities | + |
| • None/ no information available | - |

## Strong Communications Strategy

Communication strategy was scored on four key elements: (1) a strong and accessible website describing DR; (2) the development of key DR messages and/or principles; (3) the utilization of communication materials such as brochures, newsletters, and videos; (4) the utilization of webinars, PowerPoint, and other presentation materials to communicate DR to internal and external stakeholders. These key elements are based on information that is publicly available or was shared in the development of the Resource Kit.

| | |
|---|---|
| • 3-4 key elements | * |
| • 2 key elements | + |
| • 0-1 key elements | - |

| Basic Design Features Matrix | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Strong Legislation | Less-Restrictive Assignment Criteria for the DR Pathway | Used Structured Tool for Pathway Assignment | All Workers Trained in DR | Used a Coaching Model | DR Families have Full Access to Services Available under TR | Flexible Funds Available to Meet Family Service Needs | Staged Implementation Process | Utilized Extensive TA | Dedicated Staff to Manage DR Implementation | Strong Communi-cations Strategy |
| **LA County (CA)** | - | - (54%) | + | - | - | - | - | + | - | * | - |
| **SF County (CA)** | - | - (54%) | + | - | - | + | - | - | - | * | - |
| **Santa Clara County (CA)** | - | - (54%) | + | - | - | - | - | - | - | * | - |
| **Colorado** | + | * (0%, 45% including discretionary) | - | + | + | + | + | + | + | * | * |
| **Connecticut** | + | - (64%) | + | + | + | + | + | + | + | + | * |
| **Hawaii** | - | * (9%) | + | + | - | + | - | - | + | + | - |
| **Kentucky** | - | * (27%, 64% including discretionary) | - | + | - | + | - | - | - | - | - |
| **Louisiana** | + | * (27%) | + | - | - | + | + | + | + | + | - |
| **Massachusetts** | + | * (0%, 18% including discretionary) | + | + | - | + | - | - | + | * | + |

| Basic Design Features Matrix | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Strong Legislation** | **Less-Restrictive Assignment Criteria for the DR Pathway** | **Used Structured Tool for Pathway Assignment** | **All Workers Trained in DR** | **Used a Coaching Model** | **DR Families have Full Access to Services Available under TR** | **Flexible Funds Available to Meet Family Service Needs** | **Staged Implementation Process** | **Utilized Extensive TA** | **Dedicated Staff to Manage DR Implementation** | **Strong Communi-cations Strategy** |
| **Minnesota** | * | + (45%) | + | + | - | + | + | + | + | * | * |
| **Missouri** | * | * (27%) | + | + | - | + | - | + | (Not available at the time) | - | - |
| **Nevada** | * | * (0%, 9% including discretionary) | - | - | + | + | - | + | + | - | - |
| **New York** | * | * (27%) | - | - | + | + | + | + | + | + | * |
| **North Carolina** | + | + (36%) | + | - | - | + | - | + | + | * | * |
| **Ohio** | * | * (18%, 45% including discretionary) | + | + | + | + | + | + | + | * | * |
| **Virginia** | * | * (18%, 45% including discretionary) | - | + | - | + | - | + | + | + | + |
| % * | 38% | 63% | NA | NA | NA | NA | NA | NA | NA | 50% | 38% |
| % + | 31% | 13% | 69% | 56% | 31% | 88% | 38% | 69% | 73% | 31% | 13% |
| % - | 31% | 25% | 31% | 44% | 69% | 13% | 62% | 31% | 27% | 19% | 50% |

# Policy Section

Core Section Components

- Policy Section: Narrative Analysis
- Policy Section: Matrix
- Document Library Folder: https://drive.google.com/folderview?id=0B26M5TMdNUWNVXVYS0lxRF9LLW8&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhIVU1nOVE

Additional Tools/ Resources

- DR Legislative Language Matrix
- Legislative Policy Discussion
- Pathway Assignment Criteria Matrix

# Policy Section: Narrative Analysis

Agency policy guides the way in which Differential Response systems are designed after the passage of DR legislation. As reviewed in the legislative section, some case assignment criteria and track switch requirements are written into legislation, but the majority of jurisdictions have much latitude in developing pathway assignment criteria and the decision process. This section includes discussion on the following policy topics, collected from the 16 surveyed jurisdictions:

(1) Pathway assignment criteria,
(2) Pathway assignment processes, and
(3) Track switches allowed between the traditional investigation track and the family assessment track.

In addition to the perspectives gathered from jurisdictions, the discussion below includes some context and additional information gathered from the research literature and agency websites.

## Pathway Assignment Criteria

Most child welfare agencies have commonalities in the decision criteria policies for assigning a case to a traditional investigation or a family assessment. The decision criteria can be divided into three categories: (1) cases involving severe harm, (2) cases involving different types of family or environmental risk factors, and (3) cases with contributing parental factors. The Pathway Assignment Criteria Matrix provides additional description of assignment criteria, and displays the percentage of states that utilize each criterion.

*Table 1: Cases Involving Severe Harm*

Child fatality, sexual abuse, and severe physical abuse/injury all require an automatic investigation in all jurisdictions surveyed. These automatic assignments are either specified in legislation or in agency policy and fit with the principle of assigning high-risk cases to an investigation within a DR system. Child abandonment requires an investigation in 78% of surveyed jurisdictions, with some states only requiring an automatic assignment to an investigation based on the age of the child. For severe neglect, 78% of surveyed jurisdictions require an automatic assignment to an investigation, but many of the jurisdictions consider aggravating circumstances, including the age of the child, the presence of an immediate danger in the living situation, and inadequate supervision. Severe emotional abuse or harm requires an automatic investigation in 67% of surveyed jurisdictions.

*Table 2: Cases Involving Family or Environmental Risk Factors*

The most common family risk factor used to automatically assign a case to an investigation is the presence of a past report, with 50% of jurisdictions utilizing this factor. Jurisdictions approach a family's history of past reports differently; for example, Connecticut requires an automatic investigation if a family has 2 more prior substantiated investigations in the last 12 months while New York requires an automatic investigation if a child has been found to be abused in the last 5 years. Domestic violence in the household is a factor considered by 28% of jurisdictions, but most of these jurisdictions use it as a discretionary criterion and not an automatic assignment to an investigation. The age of the child is a factor in 39% of jurisdictions, although each jurisdiction treats age differently. For example, some states require an investigation for all children under a certain age, while others require an investigation for

children under a certain age only in specific maltreatment allegations. Law enforcement involvement and the classification of an allegation as a criminal offense or felony are two other common factors considered; 33% of jurisdictions require an investigation if law enforcement is involved and 44% of jurisdictions require an investigation if the allegation can be considered a criminal act.

*Table 3: Cases with Contributing Parental Factors*

Parental factors are less widely used by jurisdictions as criteria to automatically assign a case to a traditional investigative response. Substance abuse in the form of prenatal substance exposure is the most commonly used parental factor, with 44% of jurisdictions requiring an automatic investigation. Medical neglect, especially in cases of infants or children with disabilities, is used as a factor in automatically assigning cases to an investigation in 32% of jurisdictions. The behavioral health of the caregiver was used as a factor in 22% of jurisdictions. Parents' past refusal of services was identified in 22% of jurisdictions as an automatic or discretionary criterion for an investigation.

## Pathway Assignment Processes

The majority of jurisdictions that were surveyed make the track assignment decision during the central intake/hotline call. The most common tools used among jurisdictions are state-specific Structured Decision Making (SDM) tools, or a risk assessment tool similar to an SDM product. These tools lead hotline workers through a series of risk-related questions to guide the track assignment. Examples of the track assignment tools can be found in the Policy Section Matrix. The majority of jurisdictions require hotline workers to make the decision in consultation with a supervisor. However, some states, such as Colorado, utilize group decision-making such as Review, Evaluate, and Direct (RED) Teams.[8] Several county-based systems vary in their approach from one county to another, allowing for the decision to be made at the local office instead of central intake units. See the Policy Section Matrix for descriptions of track assignment processes in each jurisdiction.

## Track Switches

*Family Assessment Track to Investigative Track*

All of the 16 surveyed jurisdictions allow for a track switch from a family assessment track to the investigative track (A to I switches). Jurisdictions report that they allow for the switch when new information reveals the presence of child safety threats, a serious allegation of abuse or neglect, or sometimes the refusal of services within the family assessment track. Child welfare agencies use track switches as a safeguard, ensuring that if at any time there appears to be more of a safety threat than initially believed, or any new information that puts child safety in question, there is a mechanism to move to an immediate investigation. The refusal of services alone does not necessarily require an investigation, but the refusal of services that may cause risk to a child typically requires a switch to an investigation. Several states require this track switch in legislation, while the remaining jurisdictions require it in agency policy.

*Investigative Track to Family Assessment Track*

[8] For more information on the RED Team, see: Sawyer, R., and Lohrbach, S. (2005) Differential Response in Child Protection: Selecting a Pathway. Protecting Children, (20) 2:44-53. Available at: http://www.americanhumane.org/assets/pdfs/children/differential-response/pc-20-2-3pdf.pdf

Fewer states (31%) allow for track switches from a traditional investigation track to a family assessment track (I to A switches) (HI, MN, MO, NC, NY). If a switch is allowed after the initial investigation, generally it is because the child's safety is determined to not be at risk and because the family can be better engaged by an assessment. This switch often requires a review process that includes a supervisor and written justification from the initial worker. Many states reported that they were in ongoing dialogue around allowing for track switches from an investigation to an assessment track but reported several rationales for not allowing I to A switches. States such as Ohio, Colorado, and New York, which utilized pilot programs, reported that track switches complicated data entry and tracking during the evaluation of the pilots. New York reassessed this switch after statewide implementation and has decided to begin allowing I to A switches starting in 2014. Additional states are reconsidering a change in their policy to allow for these switches. Another common barrier to allowing this switch is the capacity of state data systems. Once a case is opened for investigation, systems do not allow for a re-classification without significant modifications to the data system. These changes can take a long time and can cost jurisdictions a significant amount of money. As a result, some states emphasized the importance of planning for data system changes very early on in the planning process, and to include system modification costs as part of the budget planning process for implementation.

| Policy Section: Matrix | | | | | | |
|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Multiple Track Types** | **Staff Responsible for DR Track Assignment Decision** | **Location of Track Assignment Decision** | **Allows Track Switch from Assessment to Investigation** | **Allows Track Switch from Investigation to Assessment** | **Track Assignment Tools** |
| **Los Angeles County, CA (2004)** | 3-Track approach including (1) Community Response (screened-out cases), (2) Child Welfare Services (CWS) and Community Response (for screened-in reports with low to moderate safety and risk concerns), or (3) CWS—High Risk Response (traditional investigation). | Individual worker with the approval of supervisor | Intake | Yes | No | A set of Structured Decision Making (SDM) tools for Hotline workers developed with the Children's Research Center's (CRC) National Council on Crime & Delinquency (NCCD). |
| **San Francisco County, CA (2004)** | 3-Track approach including Path 1 (unfounded, low to moderate risk, no safety threats), Path 2 (inconclusive or unsubstantiated, low to moderate risk, no safety threats), and Path 3 (high risk and substantiated).<br><br>San Francisco County currently investigates all cases and after initial investigation cases can be assigned to Path 2 alternative response services.<br><br>Currently no active Path 1 services are offered. | Individual worker with supervisor approval | Intake | Yes | No | A set of Structured Decision Making (SDM) tools for Hotline workers developed with the CRC NCCD. |
| **Santa Clara County, CA (2004)** | 4-Track approach including Path 1 (screened out cases receive community referral), Path 2 (screened-in cases investigated but low risk and do not meet criteria for county services – services provided by community provider), Path 3 (traditional investigation and county services provided), and Path 4 (after care services for reunified cases).<br><br>Currently in Santa Clara County screened-out cases can be assigned to Path 1 for a community referral. All screened-in cases are investigated and after initial investigation cases can be assigned to Path 2 alternative response | Individual worker with MSW level education | Intake | Yes | No | A set of Structured Decision Making (SDM) tools for Hotline workers developed with the CRC NCCD. |

| Policy Section: Matrix | | | | | | |
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| **Jurisdiction (Year of Inception)** | **Multiple Track Types** | **Staff Responsible for DR Track Assignment Decision** | **Location of Track Assignment Decision** | **Allows Track Switch from Assessment to Investigation** | **Allows Track Switch from Investigation to Assessment** | **Track Assignment Tools** |
| | services or Path 3 for traditional response services. | | | | | |
| **Colorado (2010)** | 2 track approach including (1) HRA - High Risk Assessment and (2) Family Assessment Response (FAR) (Assessment for low to moderate risk cases). | RED Team - Review, Evaluate, and Direct. The RED Team involved group decision-making by multidisciplinary and multi-level staff. | Intake | Yes | No, but CO is currently in discussion about allowing the track to change from an HRA to a FAR. | A specific maltreatment guide that walks workers through specific questions related to different types of maltreatment in order to make an assignment decision. |
| **Connecticut (2011)** | 2 track approach including (1) Traditional intake track (forensic investigations for high risk cases) and (2) Family Assessment Response (FAR) (Assessment for low to moderate risk cases). | Individual worker with the consultation of a supervisor | Intake | Yes | Not at this time, but currently assessing for a change in policy. | A Structured Decision Making (SDM) (see page 6) tool for Hotline workers developed with the CRC NCCD, and the Family Assessment Response Notebook. |
| **Hawaii (2005)** | 3-Track approach including (1) Family Strengthening Services (FSS) (low risk), (2) Voluntary Case Management (VCM) (moderate risk), and (3) Child Welfare Services (CWS) investigation (high risk/safety concern). | Caseworker and/or supervisor | Intake | Yes | Yes | Safety Assessment and Comprehensive Strengths and Risk Assessment, a web-based intake assessment tool developed in partnership with the National Resource Center for Child Protective Services (NRCCPS). |
| **Kentucky (2000)** | 4-Track approach including (1) Investigation track (reports that are accepted for a CPS response and meet the moderate to high/imminent risk standards on the level of risk matrix), (2) Family in need of services assessment (FINSA) track (reports that are accepted for a CPS response and meet the low risk standards on the level of risk matrix), (3) Law enforcement track (reports involving a non-care taker that are assigned to law | Individual worker with the consultation of a supervisor | Intake | Yes | No | A Level of Risk Matrix is used by the central intake worker. The matrix was developed in partnership with NRCCPS. |

| Policy Section: Matrix | | | | | | |
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| **Jurisdiction (Year of Inception)** | **Multiple Track Types** | **Staff Responsible for DR Track Assignment Decision** | **Location of Track Assignment Decision** | **Allows Track Switch from Assessment to Investigation** | **Allows Track Switch from Investigation to Assessment** | **Track Assignment Tools** |
| | enforcement), and (4) Resources linkage track (cases not meeting the standards for CPS response that are linked to community resources). | | | | | |
| **Louisiana (1999)** | 2-Track approach including (1) Investigation Response (for high risk cases of physical and emotional abuse, high risk neglect cases, and all sexual abuse cases) and (2) Alternative Response (for low to moderate risk cases of physical and emotional abuse and neglect). | Individual worker with the approval of supervisor | Intake | Yes | No | A set of Structured Decision Making (SDM) tools for Hotline workers developed with the CRC NCCD. Additionally, intake staff interview reporters to obtain information around six areas of child and parent functioning, which provides a more comprehensive assessment of present child safety. Using the information gathered from those areas, staff determine if danger exists. If danger is identified, the case is deemed inappropriate for alternative response family assessment. This intake assessment was developed by ACTION for Child Protection. |
| **Massachusetts (2008)** | 2 track approach including (1) CPS Investigation Response (forensic investigations for high risk cases) and (2) CPS Assessment Response (assessment for low to moderate risk cases). | Individual worker in consultation with supervisor. Can use group decision making called Screening Decision Support Sessions that includes multiple worker and | Local Office | Yes | No | Screening Practice Guidance is provided in the Integrated Casework Practice Model. |

| Policy Section: Matrix | | | | | | |
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| **Jurisdiction (Year of Inception)** | **Multiple Track Types** | **Staff Responsible for DR Track Assignment Decision** | **Location of Track Assignment Decision** | **Allows Track Switch from Assessment to Investigation** | **Allows Track Switch from Investigation to Assessment** | **Track Assignment Tools** |
| | | supervisors. | | | | |
| **Minnesota (2000)** | 3-Track approach including (1) Family Investigation (criminal or severe allegations), (2) Family Assessment (low to moderate risk cases), or (3) Family support intervention (for screened-out cases).<br><br>All counties and two American Indian Child Welfare Initiative (AICWI) tribes (White Earth and Leech Lake Bands of Ojibwe) employ a 3-track approach. | Varies by county/ AICWI tribe. Some counties rely upon a team decision-making process, such as the RED team (Review, Evaluate, and Direct).[9] | Varies by county/AICWI tribe. | Yes | Yes | Child Maltreatment Screening Guidelines that define the types of maltreatment. After a child maltreatment report is accepted for a response, MN uses Structured Decision Making (SDM) tools that assess for substantial child endangerment, and checks for 16 categories including criminally chargeable actions and risk factors. The tools were developed with the CRC NCCD. |
| **Missouri (1994)** | 2-Track approach including (1) Investigation or (2) Assessment response (in which there is no immediate safety risk to the child and low risk of future harm). | Individual worker | Intake | Yes | Yes | Structured Decision Making (SDM) tools are used to assign one of three risk levels and determine a response time. The tools were developed with the CRC NCCD. |

[9] For more information on the RED Team, see: Sawyer, R., and Lohrbach, S. (2005) Differential Response in Child Protection: Selecting a Pathway. Protecting Children, (20) 2:44-53. Available at: http://www.americanhumane.org/assets/pdfs/children/differential-response/pc-20-2-3pdf.pdf

| Policy Section: Matrix | | | | | | |
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| **Jurisdiction (Year of Inception)** | **Multiple Track Types** | **Staff Responsible for DR Track Assignment Decision** | **Location of Track Assignment Decision** | **Allows Track Switch from Assessment to Investigation** | **Allows Track Switch from Investigation to Assessment** | **Track Assignment Tools** |
| **Nevada (2007)** | 2-Track approach including (1) Investigation or (2) Assessment response (in which there is no immediate safety risk to the child and low risk of future harm). | Individual worker | Intake | Yes | No | Not available. |
| **New York (2008)** | 2-Track approach including (1) Investigation or (2) Family Assessment Response (FAR) (where the child is deemed safe from immediate harm). | Varies by county | County offices | Yes | Yes, starting in 2014 | Each district uses its own tool for screening into FAR, which is reviewed and approved by the state office. Additionally, the state office developed the Family-Led Assessment Guide (FLAG), a 23-question assessment of family strengths and needs. |
| **North Carolina (2001)** | 2-Track approach including (1) Investigation (for abuse, abandonment, and certain neglect cases) or (2) Assessment response (primarily for cases of neglect other than serious types of neglect outlined in policy). | Multiple staff is involved, including intake workers, caseworkers, supervisors, and previous caseworkers, if the family is known to the agency. | County offices | Yes | Yes | An SDM structured intake tool is used for track assignment. The tool was developed with the CRC NCCD. |
| **Ohio (2007)** | 2-Track approach including (1) Traditional Response (investigation for allegations of serious and criminal harm to a child or sexual abuse) or (2) Alternative Response (assessment response, which is the preferred response). | Varies by county | Varies by county, recorded in SACWIS system. | Yes | No, but OH is currently considering changing this policy. | The Pathway Assignment Tool, developed with American Humane Association (AHA). |
| **Virginia (1997)** | 2-Track approach including (1) Investigation (for maltreatment types mandated for investigation/high risk) and (2) Family | Individual worker with supervisor approval | Local departments of social services make track | Yes | No | CPS Intake Tool (p.46) which helps an intake worker determine response times and |

| Policy Section: Matrix | | | | | | |
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| **Jurisdiction (Year of Inception)** | **Multiple Track Types** | **Staff Responsible for DR Track Assignment Decision** | **Location of Track Assignment Decision** | **Allows Track Switch from Assessment to Investigation** | **Allows Track Switch from Investigation to Assessment** | **Track Assignment Tools** |
| | Assessment (for maltreatment types not mandated for investigation/ low-moderate risk). The Code of VA specifies reports that must be investigated. Local departments of social services may plan any valid report in the TR. | | decisions based on CPS policy, can vary by county or city. | | | appropriate track – this is not currently an SDM tool but is guided by state and local policies. |

# Legislative Language Matrix

This matrix contains an analysis of state legislation regarding Differential Response systems. The matrix analyzes key components of legislative bills and enacted revised state codes. This matrix exclusively analyzes rules and regulations that are written into law and not child welfare agency policy used to implement DR systems. For example a state may allow for track changes in agency policy but it may not be written into legislation, therefore it would not be included in this matrix. For more details on agency policy regarding implementation please see the Policy Section Matrix.

| **Jurisdiction** | **Description of Enacting Legislation and Current State Code** | **Key Definitions** (Key legislative definitions of DR, assessments, and child abuse/neglect that requires an investigation) | **Services and Community Partnerships** (Types of services described in legislation and the language used to define the partnership between public and private agencies to provide services) | **Track Switches** (As defined in legislation) | **Determination of Abuse/Neglect and/or Central Registry** (Legislative rules related to the determination of abuse/neglect for DR cases and the reporting of DR cases to a central registry) | **Pilot Program** (Description of the use of DR pilot programs, including number of demonstration sites, timeline, evaluation structure, and the need for further legislation to move to statewide implementation) |
|---|---|---|---|---|---|---|
| **California** | 2006 AB 1808 – Section 29.01 Authorizes counties to utilize funding in a flexible manor for systems improvements such as DR | N/A | N/A | N/A | N/A | N/A |
| **Colorado** | 2010 HB 1226 and CO Revised Code: 19-3-308.3 – Enacting legislation changed current code to authorize 5 counties to be part of a Differential Response Pilot Program. | Differential Response is described in the legislative intent section as an alternative approach to addressing reports of abuse or neglect in cases in which an assessment determines that the safety of the child is at low or moderate risk.<br><br>States that the program shall: (1) encourage families to participate in services, (2) expedite the delivery of such services, and (3) provide knowledge and skills to a family so they may responsibly protect their children. | N/A | N/A | Current code states there is no requirement to determine a finding for families in DR track. | Authorizes a pilot program in 5 counties to be chosen by the state department. Allows for the use of a family assessment for low to moderate risk cases. Requires a formal evaluation looking at (1) safety and permanency, (2) family and caseworker satisfaction, (3) cost effectiveness. Decision for statewide implementation by 2015. Law expires in 2015. |
| **Connecticut** | 2011 SB 1199 and CT Revised Statues Section 17a-101g – | N/A | Allows for low risk reports of abuse or neglect to be | Allows for a track change from Family | N/A | N/A |

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| | Enacting legislation changed current code to authorize the commissioner to establish a DR program. | | referred to a community provider for a family assessment and services without an investigation.<br><br>Authorizes the commissioner to establish rules for monitoring families being served by community providers and rules around information sharing. | Assessment to CPS if there is a safety concern.<br><br>Allows for a track change from CPS to Family Assessment at any time during an investigation if a family is considered low risk and an initial safety assessment has been performed and a criminal background check on those involved in the report. | | |
| **Hawaii** | N/A | N/A | N/A | N/A | N/A | N/A |
| **Kentucky** | 2000 HB 204 and KY Revised Statue 620.040 – Enacting legislation changed current code to authorize the cabinet to make an initial determination of risk and immediate safety of a child and based on the determination accept referrals for investigation or for an assessment of family needs. | N/A | Authorizes the cabinet to make referrals to any community-based services necessary to reduce risk to the child and offer family support.<br>Prohibits reports of sexual abuse or human trafficking from being referred to a community agency. | N/A | N/A | N/A |

| Jurisdiction | **Description of Enacting Legislation and Current State Code** | **Key Definitions** (Key legislative definitions of DR, assessments, and child abuse/neglect that requires an investigation) | **Services and Community Partnerships** (Types of services described in legislation and the language used to define the partnership between public and private agencies to provide services) | **Track Switches** (As defined in legislation) | **Determination of Abuse/Neglect and/or Central Registry** (Legislative rules related to the determination of abuse/neglect for DR cases and the reporting of DR cases to a central registry) | **Pilot Program** (Description of the use of DR pilot programs, including number of demonstration sites, timeline, evaluation structure, and the need for further legislation to move to statewide implementation) |
|---|---|---|---|---|---|---|
| **Louisiana** | 1999 SB 684 and Children's Code Article 612 – Enacting legislation changed current code to authorize the local department, upon receipt of a report, to assign a risk level and to promptly assess low risk cases with a family interview in lieu of an investigation. | N/A | Authorizes the department to assess family needs and match them to available community resources. | Allows for a track change from family assessment to an investigation if a child is at immediate substantial risk of harm. | N/A | N/A |
| **Massachusetts** | 2008 HB 4905 – Enacting legislation authorizes the department to implement a DR pilot program with three responses: (1) a protective response, (2) a support and stabilization response, or (3) a community resource response. | Describes the three responses:<br>(1) a protective response is required if a child is at risk of serious harm and follows the investigative process described in current code.<br>(2) a support and stabilization response requires contact with a family within 2 days and an assessment within 30 day. It also requires at least 3 department home visits and may include the immediate provision of services.<br>(3) a community resource response shall consist of providing information about and referral to community-based services but does not include an investigation or family assessment. | Allows for the department to provide information and referrals to community based services for those cases in the community resources response. | N/A | N/A | Requires a pilot program in 4 to 8 area offices that divides the office into a control group and a DR group. The DR group will be offered three responses for cases described in the key definitions.<br>Requires an independent evaluation to be reported to the legislature within 1 year after implementation and include (1) the impact on children and families, (2) the effect on racial disproportionality and disparity, (3) the associated costs, (4) any recommendations for statewide implementation, and (5) survey of children, families, and staff. |
| **Minnesota** | 1999 SF 2225, 2005 HF 1889 | Defines Family Assessment as | N/A | Requires an | Current code states that family | A pilot program was not |

| Jurisdiction | **Description of Enacting Legislation and Current State Code** | **Key Definitions** (Key legislative definitions of DR, assessments, and child abuse/neglect that requires an investigation) | **Services and Community Partnerships** (Types of services described in legislation and the language used to define the partnership between public and private agencies to provide services) | **Track Switches** (As defined in legislation) | **Determination of Abuse/Neglect and/or Central Registry** (Legislative rules related to the determination of abuse/neglect for DR cases and the reporting of DR cases to a central registry) | **Pilot Program** (Description of the use of DR pilot programs, including number of demonstration sites, timeline, evaluation structure, and the need for further legislation to move to statewide implementation) |
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| | and MN Statue 626.556 – The 1999 legislation authorizes counties to implement an alternative response system for cases that do not involve substantial child endangerment, as defined in the legislation. The 1999 legislation also authorizes the commissioner to outline rules and regulation for an alternative response system and a way for counties to apply to implement the system. Alternative response was further defined in the 2005 HF 1889 and is currently written into code in MN Statue 626.556 | a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment. Defines substantial child endangerment by listing different types of maltreatment and requires an investigation for those types. | | immediate investigation if during the family assessment response there is reason to believe that substantial child endangerment or a serious threat to the child's safety exists.<br><br>Allows the local agency to change a case from an investigation to a family assessment response. | assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment | written into legislation. However, after the passing of the 1999 SF2225 bill authorizing alternative response, a 20 county demonstration project was established and a formal evaluation conducted.<br><br>Full implementation was done in the 2005 legislation. |
| **Missouri** | 1994 SB 955 and Missouri Revised Statue 210.145 – 1994 legislation authorized a three year pilot program in 5 demonstration sites that would assign screened in cases to investigation or family assessment.<br><br>Current revised statues allow for local child welfare departments to utilize | Defines family assessment and services as: an approach to be developed by the children's division which will provide for a prompt assessment of a child who has been reported to the division as a victim of abuse or neglect by a person responsible for that child's care, custody or control and of that child's family, including risk of abuse and neglect and, if necessary, the | Mandates that the initial family assessment be done by the government child welfare department but the services be referred to community providers and progress reported to the department.<br>Mandates that services that are provided by community providers be voluntary and time-limited unless non- | Allows the department to conduct a family service approach if during an investigation it is determined an investigation is not appropriate.<br><br>Allows for the department to conduct an investigation on families in the family | Mandates the department to keep records of those involved in family assessments and investigations but only mandates those indicated in an investigative report to be reported to the central registry. | The 1994 legislation established a three year pilot program utilizing demonstration sites. The program was to be evaluated independently in order for the legislature to make a determination on state-wide implementation. |

| Jurisdiction | **Description of Enacting Legislation and Current State Code** | **Key Definitions** (Key legislative definitions of DR, assessments, and child abuse/neglect that requires an investigation) | **Services and Community Partnerships** (Types of services described in legislation and the language used to define the partnership between public and private agencies to provide services) | **Track Switches** (As defined in legislation) | **Determination of Abuse/Neglect and/or Central Registry** (Legislative rules related to the determination of abuse/neglect for DR cases and the reporting of DR cases to a central registry) | **Pilot Program** (Description of the use of DR pilot programs, including number of demonstration sites, timeline, evaluation structure, and the need for further legislation to move to statewide implementation) |
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| | structured decision making tools to assess risk of referrals and utilize family assessments instead of investigations when appropriate. | provision of community-based services to reduce the risk and support the family.<br><br>Defines a list of serious abuse and neglect cases that are crimes and mandate an investigation and law enforcement involvement. | compliance would be a risk to child safety. | service approach if they continue to refuse services or there is risk to the child's safety. | | |
| **Nevada** | 1997 Assembly Bill 356 and Nevada Revised Code 432B.260 – Enacting legislation changed the current revised code and authorized the use of an assessment of the family and the provision of services by the department or a contracted agency. | Defines a list of circumstances that mandate an immediate investigation and not an assessment. | Allows for the department to provide needed services as assessed by the family assessment or to refer a community agency that has entered into an agreement to provide the services. Requires the contracted agency to report to the department if the family refuses to participate in services or if there is a serious risk to child safety. | Allows for the department to perform an investigation on families in the family assessment track at any time. | Mandates that the department report the outcomes of an investigation to the central registry but exempts the results of a family assessment from being reported. | N/A |

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| **New York** | 2007 Senate Bill 4009, 2011 Senate Bill 4504, and NY SOS Law 427a – The 2007 enabling legislation authorizes any local office outside of New York City to apply to the state to implement a DR demonstration and outlines the requirements for applying and becoming approved. The legislation also outlines cases that must be investigated, gives authority to local office to assign other cases, outlines the minimum requirements of a family assessment and services track, and outlines how such cases should be handled within the central registry. The legislation requires a report be given to the legislature by 2011 when the legislation expires.<br>The 2011 Legislation changes current Social Service laws to make the DR system permanent and to allow New York City offices to be able to apply. | Legislation does not formally define the family assessment and services track but outlines the minimum requirements: (1) offer families notice of their involvement in a non-investigative approach and outline mandated reporter status of the caseworker, (2) offer an examination of the family's strengths, concerns, and needs to be done with the family, (3) offer appropriate assistance which should include case management that is supportive of family stabilization, (4) offer the planning and provision of services that are responsive to the family's need, and (5) offer an on-going joint evaluation and assessment of the family's progress and the risk of the child.<br>Defines a list of cases that must be investigated. | Requires the local department to provide services that match the family's needs and allows for local departments to contract with community-based providers to do so.<br>Requires community-based providers to communicate to the local department the need to investigate a family in the family assessment track and requires the local department to take the case back for investigation. | Requires that a family be changed to an investigative track if the local department or a community provider finds at any time that there is evidence of child abuse, including sexual abuse or the parent refuses to cooperate with the service plan and there is evidence of maltreatment of the child. | Mandates that family assessment and services cases not be available on the central registry.<br>Requires local department to report family assessment cases to the central registry and that the central registry seal the records and hold them for 10 years.<br>Allows the sealed record to be seen by the family, the department and community-based providers serving the family, and the courts (if the cases are being overseen by a court).<br>Allows the department to unseal records as part of the assessment in subsequent reports. | The 2007 legislation authorized any local office (other than New York City) to apply to the state to be a demonstration site, outlined the requirements for implementing a DR system, and required an evaluation be completed by 2011 at which time the legislation expires. The evaluation must look at the effectiveness of the program in promoting broader community involvement, meeting service needs, expanding and expediting access to appropriate services, improving the cooperation of families, and reducing subsequent abuse and maltreatment reports and promoting child safety. The report must also make recommendations for making DR legislation permanent. |

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| **North Carolina** | 1999 House Bill 168, 2005 HB 277 and NC General Statue Chapter 7B-300 – The 1999 legislation required a pilot program in 2-5 demonstration sites and an evaluation report to be delivered to the legislature to determine statewide implementation. The 2005 legislation defines family assessment response and changes current general statute to allow for the use of either a family assessment response or an investigation for reports of abuse and/or neglect. | Defines Family Assessment Response as: A response to selected reports of child neglect and dependency as determined by the Director using a family-centered approach that is protection and prevention oriented and that evaluates the strengths and needs of the juvenile's family, as well as the condition of the juvenile. | N/A | N/A | Requires the department to maintain a central registry of abuse, neglect, and dependency cases that are a result of alleged maltreatment. Requires the department to maintain a list of responsible individuals for investigative responses only. | Authorizes the department to perform a pilot program in 2-5 demonstration sites. Requires an evaluation to look at (1) child safety, (2) timeliness of response (3) timeliness of services, (4) coordination of local human services, (5) cost-effectiveness and, (6) any other related issues. |
| **Ohio** | 2006 Senate Bill 238, 2011 House Bill 153, and Ohio Revised Code Chapter 2151 – The 2006 legislation authorizes an 18 month pilot program for alternative response with an independent evaluation and recommendation on statewide implementation. The 2011 enacting legislation revised the current code to define alternative response and begin statewide implementation of an alternative response system in which alternative response is the preferred response for | Defines Differential Response Approach as an approach that a public children services agency may use to respond to accepted reports of child abuse or neglect with either an alternative response or a traditional response. Defines Alternative Response as the public children services agency's response to a report of child abuse or neglect that engages the family in a comprehensive evaluation of child safety, risk of subsequent harm, and family strengths and | N/A | Requires the director of Job and Family Services to adopt rules for the procedures and criteria for public child service agencies to assign and reassign response pathways. | States those families receiving an alternative response do not receive a determination as to whether child abuse or neglect occurred. | Required a pilot program be done in no more than 10 counties, lasting 18 months, and receive an independent evaluation. |

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| | cases other than those listed in legislation as needing an investigation. | needs and that does not include a determination as to whether child abuse or neglect occurred.<br><br>Defines the type of cases needing an investigation | | | | |
| **Oklahoma** | 1998 House Bill 2905 and Oklahoma State Code 10-7106 – Enacting legislation changed the current revised code to authorize county offices to respond with either an investigation or and assessment for low risk cases based on rules to be determined by the state office. | Defines an assessment as a systematic process utilized by the Department of Human Services to respond to reports of alleged child abuse or neglect which, according to priority guidelines established by the Department, do not constitute a serious and immediate threat to the child's health or safety. The assessment includes, but is not limited to, the following elements: an evaluation of the child's safety, a determination of the factors of the alleged abuse or neglect, and a determination regarding the family's need for prevention and intervention-related services<br><br>Also defines the different determination statues for a family receiving an assessment or an investigation. | Defines prevention and intervention-related services as community-based program that serves children and families on a voluntary and time-limited basis to help reduce the likelihood of incidence of child abuse and neglect. Instructs the department to provide such services to families or refer to community-based agencies for service provision. | Allows for the department to begin an immediate investigation at any time during an assessment if warranted by the priority guidelines established by the department. Can also begin investigation if family continually refuses services and worker believes child needs services for protection.<br><br>Allows for the department to conduct an assessment to cases originally referred to an investigation if it is determined an investigation is not needed. | Separates determination into four categories: (1) Services not needed –no identified risk of abuse/neglect; (2) Services recommended – an unfounded report but family still recommended for prevention and intervention related services; (3) Confirmed report – services recommended – determination of child abuse/neglect and recommended services without court intervention; (4) Confirmed report – court intervention – determination of abuse or neglect and court intervention needed | N/A |

| Jurisdiction | **Description of Enacting Legislation and Current State Code** | **Key Definitions** (Key legislative definitions of DR, assessments, and child abuse/neglect that requires an investigation) | **Services and Community Partnerships** (Types of services described in legislation and the language used to define the partnership between public and private agencies to provide services) | **Track Switches** (As defined in legislation) | **Determination of Abuse/Neglect and/or Central Registry** (Legislative rules related to the determination of abuse/neglect for DR cases and the reporting of DR cases to a central registry) | **Pilot Program** (Description of the use of DR pilot programs, including number of demonstration sites, timeline, evaluation structure, and the need for further legislation to move to statewide implementation) |
|---|---|---|---|---|---|---|
| **Tennessee** | 2005 House Bill 447 and Tennessee Law on Children, Youth, and Families 37-5-601-608 – Enacting legislation authorized a demonstration project for DR allowing for the department to use a screening tool to determine risk and offer an assessment for cases that are not at immediate risk and not alleging serious harm or sexual abuse of a child. Legislation also enacts a timeline for statewide implementation and permanent change in current law to develop a multi-response system. | Does not define a family assessment but offers details on the process of an assessment and the result of the assessment. Requires that workers meet face-to-face with a family to conduct and assessment of their needs and consult with the family on determining the appropriate services to meet their needs.<br><br>Refers to state statute that defines serious child abuse and sexual abuse and requires an investigation for such cases. | Requires the department to work with the family to identify needs and for the department to provides services or connect the family to community-based services, including faith-based services. | Requires the department to commence an immediate investigation, if, at any time the department determines there is a need for investigation under Chapter 1 part 4 and part 6 of the state code – which outlines serious child abuse and sexual abuse. | N/A | Authorized a demonstration project in 3-5 areas of the state for the first year (2006) and expansion to no less than 10 areas of the state in the following year (2007). Requires state wide implementation by 2010. Also establishes a state advisory committee to plan implementation and requires an evaluation of the pilot program. The evaluation is described in Chapter 5 part 6. |
| **Vermont** | 2008 House Bill 635 and Vermont Statues Title 33 Chapter 49 – Enacting legislation changes current code to define family assessment, to allow for a local department to provide a family assessment response, to describe the appropriate time to use family assessment and lists cases that must receive an investigation, and to describe the procedures of a family assessment. | Assessment is defined as a response to a report of child abuse or neglect that focuses on the identification of the strengths and support needs of the child and the family, and any services they may require to improve or restore their well-being and to reduce the risk of future harm. The child and family assessment does not result in a formal determination as to whether the reported abuse or neglect has occurred. | Requires the department in collaboration with the family to identify strengths, resources and services needed in order to develop a service plan that reduces the risk of harm and improves well-being. Services are voluntary. | Requires the department to conduct an immediate investigation with family assessment cases whenever the department sees it necessary. Refusal of services cannot be the sole reason for a change to investigative track. | No determination of abuse or neglect is made for family assessment responses and no information is reported to the central registry. Requires the department to record the outcome of the family assessment. Establishes a tiered central registry for all reports of abuse and neglect that balances the safety of children with the need for employment. | N/A |

| Jurisdiction | **Description of Enacting Legislation and Current State Code** | **Key Definitions** (Key legislative definitions of DR, assessments, and child abuse/neglect that requires an investigation) | **Services and Community Partnerships** (Types of services described in legislation and the language used to define the partnership between public and private agencies to provide services) | **Track Switches** (As defined in legislation) | **Determination of Abuse/Neglect and/or Central Registry** (Legislative rules related to the determination of abuse/neglect for DR cases and the reporting of DR cases to a central registry) | **Pilot Program** (Description of the use of DR pilot programs, including number of demonstration sites, timeline, evaluation structure, and the need for further legislation to move to statewide implementation) |
|---|---|---|---|---|---|---|
| | | Defines appropriate time to use family assessment and lists cases that must receive an investigation. | | | | |
| **Virginia** | 1996 House Bill 36, 2000 House Bill 1360, and Virginia Revised Code 63.2-1506 – 1996 Legislation established a pilot program to be done in 3-5 areas of the state establishing a DR system; it also required training for staff and an evaluation of the pilot program. The 2000 legislation required the statewide implementation of the DR system by July 1, 2003. It also changes the current revised code to define a family assessment, to outline when an investigation is required, and to require an annual report on the DR system. | Outlines the elements of a family assessment.<br>A family assessment requires the collection of information necessary to determine: (1) the immediate safety needs of the child, (2) the protective and rehabilitative services needs of the child and family that will deter abuse or neglect, (3) risk of future harm to the child, (4) alternative plans for the child's safety if protective and rehabilitative services are indicated and the family is unable or unwilling to participate in services.<br>Defines when an investigation is required. | Requires the department to consult with the family to arrange for necessary protective and rehabilitative services to be provided to the child and his family. Services are voluntary. | Requires the local department to perform an investigation on families in the family assessment track at any time the department determines it necessary.<br>Prohibits an investigation based solely on the refusal of services. | Prohibits any disposition of founded or unfounded for families in the family assessment track.<br>Prohibits family assessment cases from being entered into the central registry.<br>Requires the department to keep an internal record of all cases (family assessment and investigation). | Authorizes a pilot program in 3-5 areas of the state to be determined by the child welfare agency.<br>Requires an evaluation of the pilot program to include: (1) worker turnover rate, (2) changes in the number of investigations, (3) number of families receiving and rejecting services, (4) the effectiveness of the assessment in determining the appropriate level of services, (5) the impact of out-of-home placements,(6) the cost effectiveness of the system, (7) availability of services, (8) community cooperation, (9) successes and problems that occurred, (10) the overall operation of the DR system and recommendation for improvement. |

| Jurisdiction | **Description of Enacting Legislation and Current State Code** | **Key Definitions** (Key legislative definitions of DR, assessments, and child abuse/neglect that requires an investigation) | **Services and Community Partnerships** (Types of services described in legislation and the language used to define the partnership between public and private agencies to provide services) | **Track Switches** (As defined in legislation) | **Determination of Abuse/Neglect and/or Central Registry** (Legislative rules related to the determination of abuse/neglect for DR cases and the reporting of DR cases to a central registry) | **Pilot Program** (Description of the use of DR pilot programs, including number of demonstration sites, timeline, evaluation structure, and the need for further legislation to move to statewide implementation) |
|---|---|---|---|---|---|---|
| **Wyoming** | 2005 Senate File 0039 and Wyoming State Law 14-3-204 – Enacting legislation changes current law to authorize the local child welfare agency to conduct either an investigation or an assessment for allegations of abuse or neglect and defines what cases must be investigated. | Defines which cases must be investigated:<br>(1) criminal charges could be filed; (2) the child appears to be imminent danger; (3) it is likely the child will need to be removed from the home; (4) child fatality, (5) major injury; or (6) sexual abuse. | States that if during an investigation or assessment abuse or neglect is present the agency should initiate services with the family to assist in resolving the issue. | N/A | Requires that the central registry keeps reports “under investigation” and those “substantiated” through an investigation. There is no reference to cases receiving an assessment. | N/A |

# Legislative Policy Discussion

## Differential Response Legislation

All the states surveyed in the development of the Resource Kit utilized the legislative process to enact a differential response system within their state, with the exception of Hawaii. The legislative discussion below analyzes Differential Response legislation for all states surveyed for the Resource Kit plus an additional four states (OK, TN, VT, WY), for a total of 17 state laws. This section outlines five key components found in legislation across the United States:

(1) The establishment of a pilot program,
(2) Key definitions of differential response systems and family assessments,
(3) Service provision and community partnerships,
(4) Track changes, and
(5) The determination of abuse and neglect for family assessment cases and the use of a central registry.

It is important to note that this section only outlines implementation and practice guidelines that are written into legislation; jurisdictions often have established further rules and guidelines regarding DR within child welfare agency policy and procedure. For example, a state might not have language in legislation allowing for a child welfare agency to change a case from an alternative response to an investigation, but agency policy might allow for this.

## Enacting Legislation

The approach in crafting and passing legislation varies from one state to another. Some states, such as California, authorized the establishment of a DR system utilizing broad language within a budget bill, without any descriptive language defining DR or offering any implementation or practice guidelines to child welfare administrators. This approach allows child welfare administrators to have broad discretion in shaping a DR system with little legislative oversight. Other states, such as Missouri, authorized the establishment of a DR system through a series of bills outlining a pilot program and statewide implementation that offered more detailed guidance to child welfare administrators in establishing local DR systems. The more detailed legislation provides more legislative oversight to the implementation process and engages state legislators in the creation of a DR system within a state.

## Pilot Programs

Pilot programs were required to be initiated prior to statewide implementation in 47% of the state laws that were analyzed here. The legislation for the state of Minnesota did not require a pilot program, but authorized county commissioners to establish rules and guidelines for counties to apply to the state to establish a DR system, and this led to a 20 site pilot program. The majority of states requiring pilot programs required demonstration sites in 3-10 sites across the state; New York allowed for any jurisdiction other than New York City to apply to the pilot program. All states with a pilot program also required a formal evaluation of the pilot program and the majority of states outlined key components required of the evaluation, which included: safety and permanency, worker and client satisfaction, and cost-effectiveness. Missouri required an evaluation, but did not outline any components. New York, Tennessee, and Virginia included a list of 10 or more key components to be part of the evaluation (details can be found in the Legislative Language Matrix). All states with a pilot program, other than Massachusetts, also required enacting legislation to expire, with formal recommendations to be given to legislators upon implementing DR statewide; expiring legislation required legislators to pass a

follow-up bill in order to implement the program beyond the pilot sites. Tennessee's legislation put an expiration date on the pilot but included instructions for full implementation within the same bill. All of the states with pilot programs have moved towards statewide implementation with the exception of Colorado, which is under a pilot program until 2015.

## Key Definitions in DR Legislation

The majority of surveyed states utilized legislation to define differential response or family assessments into law. Common language used in the definition of family assessments includes: 'comprehensive assessment,' 'assessing child safety and risk of harm,' and 'assessing family strengths and needs.' Within the definition of DR or family assessments, several states' legislation also state that no determination of abuse or neglect be made for family assessment cases (MN, OH, VT). States also use legislation to put into law a specified set of allegation criteria that are required to receive a traditional investigation. Commonly, these cases are ones involving criminal activity as defined in the state penal code. For example, Minnesota requires an investigation for all cases involving substantial child endangerment and defines substantial child endangerment with a list of different types of maltreatment, most of which are crimes in the penal code. States without a list of cases requiring a traditional investigation utilize legislative language to indicate that family assessments are for low to moderate risk cases and allow case assignment to be determined by child welfare administrators when establishing agency policy and procedure. California is the only state to offer no descriptive language around case assignment within legislation.

## Service Provision and Community Partnerships

Service provision is discussed in 70% of the DR state laws analyzed here. States have kept the language regarding service provision fairly general, authorizing child welfare agencies to provide services to reduce the risk of future maltreatment; several states also specified that services should be matched to the strengths and needs of the family and are voluntary in nature (see Legislative Language Matrix for more details). The partnership between public and private child welfare organizations in the provision of services is discussed in 53% of states analyzed here. Some states generally speak to the partnership by allowing for child welfare agencies to refer families to community agencies or contract with community agencies for service provision. Other states, such as New York, discuss the partnership in more detail by outlining the process for information sharing between the public agency and community agencies, the process for transferring cases, and the expectations of both the public and private child welfare providers within the partnership.

## Track Switches

To ensure the most appropriate response, all DR systems allow for track switches, switching cases from an assessment track to the investigation track (A to I), as well as the reverse (I to A), in some systems. Track switches are typically made when information comes to light that reveals more about the families situation—such as the presence of safety threats, resulting in an A to I track switch. A to I track switches are described in 59% of states laws analyzed (it is important to note that some states describe track changes within the policy of the child welfare agency rather than in the law). Combining legislation and agency policies, 100% of states required A to I switches when safety threats or substantial risk to the child are later revealed. 35% of states (MO, NV, NY, OK, VA, VT) specify that cases must receive an A to I switch when a family is refusing services and placing the child's safety at risk; however, Virginia and Vermont clearly state that refusal to participate in services cannot be the sole reason for a track switch. An I to A track switch was only described in 24% of these state laws. All four of these states

(CT, MN, MO, OK) indicated that if the initial investigation determines that there is not an immediate risk to child safety and a family could be better served within the DR track, an agency can switch a family to that track.

## Determination of Abuse/Neglect and Central Registry Requirements

In practice, the majority of states with DR systems do not make a determination of abuse or neglect for assessment track cases. However, only 29% of state laws analyzed explicitly state in legislation that families served within the assessment track should have no determination of abuse or neglect. Several states describe this in the definition of family assessments, while others discuss it in a later section of the legislation. Linked to the determination of abuse and neglect is the listing of names on the state's central registry of abuse and neglect, as well as the documentation of family assessment results. States have addressed the listing of names on the central registry and the documentation of families served by DR in several different ways in state legislation. For example, Virginia and Vermont both prohibit listing families served by the DR track in the central registry, but require the agency to keep internal documentation of the results of the assessment. New York legislation requires that local agencies document the result of family assessments and send them to the central registry where the files will be sealed for 10 years and can be seen in limited circumstances, including by the agency, if there is a new allegation of abuse or neglect.

# Pathway Assignment Criteria Matrix

**Code Key:**

| | |
|---|---|
| Mandatory Investigation | Discretionary Criterion (Either County or Staff Discretion) for Investigation |

## Table 1: Severe Harm

| State | Fatality from child abuse/ neglect | Sexual abuse/ exploitation | Severe physical abuse/ injury | Abandonment | Severe neglect | Severe emotional abuse/ harm |
|---|---|---|---|---|---|---|
| **California**[iv] | X | X | X | X | X | X |
| **Colorado**[v] | X | X | X | | X | X |
| **Connecticut**[vi] | X | X | X | X | X (If the living situation is immediately dangerous ) | X |
| **Hawaii**[vii] | X | X | X | X | X | X |
| **Illinois**[viii] | X | X | X | X | X (Inadequate Supervision if the child is under age 8 or with an emotional/mental functioning of that of a child under age 8.) | X |
| **Kentucky**[ix] | X | X | X | X | X | X |
| **Louisiana**[x] | X | X | X | X | X | |
| **Massachusetts**[xi] | X | X | X | X | X | |
| **Minnesota**[xii] | X (Investigation is required for murder in the 1st, 2nd, and 3rd degree, whether it is a child or adult victim connected to the allegation.) | X | X | X | X | X (Neglect that substantially endangers the child's physical or mental health) |
| **Missouri**[xiii] | X | X | X | X | X | |
| **Nevada**[xiv] | X | X | X | X | | X |

| State | Fatality from child abuse/ neglect | Sexual abuse/ exploitation | Severe physical abuse/ injury | Abandonment | Severe neglect | Severe emotional abuse/ harm |
|---|---|---|---|---|---|---|
| **New York**[xv] | X | X | X | X | X (Reports alleging that the subject has neglected a child so as to substantially endanger the child's physical or mental health, including failure to thrive) | X (Reports alleging that the subject has neglected a child so as to substantially endanger the child's physical or mental health, including failure to thrive) |
| **North Carolina**[xvi] | X | X | X | X | | |
| **Ohio**[xvii] | X | X | X | | X | X |
| **Oklahoma**[xviii] | X | X | X | | X | |
| **Tennessee**[xix] | X | X | X | X (Abandonment of a child under the age of 8) | | X |
| **Virginia**[xx] | X | X | X | Discretionary | Discretionary (Lack of supervision that causes injury or illness; injury or threat of injury due to use of weapons in the home.) | Discretionary (Child is experiencing serious distress or impairment; child's emotional needs allegedly are not being met or are severely threatened.) |
| **Wyoming**[xxi] | X | X | X | | | |
| **Counts** (Mandatory and Discretionary Criteria) | 18 | 18 | 18 | 14 | 14 | 12 |
| **Percentage** | 100% | 100% | 100% | 78% | 78% | 67% |

## Table 2: Family Risk/ Environmental Factors

| State | Past reports | Past child removal/ Need for removal | Domestic violence | Age of child | Law Enforcement involvement/ Meth Lab | Felony/ Criminal charges |
|---|---|---|---|---|---|---|
| **California** | X (Prior history of physical abuse) | | X | X (Under 2, or capability equivalent) | | |
| **Colorado** | Discretionary (Currently open investigation response, Frequent, similar, recent referrals, or Previous serious child harm offenses) | | Discretionary (Violent activities in the household) | Discretionary (High child vulnerability) | | Discretionary (Court ordered investigation) |
| **Connecticut** | X (Two or more substantiated investigation on a current household member in the past 12 months or a previous risk assessment of high within the last 12 months) | | | X (Physical abuse cases with significant marking or in need of medical attention and under the age of 6) (Neglect cases where a child is left unsupervised and is under the age of 8) | X | X |
| **Hawaii** | | | | | | |
| **Illinois** | X (Any prior "indicated" reports) | | | X (Inadequate Supervision if the child is under age 8 or with an emotional/mental functioning of that of a child under age 8.) | | |
| **Kentucky** | Discretionary (Prior substantiated or FINS reports) | X (Child removed from home by DCBS/DPP) | X | X (7 or younger) | | Discretionary (Weapons/ threatened violence) |
| **Louisiana** | X (A new report/incident of child abuse/neglect on an active OCS case. This includes an open investigation) | | | | X (Any report that will be co-investigated with law enforcement and/or must be initiated with law enforcement | |

| State | Past reports | Past child removal/ Need for removal | Domestic violence | Age of child | Law Enforcement involvement/ Meth Lab | Felony/ Criminal charges |
|---|---|---|---|---|---|---|
| | | | | | due to the potential danger from the caretaker or such circumstances as the possible presence of a methamphetamine lab/ child is in danger and law enforcement is needed.) | |
| **Massachusetts** | | | Discretionary | | | |
| **Minnesota** | X (Currently open investigative assessment, or frequency, similarity, or recentness of past reports) | X (Parental behavior, status, or condition which mandates that the county attorney file a TPR petition) | | | | |
| **Missouri** | | | | | X | X |
| **Nevada** | X (The child lives in a household in which another child has died, or the child is seriously injured.) | | | | | |
| **New York** | X (the child has been previously found, within the five years immediately preceding to be an abused child) | | | | | X |
| **North Carolina** | | X (A child hospitalized (admitted to hospital) due to suspected abuse/ neglect) | | X (A child under 1 receiving corporal punishment) | X (The suspected or confirmed presence of a methamphetamine lab where children are exposed ) | |

| State | Past reports | Past child removal/ Need for removal | Domestic violence | Age of child | Law Enforcement involvement/ Meth Lab | Felony/ Criminal charges |
|---|---|---|---|---|---|---|
| **Ohio** | • X (Currently open traditional case)<br>• Discretionary (Frequency, similarity, or recentness of past reports)<br>•Discretionary (Previous child harm offenses charged against the alleged perpetrator) | | Discretionary | | | X (Reports containing allegations that could result in charges of felony child endangering.) |
| **Oklahoma** | | | | X (Injury to a child under 5, resulting from excessive discipline that requires medical attention) | | |
| **Tennessee** | | X (Any report of harm alleging facts that would result in the removal of a child from the home pursuant to department policy or rule.) | | | X (Infants exposed to illegal narcotics, including methamphetamine. Or, a child left without supervision in a dangerous environment;) | |
| **Virginia** | X (After a family has received two valid CPS reports within 12 months, the third report must be investigated) | X (A child has been taken into the custody of the local department of social services, or Child taken into protective custody by physician or law enforcement) | | | Discretionary (Reports of children present during the sale or manufacture of illegal substances) | Discretionary (Lack of supervision that causes injury or illness; injury or threat of injury due to use of weapons in the home.) |

| State | Past reports | Past child removal/ Need for removal | Domestic violence | Age of child | Law Enforcement involvement/ Meth Lab | Felony/ Criminal charges |
|---|---|---|---|---|---|---|
| **Wyoming** | | X (The child appears to be in imminent danger and it is likely the child will need to be removed from the home) | | | | X (That criminal charges could be filed,) |
| **Counts** (Mandatory and Discretionary Criteria) | 11 | 6 | 5 | 7 | 6 | 8 |
| **Percentage** | 61% | 33% | 28% | 39% | 33% | 44% |

## Table 3: Parental Factors

| State | Refusal/ Non-voluntary | Infant substance exposure | Behavioral health concerns/ malicious punishment | Medical neglect | Non-organic Failure to thrive |
|---|---|---|---|---|---|
| **California** | | X | X (Prior history of caregiver mental health, or substance abuse concerns/ caregiver's behavior is cruel, bizarre, or extremely dangerous) | X | |
| **Colorado** | Discretionary (Caregiver declined services in the past) | | | | |
| **Connecticut** | | X | X( For neglect cases if severe substance abuse, developmental disabilities, or mental illness is present) (For physical abuse if punishment is severe or bizarre and leaves significant markings) (For all cases if parent is currently incapacitated due to drugs, alcohol, or mental illness) | X (if the child appears to be seriously ill or injured or is in need of immediate care or attention or if they seem to be adversely affected by a delay or denial of care and/or attention) | |
| **Hawaii** | X | | | | |
| **Illinois** | | X | | X (Medical neglect of disabled infant.) | |
| **Kentucky** | | Discretionary | Discretionary | | |
| **Louisiana** | | X | | | |
| **Massachusetts** | | Discretionary | | | |
| **Minnesota** | X (Declined services in the past) | | X (Malicious punishment or neglect or endangerment of a child) | | X |
| **Missouri** | | | | X | |

| State | Refusal/ Non-voluntary | Infant substance exposure | Behavioral health concerns/ malicious punishment | Medical neglect | Non-organic Failure to thrive |
|---|---|---|---|---|---|
| **Nevada** | | Discretionary (The alleged effect of prenatal illegal substance abuse on or the withdrawal symptoms of the newborn infant may not be eliminated from participation in social or health services) | | | |
| **New York** | | | | | X (Reports alleging that the subject has neglected a child so as to substantially endanger the child's physical or mental health, including failure to thrive) |
| **North Carolina** | | | | X (The medical neglect of disabled infants with life threatening condition) | |
| **Ohio** | Discretionary (Parent/legal guardian has declined services in the past) | Discretionary | | | |
| **Oklahoma** | | | | | |
| **Tennessee** | | | | X (Lack of care that results in a life-threatening condition or hospitalization) | X |
| **Virginia** | | | | | Discretionary |
| **Wyoming** | | | | | |
| **Counts** (Mandatory and Discretionary Criteria) | 4 | 8 | 4 | 6 | 4 |
| **Percentage** | 22% | 44% | 22% | 33% | 22% |

# Practice Section

Core Section Components

- Practice Section: Narrative Analysis
- Practice Section: Matrix
- Document Library Folder: https://drive.google.com/folderview?id=0B26M5TMdNUWNRHB3TXp4UVBOTGM&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhIVU1nOVE

# Practice Section: Narrative Analysis

DR practice varies considerably across jurisdictions, as jurisdictions have adapted the DR approach to fit local needs and existing system structures. While variation is the rule and not the exception in DR practice, many lessons can be learned from the diverse experiences of jurisdictions to guide better practice (For more information on practice differences between DR and TR, see the discussion on model fidelity in the Evaluation Section, as well as Ohio's Practice Profiles). This section includes discussion on the following practice topics, collected from the 16 jurisdictions:

(1) Staffing models: specialized vs. generalized caseloads;
(2) Process and types of staff training;
(3) Service array offered across tracks;
(4) Flexible funds available to meet family needs; and
(5) Service linkages: can families access services without a CPS report?

In addition to the perspectives gathered from jurisdictions, the discussion below includes some context and additional information gathered from the research literature.

## Staffing Models: Specialized vs. Generalized Caseloads

When designing and building new structures associated with new initiatives, jurisdictions have often learned through trial and error. In the course of separating out the DR track from the traditional investigative track, jurisdictions considered various ways of staffing the newly created track. Regarding staffing models, jurisdictions made the following decisions: 56% allow for county/ local office discretion in case staffing (CO, CT, LA, MN, MO, NY, NC, OH, VA), 38% require specialized caseloads of DR-only workers and traditional response (TR)-only workers (LA County, SF County, SC County, HI, MA, NV), and 7% expect all workers to staff all case types, as a generalized or mixed caseload throughout the state (KY).

Participants shared that, in general, more densely populated areas have larger organizational capacity and are better able to develop specialized units. Likewise, smaller, or more rural areas tend to have mixed caseloads, as fewer workers are available and some take on multiple roles. Nonetheless, allowing for local variation means that some counties experiment with generalized or specialized caseloads regardless of county size and geography. North Carolina reported that some larger counties have generalized caseloads, while some smaller counties utilize specialized workers. In some county-administered systems, the state agency recommended that counties use specialized caseloads when possible, but also allows for counties to choose for themselves (MN, NY, OH). One state initially required specialized caseloads, but now allows for county discretion (CO).

Among jurisdictions with specialized caseloads, most of these jurisdictions have a privatized DR system, in which the case is handed off to a private agency for DR case management and services. Additionally, most jurisdictions utilizing specialized workers comprise smaller geographic areas, with more concentrated urban populations.

## Process and Types of Staff Training

Jurisdictions have described numerous processes for staff development in DR systems. In 44% of jurisdictions, both DR and TR workers receive the same set of trainings (CO, CT, HI, MN, MO, OH, VA). In 38%, all workers receive the same core trainings, but DR workers receive additional training on conducting family assessments and the DR approach (SF County, KY, LA, MA, NY, NC). Additionally, in 19% of jurisdictions, private agencies train their

own staff, but some cross-training between public and private agency staff is provided (LA County, SC County, NV). Two states described that, initially, they only trained DR workers on DR policy and practice, but they later decided to expand DR training to include TR workers as well (CO, OH). Colorado came to the conclusion that in order to create organization-wide changes to practice that were congruent with the DR approach, they needed to train all workers on the new approach. Ohio now recommends that counties train all workers when possible, as the prior exclusion of TR workers from DR training created rifts between these sets of workers. Instead, the state intends for all workers to have a solid understanding of DR, and they believe that those skills are helpful and critical for any worker.

Five states mentioned the use of coaching as an important component of staff development (CO, CT, NV, NY, OH). In Colorado, coaches provide support to workers in parallel to supervisors. In Colorado's model, coaches have no direct oversight, and are therefore able to build different types of relationships with workers in order to focus solely on building and reinforcing practice skills. Ohio noted that the state promotes the use of coaching and shadowing among counties, as they provide opportunities for real-world learning; their philosophy is that better practice becomes real when workers see it in action, and have opportunities to apply new skills directly into practice.

## Service Array Offered Across Tracks

When determining how to build service capacity to meet the needs of the new DR track, jurisdictions often reported using the same set of services, in combination with the use of flexible funds to meet the concrete needs of families. Most jurisdictions (69%) allowed for both tracks to access the same set of services (SF County, CO, HI, KY, LA, MA, MO, NY, NC, OH, VA). In 2 states, DR offers an expanded service array compared to TR (CT, NV). Also, in 2 California counties, DR offers a more limited service array compared to TR, due to funding limitations (LA County, SC County).

In Minnesota, the decision to offer the same or expanded service array varies by county. Some jurisdictions discussed the importance of creating a robust service array, including evidence-based practices (EBP),[10] in order to create opportunities for supporting families in their own homes and communities. While the evidence base for child welfare services is currently growing, some jurisdictions (including a younger generation of DR jurisdictions, not surveyed here) were able to combine performance-based contracting (PBC) with the development of evidence-based practices in order to expand both service capacity and service effectiveness (for example, see Washington state, which included PBC and EBP, centered around DR, as the core component of its Title IV-E Waiver).[11]

Typical service arrays mentioned by the surveyed jurisdictions include traditional child welfare services such as substance abuse treatment, in-home services, mental health counseling, and parenting skills education, while also including non-traditional services focused on meeting concrete needs, such as the use of flexible funds applied to rent assistance, child care, car maintenance, furniture, exterminators, and beyond. Jurisdictions reported that the use of flexible funds provides workers with new ways of engaging families and meeting family needs in ways that previously could not be addressed.

[10] For more information on the evidence behind evidence-based practices, see the California Evidence-Based Clearinghouse for Child Welfare: http://www.cebc4cw.org/
[11] For more information on Washington State's waiver application, see: http://www.dshs.wa.gov/ca/about/flexfunding.asp

## Service Linkages: Can Families Access Services Without a CPS Report?

In general, differential response embodies a more preventive approach than traditional CPS systems, as the DR approach involves helping families to gain access to services more quickly in order to achieve family engagement and better outcomes. When asked about the possibility of families receiving services in the absence of a CPS report, 63% of surveyed jurisdictions indicated that preventive service linkages are allowed (LA County, SF County, MA, MN, MO, NC, NV, NY, OH, VA). Nonetheless, while these jurisdictions have policy which allows for such linkages, some consider this a technicality, or an option which is rarely utilized or made public. Other jurisdictions indicated that service linkages are more routine and widely utilized. In some of these jurisdictions, the option for community service referrals without a CPS report actually predated the DR system (NY, OH)—an indication that preventive thinking has been present in the jurisdiction for a long time.

## Flexible Funds Available to Meet Family Service Needs

Flexible funds can be used to provide a robust set of family support services from the community, where the economic, health, mental health and other needs of these families that brought them to the attention of child welfare can be addressed. Some DR jurisdictions have reported that the use of flexible funds to meet family needs became a critical part of their DR system, and was an important factor in driving positive changes in family outcomes. Among surveyed jurisdictions, 38% of jurisdictions indicated that flexible funds were made available for workers to use for purchasing services and concrete goods as part of the DR implementation (CO, CT, LA, MN, NY, OH). During the Ohio pilot, counties received a financial reimbursement of $1,000 for every DR family (up to a predetermined maximum number of families), which was used for the provision of concrete goods, as well as implementation costs.[xxii] For families that are typically assigned to the DR track (lower-risk, neglect cases), a significant majority struggle with poverty and meeting basic household needs. These funds helped families address some financial needs, and in some cases, workers reported that these funds helped alleviate the problem that brought the family to the attention of child welfare.[xxiii] In Minnesota, the use of flexible funds to meet the practical needs of families expanded the ways that many workers thought about services--in effect, leveraging a different way of acting and helping with families.[xxiv]

| Practice Section: Matrix | | | | | |
|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Staffing model: specialized vs. generalized caseloads** | **Process and types of staff training** | **Service Array Offered Across Tracks** | **Service linkages: Can families access services without a CPS report?** | **Flexible Funds Available to Meet Family Service Needs** |
| **Los Angeles County, CA (2004)** | Specialized caseloads of DR-only workers and TR-only workers. DR path (Path 2) is contracted out to a private agency. | Private agencies train their own staff but there is some cross-training between public and private agency staff. | DR (Path 2) offers a limited service array compared to TR, as funding is not as deep. DR service array includes: in-home counseling, household management, parenting classes, and transportation assistance. DR has the ability to be linked to prevention and aftercare services as needed. | Yes, in new service contracts families can be referred directly to community prevention services. | No |
| **San Francisco County, CA (2004)** | Specialized caseloads of DR-only workers and TR-only workers. DR path (Path 2) is contracted out to a private agency. | All private agency staff receive some basic training of safety and risk assessment (training on SDM tools), but the remainder of training requirements are determined by the individual agency. | Both tracks (Path 2 and Path 3) have access to the same services. Service array includes: counseling, parenting classes, substance abuse treatment, in-home services, SafeCare (health and wellness for ages 0-5), Triple P, The Incredible Years, Public Health Nurses for Ages and Stages development assessments, TANF, SNAP. Services are provided through Family Resource Centers, which serve as a hub of resource services. | Yes, families can go directly to Family Resource Centers to access resources. This would also be considered Path 1, even in the absence of a report. | No |
| **Santa Clara County, CA (2004)** | Specialized caseloads of DR-only workers and TR-only workers. DR path (Path 2) is contracted out to a private agency. | Private agencies train their own staff as determined in contracts with the public agency (40 hours of training for new hires and 20 hours each year thereafter). | DR (Path 2) offers a limited service array compared to TR, as funding is limited by service dollars and contracts. | No | No |
| **Colorado (2010)** | Allows county/ local office discretion for how to staff cases. For the initial pilot, the state planned for specialized caseloads, but they now leave it up to counties. | DR and TR workers receive the same trainings. Initially, CO only trained DR workers on DR practices. They later concluded that in order to create an organization-wide change, they needed to train all workers. DR training is 8 hours long, including the history, philosophy, and practice of DR, and entering data into the SACWIS system. To reinforce and build DR practice skills, CO developed a coaching model, which involves coaches who operate independently from supervisors, and focus solely on building practice skills. | Both tracks have access to the same services. Service array includes: substance abuse monitoring and treatment, mental health treatment, parenting skills coaching, household management, concrete assistance, domestic violence services and shelters, transportation assistance, TANF. | Uncertain, this is still being determined in policy, which allows service linkage only if a referral is generated. “Community Response” track is currently being implemented in several counties throughout the state, which would provide for families who would not qualify for assignment but would benefit from services. | Yes |

| Practice Section: Matrix | | | | | |
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| **Jurisdiction (Year of Inception)** | **Staffing model: specialized vs. generalized caseloads** | **Process and types of staff training** | **Service Array Offered Across Tracks** | **Service linkages: Can families access services without a CPS report?** | **Flexible Funds Available to Meet Family Service Needs** |
| **Connecticut (2011)** | Allows county/ local office discretion for how to staff cases. Larger offices tend to have specialized units and workers, while this is difficult for smaller offices. In smaller offices, the supervisor oversees both tracks, while some workers have generalized caseloads. | DR and TR workers receive the same trainings. Before implementation, CT first trained managers and supervisors on changes required by DR, then trained both sets of workers. Now, new hires are trained and oriented to both tracks. After conducting a case review, CT found gaps in worker skills and will initiate a second round of training to address those gaps. New Foundational Training is 8 days long. A coaching model was piloted in 4 area offices. | DR offers an expanded service array compared to TR. DR service array includes: Community Supports for Family Programs, some concrete assistance (such as rent assistance). | No | Yes |
| **Hawaii (2005)** | Specialized caseloads of DR-only workers and TR-only workers. | DR and TR workers receive the same trainings. Contracted providers are also required to attend all core child welfare trainings, and they additionally attend their own agency trainings. | Both tracks (VCM and OCWS) have access to the same services. Service array includes: family conferences, parenting classes, domestic violence services. | No | No |
| **Kentucky (2000)** | Generalized caseloads where all workers staff all case-types. | All workers receive the same core trainings from the state training academy. Back at their local office, their supervisor is responsible for all staff development needs. | Both tracks have access to the same services. | Not through the CPS system, but they do allow for community service referrals, which would receive a different type of response. | No |
| **Louisiana (1999)** | Allows county/ local office discretion for how to staff cases. LA began their DR implementation with specialized workers, then they realized that only urban areas had the capacity for specialized caseloads. | All workers receive the same core training. DR training is conducted at the local level, which varies in the extent of DR training offered to both types of workers. | Both tracks have access to the same services. | No | Yes |
| **Massachusetts (2008)** | Specialized caseloads of DR-only workers and TR-only workers. MA tries to minimize the number of workers that work with each family. An assessment worker will never | All workers receive the same core trainings, including DR training. However, investigators receive additional training on investigations. | Both tracks have access to the same services. Service array includes: therapy, child care, in-home services, housing, substance abuse treatment, mental health treatment, physical health. | Yes, MA does accept voluntary requests for services, but in the current economic environment, funds are limited. Families would receive the same set | No |

| Practice Section: Matrix | | | | | |
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| **Jurisdiction (Year of Inception)** | **Staffing model: specialized vs. generalized caseloads** | **Process and types of staff training** | **Service Array Offered Across Tracks** | **Service linkages: Can families access services without a CPS report?** | **Flexible Funds Available to Meet Family Service Needs** |
| | handle investigations, but an investigator might do an assessment. | | | of services available under DR, just without a track assignment or finding. | |
| **Minnesota (2000)** | Allows county/ tribal/ local office discretion for how to staff cases. Due to being a county-administered system, there are many models. The state recommends a one-worker, one-family model. | DR and TR workers receive trainings that are integrated across tracks, as they both use the same SDM tools for safety assessment, etc. The Child Protection Training System is operated at the state-level, which requires 6 weeks of training to be completed in the first 6 months of employment and includes a computerized curriculum in preparation for the on-site classroom training. No coaching or shadowing opportunities are provided at the state level, but may occur at the local level. Additionally, the state periodically conducts specialized trainings, such as family engagement skill-building. | Service array varies somewhat by county/ AICWI tribe. The state distributes some money for certain services to counties/ AICWI tribes, including: case management, after-care services, in-home services, counseling, parent education, domestic violence services, concrete assistance, child care. Overall, DR pathway focuses much more on connecting families with resources to meet basic needs, such as rent, utility assistance, car maintenance, etc. | Yes, Minnesota's Parent Support Outreach Program (PSOP), which serves as a 3rd track for screened-out cases, allows for community service referrals and self-referrals. PSOP is implemented statewide and is considered part of MN's child welfare system. | Yes |
| **Missouri (1994)** | Allows county/ local office discretion for how to staff cases. Most circuits allow for generalized caseloads. | DR and TR workers receive the same trainings. Child Welfare Basic Training consists of 3 full weeks of training and a 3-day follow-up. After one week off, workers begin carrying cases, and receive in-depth case supervision. For the first 72 hours, new workers receive consultation on every case, including review of how safety was assured, additional decision-points, and collateral contacts that need to be made. In the first year of employment, new workers also receive shadowing opportunities and in-depth coaching by supervisors. | Both tracks have access to the same services. Service array includes: intensive in-home services, community referrals, concrete assistance. | Yes, MO receives many hotline calls from mandated reporters looking to connect families to services. Families can also go to a local office and ask for help, without an allegation, and they can receive services. | No |

| Practice Section: Matrix | | | | | |
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| **Jurisdiction (Year of Inception)** | **Staffing model: specialized vs. generalized caseloads** | **Process and types of staff training** | **Service Array Offered Across Tracks** | **Service linkages: Can families access services without a CPS report?** | **Flexible Funds Available to Meet Family Service Needs** |
| **Nevada (2007)** | Specialized caseloads of DR-only workers and TR-only workers. DR path is contracted out to Family Resource Centers (FRCs). | Cross-training between public and private agency staff is provided by the state. This training includes DR policies and procedures, administering the assessment tool, and data entry into the system. Additionally, private agency staff observe the intake process and the court process, and the whole process lasts for 1.5 weeks. After this, there are no additional mandatory trainings, but the state offers opportunities for ongoing training, both online and in-person. Each jurisdiction also provides at least 2 staff who are available for ongoing DR coaching. Every month, site-based training is offered, where public agency supervisors meet with contracted DR workers to staff difficult cases. | DR offers an expanded service array compared to TR. Service array includes: case management, SNAP, TANF, Medicaid, concrete assistance (which has been used for household items, furniture, exterminators, McDonalds gifts cards as incentives for kids, etc.) | Yes, families can access resources through Family Resource Centers, although this is not considered part of the DR track. | No |
| **New York (2008)** | Allows county/ local office discretion for how to staff cases. Overall, the state recommends specialized caseloads, but they do not prohibit generalized caseloads. | All workers receive the same core trainings, but DR workers receive additional training on family assessment. DR workers also receive coaching provided through the Butler Institute. | Both tracks have access to the same services, but DR workers tend to connect families to additional formal and informal resources in the community. | Yes, if a family approached CPS with a need, they can access preventive services in the absence of a report. However, this option predated DR in NY. | Yes, the county office can access CPS funds (State and local share) to use to meet immediate needs. |
| **North Carolina (2001)** | Allows county/ local office discretion for how to staff cases. There is much variation throughout the state. Some large counties have generalized caseloads, while some smaller counties have specialized caseloads. | All workers receive the same core trainings, but DR workers receive additional training. All workers are required to complete what is called the 200 series trainings. The training is focused on the area of work that the Social Worker is assigned to carry out, where an Assessment Social Worker receives a 32-hour training on Assessments (both investigative and family assessments). Continuing workers are statutorily required to complete 24 hours of training each year. | Both tracks have access to the same services. | Yes, families can access community based services and some local child welfare agencies have specialized personnel to help link families to services. | No |

| Practice Section: Matrix | | | | | |
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| **Jurisdiction (Year of Inception)** | **Staffing model: specialized vs. generalized caseloads** | **Process and types of staff training** | **Service Array Offered Across Tracks** | **Service linkages: Can families access services without a CPS report?** | **Flexible Funds Available to Meet Family Service Needs** |
| **Ohio (2007)** | Allows county/ local office discretion for how to staff cases. Overall, the state recommends specialized caseloads, but this is often not feasible for smaller counties. There are different timeframes between the pathways, and the state realizes that this creates a challenge for workers with generalized caseloads. They have found that it is easier to manage these timeframes with specialized caseloads. | DR and TR workers receive the same trainings. The state recommends that counties train all workers when possible. Initially, only DR workers received trainings on DR, which created rifts between DR and TR workers. Additionally, they found that if they only trained DR workers, this complicated expansion efforts, as DR was expanded throughout offices and counties. Instead, they want everyone to have a good solid understanding of DR, and they believe that those skills are helpful and critical to any worker. Additionally, the state promotes the use of coaching and shadowing, which provide real opportunities for learning; better practice becomes real when workers see it in action, and have opportunities to apply new skills through practice. | Both tracks have access to the same services, although there is some variation across counties. The state provides some additional flexible funds to DR counties at the point of initial implementation of DR. Each new DR county is eligible to receive an additional $40,000, to be used for concrete assistance, services, or training. OH notes that having access to additional resources helps the process considerably, especially when encouraging workers to work in new ways with families. | Yes, although this is not part of the DR system. Families who self-refer to the agency and do not meet the threshold for a child abuse or neglect referral may be served as a Family in Need of Services (FINS). FINS families can access the entire service array, and they often utilize concrete items, such as utility assistance, work uniforms, beds, and other assistance with immediate issues. FINS is available in all OH counties. Funding for FINS is not from the same DR pool, and funding may vary substantially by county. FINS predated DR, so it does not require all of the steps of a traditional intake. | Yes |
| **Virginia (1997)** | Allows county/ local office discretion, as local departments of social services determine staffing model. Larger counties have specialized caseloads while smaller county workers often have multiple roles and responsibilities. | DR and TR workers receive the same trainings, as all workers need knowledge of all parts of the system. | Both tracks have access to the same services. Services offered to families are based on the risk assessment, not the track assignment. Typical services available statewide include: parenting classes, counseling, etc. | Yes, but limited. VA has policy guidance on prevention, and some localities provide this, but not under CPS. | No |

# Implementation Processes Section

Core Section Components

- Implementation Processes Section: Narrative Analysis
- Implementation Processes Section: Matrix
- Document Library Folder: https://drive.google.com/folderview?id=0B26M5TMdNUWNRHB3TXp4UVBOTGM&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhIVU1nOVE

Additional Tools/ Resources

- Barriers and Strategies Matrix

# Implementation Processes Section: Narrative Analysis

For jurisdictions considering whether to move forward with DR, more knowledge and evidence regarding how to achieve successful implementation is available now than ever before. Implementation science[12], research evidence, and practice wisdom have accumulated, and offer guidance on some key levers that facilitate smooth and effective roll-out processes. This section includes discussion on the following implementation topics, collected from the 16 surveyed jurisdictions:

(1) Implementation staging process;
(2) Types of TA utilized and sources;
(3) Funding sources for DR implementation and ongoing operations; and
(4) Dedicated staff to manage DR implementation.

In addition to the perspectives gathered from jurisdictions, the discussion below includes some context and additional information gathered from the research literature.

## Implementation Staging Process

Jurisdictions planned for implementation staging in two primary ways. Among the 16 surveyed jurisdictions, 69% used a phasing-in implementation process over time, such that initial pilot counties or regions implemented the model, and then subsequent stages of implementation eventually reached throughout the state or county (LA County, CO, CT, LA, MN, MO, NV, NY, NC, OH, VA). 31% of jurisdictions implemented throughout the state or county simultaneously (SF County, SC County, HI, KY, MA). Jurisdictions that implemented simultaneously tended to be individual counties, or encompass smaller geographic areas, which made the scaling process more manageable than it might have been for larger states. One large state not surveyed here (IL) attempted a simultaneous statewide implementation, but DR was later discontinued in the state, primarily due to funding reasons. Some jurisdictions utilized a deliberate, systematic process of staging implementation throughout the jurisdiction in groups or waves of counties, often recruiting cohort counties through an RFP process (CO, NC, NV, NY, OH, VA). A few jurisdictions' implementation process went through fits and starts, in which a pilot began, then gained and lost momentum over time. Sometimes the momentum was picked up again, at 5 or even 10 years later, and implementation continued to spread.

## Types of Technical Assistance (TA) Utilized and Sources

Nearly all surveyed jurisdictions identified multiple sources of technical assistance, when it was available, to help with multiple tasks, including:

- Drafting legislation,
- Developing system components such as assessment tools,
- Implementation planning and sequencing,
- Defining and describing changes to practice,
- Organizational capacity building and staff development, and
- Data system changes and evaluation planning.

[12] For more information about Implementation Science, see the National Implementation Research Network (NIRN) at: http://nirn.fpg.unc.edu/
Also, see the Resource Kit Document Library folder on Implementation Science for gathered materials: https://drive.google.com/folderview?id=0B26M5TMdNUWNRHB3TXp4UVBOTGM&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhIVU1nOVE

Numerous jurisdictions highlighted the value of peer-to-peer consultation (technical assistance from outside jurisdictions or internal pilot areas that have accumulated more DR experience) in planning and spreading the DR model. DR systems have largely been built on the shoulders of those who have gone before, capitalizing on important lessons learned, as well as barriers to avoid.[13] Several surveyed jurisdictions shared that successful statewide implementation was achieved through the help of peer-to-peer guidance and county-to-county mentoring, which facilitated the spread of DR knowledge and experience statewide. One jurisdiction emphasized the importance of understanding the broader Implementation Science and drew upon tools and resources developed by the National Implementation Resource Network (NIRN)[14], and other entities, to successfully move forward with planning.

Among the TA sources most commonly identified by the surveyed jurisdictions, 56% received TA from other DR states, or conducted site visits with states that have considerable experience with DR, such as Minnesota or Missouri. 56% of jurisdictions also identified that they received some form of internal TA, such as county-county assistance, where pilot counties assisted later-implementing counties. 63% received TA from other types of external consultants such as the Children's Research Center (CRC), Institute of Applied Research (IAR), Casey Family Programs (CFP), or NIRN. 50% received TA from federally-funded Training and Technical Assistance (T/TA) Centers, including the Quality Improvement Center for DR (QIC-DR), the National Resource Center for In-Home Services (NRC-IHS), or the National Resource Center for Child Protective Services (NRC-CPS).

## Funding Sources for DR Implementation and Ongoing Operations

Many surveyed jurisdictions drew upon additional external funds for implementation of DR and system maintenance over time. LA County, New York, Minnesota, and Ohio were able to use external funds including foundation grants/ technical assistance, and Federal Title IV-B Promoting Safe and Stable Families (PSSF) funds, and two states (Colorado and a consortium of 6 counties in Ohio) received a federally funded grant from the QIC-DR. Several jurisdictions were able to access expanded funding from state and county sources, or through the establishment of dedicated revenue streams, such as a tobacco tax (LA County, SF County, HI, MN, NY, NC, OH). These funding sources were used both for upfront implementation and ongoing costs.

Seven jurisdictions (44%) did not have access to expanded funding, and implemented DR on a cost-neutral basis compared to the existing system (CT, KY, LA, MO, NY, NC, VA). North Carolina implemented DR as one part of a larger system transformation of creating a family-centered approach to child protection, which relied on federal grant funding. However, DR by itself received no additional funding and was believed to be cost-neutral compared to the earlier system. Cost-neutral jurisdictions reported that the lack of additional funds required greater creativity to access services to meet case-specific needs of children and families, which was often achieved through building relationships with community organizations.[xxv] Cost-neutrality is a key aspect of Title IV-E waivers offered by the federal Administration for Children and Youth Services (ACYF).[15] Through states' waiver demonstration projects, they are seeking to demonstrate cost-neutrality over a five-year period. This fits well with DR, in that DR often requires additional upfront investments in implementation and front-end

[13] For more information on barriers to implementation and strategies for overcoming them, see the Barriers and Strategies Matrix.
[14] For more information about NIRN, see: http://nirn.fpg.unc.edu/
[15] For more information on the Administration for Children, Youth, and Families Title IV-E waiver process, see: http://www.acf.hhs.gov/programs/cb/programs/child-welfare-waivers

services, and then may return cost savings over time through reductions in foster care maintenance costs, as well as future family involvement in child welfare.

## Dedicated Staff to Manage DR Implementation

Considering the wide range of implementation activities required to effectively change frontline practice, most jurisdictions have created dedicated staff positions or have redirected staff responsibilities to manage the implementation process for DR. In 50% of jurisdictions, at least one dedicated staff position was created to manage the DR program and implementation process, with no other duties assigned (LA County, SF County, SC County, CO, MA, MN, NC, OH,). Another 38% had at least one primary staff member who focused on DR implementation, but had other assigned responsibilities (CT, HI, LA, NV, NY, VA). Dedicated staff positions varied across jurisdictions, from high-level director positions to mid-level manager positions. Some larger jurisdictions created two or more dedicated positions, while one county created a single part-time position. Drawing upon Minnesota's example, Gary Siegel from the Institute for Applied Research summarized the rationale for dedicated positions: "New programs don't automatically coalesce operationally around pieces of paper and don't run themselves. While this seems obvious it is not always put into practice, sometimes because a state lacks the financial resources to establish new management positions or because of statutory constraints inhibiting their creation or because of administrative short-sidedness. In this case [Minnesota], the establishment of these two state-level managers should be viewed as exemplary administrative practice, as important to the ultimate success of the project statewide as the design of the program model itself. Every child needs a parent, even a child prodigy."[xxvi]

| Implementation Processes Section: Matrix | | | | |
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| **Jurisdiction (Year of Inception)** | **Implementation Staging Process** | **TA utilized and sources** | **Funding Sources for DR Implementation and Ongoing Operations** | **Dedicated staff to manage DR implementation** |
| **Los Angeles County, CA (2004)** | Phased-in implementation process. | Utilized limited TA. | The Clark Foundation provided a grant to initiate the pilot, which was time-limited Family Preservation Services for families whose abuse and/or neglect allegations were deemed to be inconclusive and the risk level was either low or moderate. Later, funds were provided by the Foundation Consortium for California's Children & Youth funds, Casey Family Programs, and the Marguerite Casey Foundation, which also provided Technical Assistance. Operating costs are paid from Title IV-B PSSF, state Child Welfare Services Outcomes Improvement Project (CWSOIP), California First 5 (collected from a tobacco tax), State Family Preservation (SFP), and LA County Prevention Initiative funds. | Dedicated staff person to manage the implementation process, with no other duties assigned. |
| **San Francisco County, CA (2004)** | Implemented throughout the county simultaneously. | Internal TA (county-county assistance), as part of California's 11 County Breakthrough Series Collaborative initiative on DR implementation. | California First 5 (tobacco tax) contributed funds to Family Resource Centers. | Dedicated staff person to manage the implementation process, with no other duties assigned. Dedicated staff was a lower-level Program Manager, not a director. |
| **Santa Clara County, CA (2004)** | Implemented throughout the county simultaneously. The county phased in additional contracted service providers over time to provide more services to targeted populations. It took roughly two years to arrange for all of the contracted services that are currently in place. | Internal TA (county-county assistance), utilized some TA from other counties, but not on a formal basis. | California First 5 (tobacco tax) | Dedicated staff person to manage the implementation process, with no other duties assigned. Part-time project manager initially focused on the contracting of services and monitoring of contracts for DR. Later, a Program Coordinator was hired as the full time dedicated staff to work on program design and to implement the program on the ground. |
| **Colorado (2010)** | Phased-in implementation process. Five counties were part of the initial DR pilot. As of early 2014, CO will have 28 of 64 total counties that have either implemented or are in planning stages for DR. | Internal TA (county-county assistance), federal resource centers (National Resource Center for In-Home Services (NRC-IHS) (Rob Sawyer)), and other external consultants (Children's Research Center (CRC)). | Demonstration grant from the Quality Improvement Center on Differential Response (QIC-DR) | Dedicated staff person to manage the implementation process, with no other duties assigned. As a state supervised, county administered system, CO deemed it important that the state put forward resources for the initial |

| Implementation Processes Section: Matrix | | | | |
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| **Jurisdiction (Year of Inception)** | **Implementation Staging Process** | **TA utilized and sources** | **Funding Sources for DR Implementation and Ongoing Operations** | **Dedicated staff to manage DR implementation** |
| | | | | consideration of the system reform. As a result, the state provided a Child Protection Manager to serve in this capacity. |
| **Connecticut (2011)** | Phased-in implementation process. CT initially rolled out DR by region. Then, in 2011, a new administration required the agency to roll out DR statewide, instead of by region. | Internal TA (county-county assistance), federal resource centers (National Resource Center for Child Protective Services (NRC-CPS)), Peer TA from other states (MN, NC), and other external consultants (Casey Family Programs (CFP)). | Cost-neutral implementation. No new state funding, CT used existing funds. | Primary staff who focused on DR implementation, but had other assigned responsibilities. |
| **Hawaii (2005)** | Implemented throughout the state simultaneously. | Federal resource centers (NRC-CPS (Theresa Costello)) | Hawaii is currently utilizing Title XX TANF Transfer funds and state general funds. | Primary staff who focused on DR implementation, but had other assigned responsibilities. |
| **Kentucky (2000)** | Implemented throughout the state simultaneously. | Unknown | Cost-neutral implementation | Did not identify a dedicated or primary staff person to manage the implementation process. |
| **Louisiana (1999)** | Phased-in implementation process. DR remained limited to a pilot project for a long period of time. A slow implementation process began in 1998 in New Orleans suburbs (Jefferson Parish). In 1999, they expanded to the city of New Orleans, with a limited number of cases per month. In 2006, DR was initiated in the Baton Rouge region on a limited basis. In 2007, they made the decision to go statewide, and implemented in the last region in 2008. | Peer TA from other states (MO, MN), federal resource centers (Quality Improvement Center for Differential Response (QIC-DR)), other external consultants (American Humane Association (AHA)). | Cost-neutral implementation | Primary staff who focused on DR implementation, but had other assigned responsibilities. |
| **Massachusetts (2008)** | Implemented throughout the state simultaneously. However, the initial implementation process was for 2 tracks, and the 3rd track was | Internal TA (county-county assistance), other external consultants (CRC, CFP, Annual DR Conference). | Unknown | Dedicated staff person to manage the implementation process, with no other duties assigned. The job of the Integrated Case Practice |

| Implementation Processes Section: Matrix | | | | |
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| **Jurisdiction (Year of Inception)** | **Implementation Staging Process** | **TA utilized and sources** | **Funding Sources for DR Implementation and Ongoing Operations** | **Dedicated staff to manage DR implementation** |
| | implemented 3 years later in 2012. | | | Model Coordinator was to coordinate and guide all aspects of the implementation, and this person served as an in-house high-level consultant to staff, who was dedicated to the larger case practice model. |
| **Minnesota (2000)** | Phased-in implementation process. Initial pilot began with 20 counties, then expanded statewide by 2005. | Peer TA from another state (MO). | In 2001, 20 counties participated in the FAR demonstration funded in part by The McKnight Foundation with additional contributions from federal, state, and county sources. Current operations rely heavily upon county dollars, utilizing 15% state dollars, 35% Title IV-B 1 & 2 funds, and 50% county/ AICWI tribe funds. | Dedicated staff persons (2) to manage the implementation process, with no other duties assigned. |
| **Missouri (1994)** | Phased-in implementation process. The demonstration began in 14 small and medium-sized counties across the state and in certain St. Louis zip codes. Based on the generally positive results of the Demonstration, the Legislature in 1998 made the FAR model permanent and extended it statewide. Counties were gradually added to the system during the following 18 months. | DR was a local innovation, no TA was available at the time. | Cost-neutral implementation. As a result, no additional funds were made available or tracked for implementation of the pilot. An essential element of the new approach involved establishing stronger ties to resources within the community to assist children and families. | Did not identify a dedicated or primary staff person to manage the implementation process. |
| **Nevada (2007)** | Phased-in implementation process. Nevada began implementation of its DR pilot project in early 2007, and by 2009 the project was operating in all but the most rural parts of the state. | Other external consultants (AHA/ QIC-DR, Institute for Applied Research (IAR)). Additionally, NV representatives attended the first Annual DR Conference in San Diego, and have attended this conference every year since, which they say has been helpful. | The current model and funding structure restricts family assessments to a relatively small percentage of cases. In Washoe County (Reno), DHHS funded two DR staffs housed in the local FRC. To maximize DR in the region, the Washoe County consortium of community agencies and local government decided to finance additional DR staff independently through the Children's Cabinet.[xxvii] | Primary staff who focused on DR implementation, but had other assigned responsibilities. |

| Implementation Processes Section: Matrix | | | | |
|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Implementation Staging Process** | **TA utilized and sources** | **Funding Sources for DR Implementation and Ongoing Operations** | **Dedicated staff to manage DR implementation** |
| **New York (2008)** | Phased-in implementation process. Upon passage of the DR law, the state agency reached out to local social services districts to assess interest in becoming a pilot site. Round 1 consisted of 6 counties that began accepting families to the FAR track in late 2008. Subsequently, 8 Round 2 counties and five Round 3 counties joined the demonstration project by July 2010. As of the end of 2013, 24 counties provide FAR . | Peer TA from another state (MN), other external consultants (AHA (in which most DR staff later transitioned to the Kempe Center), Butler Institute, and the Schuyler Center for Analysis and Advocacy). | Cost-neutral implementation. NY intended to implement FAR without any additional state funding, and no new funding sources were established in the budget. However, some state Quality Enhancement funds were set aside for FAR. These funds were transformed into flexible funds, which paid for concrete services for families. The Marguerite Casey Foundation provided a grant to make flexible wraparound funds available. Casey Family Programs supported a quality assurance review, and later provided some funds for American Humane Association to provide start-up training and coaching assistance to additional counties. | Primary staff who focused on DR implementation, but had other assigned responsibilities. These included staff from the Policy, Operations and Legal divisions, who led the DR implementation. The legislation provided no allocation to add staff. Existing staff formed a workgroup to manage the process. |
| **North Carolina (2001)** | Phased-in implementation process. Ten pilot counties began preliminary implementation of MRS in 2002. MRS was expanded to 42 additional counties in 2003 (wave 2), following the passage of legislation that increased the number of counties allowed to implement an alternative response system in child protection. As of 2006, all 100 North Carolina counties are implementing the Multiple Response System. | Peer TA from another state (MN), other external consultants (National Implementation Research Network (NIRN), and Appalachian Family Innovations). | Cost-neutral implementation. North Carolina implemented MRS without additional funding. MRS was included as one component among 6 others that represented a wider system transformation towards a family-centered approach to child protection. The state initially developed System of Care (SOC) using federal grant funding; no state or local funds were utilized. The state additionally draws upon Title IV-E funds for eligible families. After the first evaluation report from Duke, funds were allocated to bring caseloads down to under 10 for CPS. These funds were awarded by the County Director's Association based on the annual staffing survey. | Dedicated staff person to manage the implementation process, with no other duties assigned. However, initially there was no dedicated staff person. This position was added in 2002, to serve as a dedicated Policy Consultant specifically for MRS. A second dedicated MRS staff position was added in 2005, although it has been moved to Staff Development. |
| **Ohio (2007)** | Phased-in implementation process. The state agency initiated an RFP process to help counties implement consistently across the state. Counties applied to become pilot sites as they became ready to move forward with implementation, inviting about 10 counties for each wave. All 88 counties will have implemented DR in Ohio by June | Internal TA (county-county assistance, as well as TA provided by the state to counties), peer TA from other states (site visits to MN), federal resource center (QIC-DR), other external consultants (AHA, IAR). OH assembled a team of technical assistance for help with planning, implementation, and evaluation called the AIM team, | Funding sources include Ohio Children's Trust Fund support for family services during the pilot, Federal Discretionary dollars through a Basic State Grant, Children's Justice Act dollars, local levy funds, and Casey Family Programs (provided a county allocation to assist with the costs of transitioning to AR). Additionally, 6 counties are also receiving funds from the Quality Improvement Center on Differential Response (QIC-DR) for their demonstration project. | Dedicated staff persons (2) to manage the implementation process, with no other duties assigned. The state office added 2 fulltime positions, DR Manager (in 2010) and DR Coordinator (in 2012). OH mentioned that they could also use a 3rd staff person. The DR Manager manages contracts with consultants, assists |

| Implementation Processes Section: Matrix | | | | |
|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Implementation Staging Process** | **TA utilized and sources** | **Funding Sources for DR Implementation and Ongoing Operations** | **Dedicated staff to manage DR implementation** |
| | 30, 2014. | which consisted of AHA, IAR, and Minnesota state partners. | | with new counties coming on board, provides implementation support, assists with planning and orientation for new counties, plans site visits to other counties, organizes educational meetings for community groups, etc. |
| **Virginia (1997)** | Phased-in implementation process. Five local departments of social services piloted a multiple response system and received training, technical assistance, and $10,000 annually from the State to support their efforts. A detailed program evaluation has been conducted annually. DR was implemented statewide in 2002. | Internal TA (county-county assistance), peer TA from other states (MO, FL), other external consultants (American Public Human Services Association (APHSA)). | Cost-neutral implementation. | Primary staff who focused on DR implementation, but had other assigned responsibilities. |

# Barriers and Strategies Matrix

Information contained in the following matrix was gathered from the 16 jurisdictions. The Resource Kit Team asked about barriers they encountered and strategies for overcoming them, as well as lessons learned that they would like to share with other jurisdictions about their implementation process. Additionally, these barriers and strategies reflect findings from Implementation Science,[16xxviii] which has demonstrated the efficacy of many of these strategies.

| Potential Barrier to Successful Implementation | Suggested Strategies for Addressing Barrier |
|---|---|
| Distrust of the new DR approach or resistance to change among *external stakeholders*. For example, community values do not seem to be in alignment with DR. | • Utilize strategic outreach and media campaigns as ways to engage key stakeholders (especially legislators, judges, and law enforcement officials) in subsequent deeper conversations about how to best engage families and improve outcomes.<br>• Spend the time to have conversations with stakeholders about their concerns and fears in moving forward with DR. By better understanding their fears, the agency can better respond to those fears, potentially redesigning the DR model or implementation plan to address them. Just as the DR approach seeks to engage families in collaborative ways, this approach can serve as a parallel process with community/stakeholder engagement, modeling collaborative efforts through every step of the implementation process.<br>• Build DR champions from multiple disciplines and help them connect with their respective colleagues who share professional training and values. For example, judges may be more receptive to hearing from fellow judges, and legislators may be more receptive to fellow legislators.<br>• Invite stakeholders to participate on the implementation planning team as a strategy to engage the community. By providing opportunities to listen to and incorporate their feedback, they can feel a sense of ownership by having "skin in the game."<br>• Provide opportunities for stakeholders to hear and learn from other states. For example, stakeholders can learn from DR advocates who have experience with DR implementation from other states.<br>• Develop and launch a new communications strategy, defining DR messaging that is targeted to specific stakeholder groups. Child welfare often needs to better sell its successes and develop messaging related to such successes.<br>• Listen to stakeholder feedback; create a clear process of feedback loops with stakeholder groups, allowing for information to flow in both directions.<br>• Create a dedicated DR staff position as the primary point of contact that can focus solely on the DR implementation process and address concerns as they arise. |

[16] For gathered materials on Implementation Science, see the Resource Kit Document Library folder on Implementation Science: https://drive.google.com/folderview?id=0B26M5TMdNUWNRHB3TXp4UVBOTGM&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhIVU1nOVE

| Potential Barrier to Successful Implementation | Suggested Strategies for Addressing Barrier |
|---|---|
| Distrust of the new DR approach or resistance to change among *internal stakeholders*. For example, workers may feel "initiative fatigue," or doubt that DR will last in the midst of other agency priorities. | • Leadership must demonstrate their firm commitment to DR. Without strong support and buy-in at the leadership-level, workers may not trust that their efforts to shift practice will be worthwhile.<br>• Create a Practice Model to precede/ be rolled-out in parallel with DR. One jurisdiction reported that the practice model created substantial practice changes and this helped to make the shift towards new family engagement practices associated with DR.<br>• Capitalize upon peer technical assistance opportunities to learn from other states/ counties who have been able to move past similar barriers. One state emphasized the importance of hands-on learning, which was critical to the learning process across offices and counties.<br>• Provide regular opportunities to listen to feedback from line workers to better understand how they view the implementation process and practice changes.<br>• Use/develop structured assessment tools that focus on assessing strengths and needs of the whole family, as a way to facilitate assessment-oriented thinking.<br>• Develop strong legislation and policy to support new practice. Legislation creates the structural basis so that DR will not fade away upon the next leadership change.<br>• Expand training targeted to key stakeholder groups.<br>• In addition to supervision, utilize coaching as a way to reinforce practice skills through practical applications of DR concepts and principles.<br>• Utilize Implementation Science to create a comprehensive implementation plan that addresses competency and organizational drivers. |
| Practice expectations for DR track are not clearly defined; how exactly is DR different from traditional response (TR) No model exists that workers can be held accountable towards, and fidelity cannot be ascertained. | • Define the DR model in behaviorally-based terms, such that the model becomes teachable, learnable, and measurable. (See Ohio's "Practice Profiles") |

| Potential Barrier to Successful Implementation | Suggested Strategies for Addressing Barrier |
|---|---|
| Fidelity concerns, or DR practice is not very different from TR practice. Additionally, there may be "model drift" away from DR practice as it was originally intended. | • From the beginning of the process, regularly assess practice and observe how workers are interacting with families by building a continuous quality improvement (CQI) process into the new initiative. One jurisdiction noted that at the time of implementation, they did not have an appreciation for how long it would take to make a change of that magnitude.<br>• Use/create fidelity assessment tools, which define and describe foundational DR practice. At the county / office level, fidelity tools can be administered by independent multi-county teams, combined with a self-assessment process.<br>• Provide ongoing training and coaching to develop and sustain practice changes over time. One jurisdiction shared that practice changes need to be continually reinforced; a single training is not enough. |
| Lack of funding and/or difficulty maintaining existing resources. | • Reach out to leadership and use research data to demonstrate that DR works. Data should be collected as part of the implementation process, and potentially, new measures may need to be developed to track DR case outcomes. Good data generated from well-functioning data-systems can help to make the case to strengthen and maintain funding over time. Data from other jurisdictions have shown that DR is a good investment in terms of cost-effectiveness (See Evaluation Matrix).<br>• Consider a compromise to offer up funding cuts for programs that are less of a priority, demonstrating the agency's commitment to DR. |
| DR utilization is low; cases are not assigned to DR at the expected levels, or utilization of the DR track begins very slowly. | • One jurisdiction reported that this barrier resulted because hotline/pathway assignment staff and field staff had differing levels of knowledge and trust in DR. As a result, hotline staff needed additional training on DR to build more trust that cases would be handled adequately and safely under the DR track. Also, they developed additional SDM tools to ensure better consistency with path assignment.<br>• Expand pathway assignment criteria so that more cases are eligible for DR.<br>• One jurisdiction noted that a centralized intake system creates fewer opportunities for inconsistencies in screening and pathway assignment decisions. |

| Potential Barrier to Successful Implementation | Suggested Strategies for Addressing Barrier |
|---|---|
| Over the course of DR implementation, TR workers feel left out, given that new attention and resources are being directed to DR workers. Tension within the agency leads to additional issues. | • Invest in rebuilding relationships, and restate that investigative workers have an important role as well. Articulate how TR workers contribute to improving the lives of children and families.<br>• Create a set of Practice Profiles for TR workers as well. Just as DR workers need a clear model of best practice in DR, TR workers need a model of best practice in TR, so they can focus upon achieving goals articulated in the model.<br>• Train both DR and TR workers on the new DR approach so that TR workers don't feel left out of the new changes. One state shared that it's important not to leave anyone out, and to make sure that the whole system is attended to.<br>• Conduct a workload study to examine time and workload across tracks and realign caseload standards in accordance with actual workload. |
| Data system is fragmented, requiring ongoing patches to make the system functional. | • Start making data system changes early into the planning process, as SACWIS changes can take a long time. Making system investments can improve case tracking and outcomes reporting mechanisms—important steps in generating and using data for CQI, as well as sharing data successes with stakeholders to maintain buy-in. |
| DR implementation efforts have lost momentum, and are no longer moving forward. | • Create a new launch of a communications campaign, and strategic outreach to partners and stakeholders.<br>• Initiate a new round of staff development including the use of practice coaches to retrain staff on family-engagement skills and reinvigorate practice. |

# Communications and Engaging Stakeholders Section

Core Section Components

- Communications and Engaging Stakeholders Section: Narrative Analysis
- Communications and Engaging Stakeholders Section: Matrix
- Document Library Folder: https://drive.google.com/folderview?id=0B26M5TMdNUWNdkt2SlFwTTkzVjQ&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhlVU1nOVE

Additional Tools/ Resources

- Communications Materials Matrix

# Communications and Engaging Stakeholders Section: Narrative Analysis

Participants were asked about the communication and messaging strategies that were used during their implementation of Differential Response, targeted to both internal and external stakeholders. This section includes discussion on the following communications topics, collected from the 16 surveyed jurisdictions:

(1) Communications strategies used by jurisdictions,
(2) Target audiences of communications,
(3) Feedback loops for communicating concerns about implementation, and
(4) Strategic Communications

In addition to the perspectives gathered from jurisdictions, the discussion below includes some context and additional information gathered from the research literature and agency websites.

## Communications Strategies used by Jurisdictions

To initiate dialogue for the DR communications process, many states used scheduled meetings, either in-person or through teleconferencing, to describe DR to staff and explain the rationale behind why it was chosen to be implemented in their agency. These communications meetings were held frequently in the beginning of the planning process, usually weekly or every other week, and transitioning to monthly as the planning process progressed. Participants from one jurisdiction asserted that these meetings were crucial for the sustainability of DR and that the monthly meetings continue on, well after implementation has ended.

To inform external stakeholders about DR, kick-off meetings, in-person presentations, and/or webinars were provided across the jurisdictions that explained the purpose of DR and shared desired outcomes around child safety and permanency. These presentations typically focused on key messaging around the values of child welfare, such as better engagement with families and becoming outcome-driven rather than incident-driven. The presentations also included a discussion of existing evaluation outcomes from other jurisdictions, which was pivotal in gaining community acceptance of DR in several cases.

Jurisdictions also developed communications materials and created websites that typically provide descriptions of DR, an explanation of the key principles, and the philosophy behind the approach. Newsletters and brochures were a popular way to communicate about DR to staff and external stakeholders using concise and simple language. Ohio used the newsletters to circulate information about research outcomes, spotlight pilot site progress, include testimony in support of DR by workers, and give updates on implementation. A few jurisdictions also reached out to different media outlets by developing press packages and press releases. Louisiana utilized a media specialist that assisted them with the media outreach.

In addition to a newsletter and listserv to get the word out about DR, North Carolina held a handful of three-day DR learning institutes to immerse staff in the DR approach. The agency also brought in speakers from other states, offered networking opportunities, and conducted site visits to other jurisdictions. They took this opportunity to inform staff about DR but also focused on Family Group Decision Making (FGDM) and other strategies to become a more family-centered agency.

## Target Audiences of Communications

The majority of jurisdictions targeted both internal staff and external stakeholders with their communication plans. Communications were targeted to mandated reporters such as school personnel, medical professionals, and law enforcement, and within these groups, agencies shared materials and presentations explaining DR and the new approach. Participants emphasized the importance of highlighting the research outcomes around safety since that is a major concern for those skeptical of DR. Jurisdictions also targeted judges, Guardians Ad Litem, and other legal representatives, and one state shared their communication materials with the legislature. A couple of participants expressed that they had only communicated with internal staff about DR and in hindsight wished that they had reached out more to external stakeholders.

In Ohio, counties explored multiple avenues of outreach, including: written communications through newsletters and individual letters to community partners; informational sessions offered in hospitals, schools, and mental health agencies in the community; and regular informal updates and presentations about DR. Several of the counties also focused on outreach to their juvenile courts. In addition to reaching out to community partners to make them aware of the pilot, counties focused on developing new partnerships in their communities to support the work of the pilot.

## Feedback Loops for Communicating Concerns about Implementation

The majority of jurisdictions had processes which allowed stakeholders to communicate their concerns about how DR was being implemented, some of which were formal and some of which were informal. Participants emphasized the importance of developing this process at the beginning of the planning stage. Some of the informal ways in which jurisdictions solicited information included community forums and direct meetings with stakeholders, where they were asked to express their concerns. The workgroups and advisory groups also played an important role in formalizing the process; some jurisdictions created new advisory groups within the workgroup to specifically serve this purpose. Such processes led to a continuous feedback loop between the people making the decisions about DR policy and those that would be most impacted by the change in practice. A few jurisdictions solicited feedback through surveys and focus groups with workers and supervisors as part of their evaluation efforts. In addition, when a DR program manager position was put in place, they became the direct point of contact for all matters related to DR implementation.

## New Approaches to Strategic Communications

Nearly half of the 16 surveyed jurisdictions did not dedicate significant resources towards developing messaging for DR, or utilize a variety of communications methods as part of their implementation process. Some participants expressed that, in hindsight, they wished that they had devoted more time to messaging for DR and communicating the new approach. However, many jurisdictions emphasized the value of a strong internal and external communications plan. As a result, the next generation of DR jurisdictions have placed more emphasis on establishing buy-in amongst internal and external stakeholders and many are utilizing innovative strategies to reach out to various groups. For specific examples of communications strategies utilized by this next generation of DR jurisdictions, see the Communications Materials Matrix.

Among this newer wave (not included as part of the 16 surveyed jurisdictions), Iowa serves as an example of a jurisdiction that has built upon the communication lessons of others. Iowa's DR implementation team developed a comprehensive communication plan early in their implementation process. The plan outlined the process for utilizing written and in-person

communications to promote DR with internal and external stakeholders. The Iowa team also developed a State Target Audience Analysis that identifies key external and internal stakeholders and tailored DR messaging to better reach those specific stakeholder groups. Individual members of the implementation team were then assigned to stakeholder groups to ensure that the messaging was disseminated prior to implementation. The communication plan and State Target Audience Analysis can be found in the Communications Document Folder.

Oregon has also put considerable efforts into communicating about the implementation of DR throughout the state. They developed a strong vision statement for DR that clearly articulates why the state is moving to DR and what the state hopes to accomplish for children and families. They developed common principles of DR and traditional investigation to communicate how DR services will build upon and strengthen the current system. Oregon also used creative communication strategies including, a promotional video and a weekly DR bulletin where the Child Welfare Director answers frequently asked questions about the implementation of DR. Oregon is utilizing a comprehensive DR Webpage to make all of this information accessible to both child welfare workers and the larger community.

| Communications Section: Matrix | | | |
|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Communications/ Messaging Strategies Used** | **Target Audience of Materials** | **Feedback Loops: Process for Communicating Concerns about the Implementation Process** |
| **Los Angeles County, CA (2004)** | Internal communication about DR was done in staff meetings.<br><br>External communication was completed through Town Hall meetings; there were at least 3 or 4 meetings at the University of Southern California. Faith-based organizations were given a survey of ways the agency could improve services. As a result, a matrix of services and organizations was developed. | Internal and external stakeholders were targeted, including private providers and members of the faith-based community. | Community organizing meetings (e.g., Compton Project) allowed for concerns to be expressed. The agency also developed two Advisory Councils: the Community Advisory Council for service providers and the general community, and the Faith-Based Advisory Council for faith-based organizations and churches. These Councils met once a month and any concerns around DR implementation were discussed at those times. |
| **San Francisco County, CA (2004)** | The county agency assisted providers in developing their messaging, using research evidence such as "DR helps to reduce referrals." | Community stakeholders and providers who would be the point of referral. | There were monthly meetings with DR providers and subcontractors from Family Resource Centers (FRCs). During these meetings, concerns about DR were discussed. |
| **Santa Clara County, CA (2004)** | Agency did not communicate directly; providers communicated about the services that they could provide to social workers | Providers targeted materials to agency social workers. | SCC engaged unions due to contracted services. Feedback loops were used through existing advisory groups. |
| **Colorado (2010)** | Colorado took a grassroots approach where counties informed their local community. Most counties gave presentations and an orientation to stakeholders. | Educators, legal representatives, medical professionals, hospital social workers, law enforcement. | The communication process utilized forums, meetings, and trainings. Additionally, a formal group was established in each county, which also served to receive feedback. |
| **Connecticut (2011)** | The state's Communication Director provided assistance with DR messaging.<br><br>The agency developed a "Notebook," which defined DR and why they were adopting it. They also developed standard PowerPoint presentations using common language, which were shared with all major stakeholder groups. In addition, a brochure was shared with the public. | Head Start, schools, law enforcement, community groups (i.e. System of Care). | N/A |
| **Hawaii (2005)** | Hawaii held a large kickoff meeting with stakeholders and followed up with monthly teleconferences. | Trainings included judges, GALS, attorneys, and traditional response workers. | The agency held workgroups and teleconferences where feedback about DR was solicited. |

| Communications Section: Matrix | | | |
|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Communications/ Messaging Strategies Used** | **Target Audience of Materials** | **Feedback Loops: Process for Communicating Concerns about the Implementation Process** |
| **Kentucky (2000)** | Statewide video conference and training manual for internal staff. | Internal stakeholders within child welfare. They did not reach out to external stakeholders. | There were opportunities for stakeholders to interface with leaders at multiple levels throughout the agency. |
| **Louisiana (1999)** | Communication strategies included the utilization of media specialists, public service announcements, a DR website, and brochures. | Professional stakeholders and the general public. | Unknown |
| **Massachusetts (2008)** | Webinars, letters, guide for mandated reporters, and an Integrated Case Practice Model newsletter. | Targeted both internal and external stakeholders. | Focused predominately on an internal stakeholder feedback loop, which allowed for input on a regular basis and was effective in identifying gaps. |
| **Minnesota (2000)** | The McKnight Foundation funded a variety of communication strategies, including press releases, fact sheets about research on DR, presentations, a website, TV spots, and training for mandated reporters. | Mandated reporters, children's advocates, family attorneys, judges, and communities of color. | There was no formal process for communicating about concerns; counties/ tribes worked this out at the local level. However, the two state DR Manager positions served as primary points of contact. |
| **Missouri (1994)** | Unknown | Unknown | Unknown |
| **Nevada (2007)** | A state steering committee met twice per month, sometimes in person and sometimes over video conference. The leaders in these meetings would then communicate to local county staff. Brochures were also developed at the local agency level. | Internal stakeholders only, which created barriers down the road. In hindsight, they wished they had reached out to judges, legislators, and the community. | If someone had a concern they could contact the DR contact person. |
| **New York (2008)** | Communication strategies included monthly calls with counties, meetings with interested counties, sharing of draft materials and application with counties. NY also used a consistent DR PowerPoint for regional and county presentations to stakeholders. Materials were also shared with the Governor's office, and presentations were made about DR at statewide conferences. | Legislators, governor's office, all counties, county service providers and other stakeholders. | The communication process varied across counties, but many formed advisory boards for community stakeholders. Regularly scheduled conference calls were a forum for concerns by the earliest implementing counties. The OCFS implementation team met weekly to identify and address both internal concerns and those from the field. |

| Communications Section: Matrix | | | |
|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Communications/ Messaging Strategies Used** | **Target Audience of Materials** | **Feedback Loops: Process for Communicating Concerns about the Implementation Process** |
| **North Carolina (2001)** | The state agency initially held monthly meetings with the 10 pilot counties and then regional meetings, Once the second wave of counties began to plan in earnest, counties implemented DR. The state also developed an MRS quarterly newsletter and a listserv to disseminate news and policy issues. | Local child welfare agencies and various stakeholder groups including: mental health, the court system, service providers, etc. | The feedback process was connected to evaluation efforts. As part of the evaluation, they conducted focus groups with workers and supervisors, phone surveys, and collected feedback from links on the MRS webpage. |
| **Ohio (2007)** | Regional forums were offered throughout the state to educate counties about the project, answer county questions about the pilot, and provide information on the site selection process. The counties offered written communications such as newsletters and individual letters to community partners. Counties also offered informational sessions in hospitals, schools, and mental health agencies in the community. Regular informal updates and presentations about AR were also provided to Family and Children First partners and other relevant boards/committees. | Internal staff, hospital staff, school staff, mental health agencies, and judges. | Ohio had processes at state and county levels to collect feedback from stakeholders, including legal advocates, education advocates, and pediatricians. These stakeholders were asked to complete surveys and provide feedback. They also developed a self-assessment tool to assess community outreach. |
| **Virginia (1997)** | Virginia gave presentations to internal and external stakeholders. They created press releases, developed a binder of DR materials, and created a brochure for the website. | Other public agencies, including schools, mental health, juvenile justice; as well as elected officials, etc. | The agency held meetings with a wide range of stakeholders at the state-level and gave them opportunities to share concerns. |

# Communications Materials Matrix

| Jurisdiction | Website | Key Messaging Framework | Newsletters, Brochures, Videos and Communication Plans |
|---|---|---|---|
| **Colorado** | Differential Response Homepage<br>Key Components:<br>(1) Short description of the current pilot,<br>(2) Links to key DR materials including a practice model, case assignment information, legislative information, case flow information, and an implementation guide, and<br>(3) A link to the DR newsletter. | Colorado developed a DR Practice Model that guides their work and communication related to DR.<br>6 key principles:<br>• Safety Focus<br>• Constructive Engagement<br>• Collaborative Engagement<br>• Family and Community Inclusion<br>• Assessment of Risk and Protective Capacity<br>• Transparency | • Newsletter: Colorado DR Newsletter<br>• Brochure: N/A<br>• Video: N/A<br>• Communication Plans: N/A |
| **Connecticut** | Differential Response Homepage<br>Key Components:<br>(1) Information on the state differential response system, including a note from the commissioner, model information, and the drive to enacting the new system,<br>(2) Brochures on the family assessment response,<br>(3) Additional DR resources including research from other states, and<br>(4) Contact information. | Connecticut developed a DR Model Overview with key drives and principles.<br>Key drives for moving to a DR System:<br>Be more flexible in the response to child abuse and neglect reports<br>• Recognize that an adversarial focus is neither needed nor helpful in all cases<br>• Better understand the family issues that lie beneath maltreatment reports<br>• Engage parents more effectively to use services that address their specific needs<br>• Increase sharing responsibility and accountability for families and communities<br><br>Shared Principles of Traditional CPS and DR:<br>• Focus on safety and well-being of the child<br>• Promote permanency within the family through engaging kin and community supports<br>• Recognize the authority of CPS to make decisions about removal, out of home placement and court involvement, when necessary<br>• Acknowledge that other community services may be more appropriate than CPS in some cases | • Newsletter: N/A<br>• Brochure: Family Assessment Response Brochure in English and Family Assessment Response Brochure in Spanish<br>• Video: N/A<br>• Communication Plans: N/A |
| **Hawaii** | N/A | N/A | N/A |
| **Iowa** | Child Welfare Protective Services Homepage– Iowa does not have a home page specifically for DR but their CPS site is primarily focused on DR. The page contains links to policy statements explaining DR, case examples, pathway assignment criteria, and a statewide webinar. | Iowa Developed Policy Statements to answer questions and communicate the main goals and principles of DR:<br>Policy Statement 1<br>Policy Statement 2<br>Policy Statement 3 | • Newsletters: N/A<br>• Brochure: N/A<br>• Video: Webinar on website<br>• Communication Plans: Marketing and Communications workgroup Communication Flow Chart |

| Jurisdiction | Website | Key Messaging Framework | Newsletters, Brochures, Videos and Communication Plans |
|---|---|---|---|
| | | | • State Target Audience Analysis |
| **Kentucky** | N/A | N/A | N/A |
| **Louisiana** | N/A | N/A | N/A |
| **Massachusetts** | Screening, Investigation, and Initial Assessment Page – Massachusetts does not have a home page for their DR system but does briefly describe it under CPS Initial Assessment section. | N/A | • Newsletter: N/A<br>• Brochure: New Approach to Working with Families<br>• Video: N/A<br>• Communication Plans: N/A |
| **Minnesota** | Family Assessment Response Homepage<br>Key Components:<br>(1) Principles of FAR with explanations,<br>(2) Brochure for FAR program,<br>(3) Reports on FAR program, and<br>(4) FAR training information. | Minnesota's FAR Home Page is organized around six key principles:<br>• Ensuring child safety while supporting families<br>• Responding to families' needs<br>• Assessing families' strengths<br>• Minimizing negative labeling<br>• Participation<br>• Community involvement<br><br>Minnesota's Brochure uses the following key messages to describe FAR:<br>• Ensuring children are safe<br>• Avoiding negative labels for parents<br>• Setting aside the issue of fault<br>• Working in partnership with parents<br>• Identifying families' needs<br>• Providing services and resources matched to families' needs<br>• Building on parents' and communities' strengths and resources. | • Newsletter: N/A<br>• Brochure: FAR Program Brochure<br>• Video: N/A<br>• Communication Plans: N/A |
| **Missouri** | N/A | N/A | N/A |
| **Nevada** | N/A | N/A | N/A |
| **New York** | New York State DR Homepage<br>Key Elements:<br>(1) Description of FAR,<br>(2) Approach,<br>(3) Philosophy, and<br>(4) Safety points.<br><br>DR Page under CFSR page in New York State | New York State developed key principles which were used to communicate DR.<br>6 Key Principles:<br>• Judgments Can Wait<br>• Everyone Has Strengths<br>• Everyone Desires Respect<br>• Partners Share Power<br>• Everyone Needs to Be Heard (and Understood)<br>• Partnership Is a Process | • Newsletters: NY State DR Quarterly Newsletters<br>• Brochures: N/A<br>• Videos: NY State DR video and County Video<br>• Communication Plans: N/A |

| Jurisdiction | Website | Key Messaging Framework | Newsletters, Brochures, Videos and Communication Plans |
|---|---|---|---|
| | New York has additional DR resources under their Child and Family Service Review Page.<br>Key Elements:<br>(1) Description of DR,<br>(2) Links to DR videos,<br>(3) Links to DR newsletters, and<br>(4) Links to trauma informed care resources. | | |
| **North Carolina** | North Carolina Multiple Response System Homepage<br>Key Elements:<br>(1) Evaluations and reports,<br>(2) Policy brief,<br>(3) Newsletters, and<br>(4) Conference call notes. | North Carolina developed key principles used to communicate their Multiple Response System.<br>6 Key Principles:<br>• Everyone desires respect<br>• Everyone needs to be heard<br>• Everyone has strengths<br>• Judgments can wait<br>• Partners share power<br>• Partnership is a process | • Newsletters: Quarterly Newsletters from 2005-2013<br>• Brochures: N/A<br>• Videos: N/A<br>• Communication plans: N/A |
| **Ohio** | Ohio Differential Response Homepage – hosted by the state agency<br>Key elements:<br>(1) Description of DR,<br>(2) Explanation of two tracks,<br>(3) Research and outcomes,<br>(4) Links to more information.<br><br>Ohio Differential Response Page – hosted by an Ohio university and focuses mostly on the implementation of DR.<br><br>Alternative Response Page for Clark County<br>Key elements:<br>(1) Description of DR,<br>(2) Research on DR, and<br>(3) Benefits of DR for Clark County.<br><br>Alternative Response Page for Franklin County<br>Key elements:<br>(1) Description of DR, | Ohio Developed Differential Response Practice Profiles that outline key practice components and principles of their Alternative Response System.<br><br>Principles of CPS Intervention:<br>• Child safety comes first, and all policies, guidelines and practices are child-centered and family-focused.<br>• CPS emphasizes family engagement and involvement in all aspects of our practice.<br>• CPS supports assessment and intervention processes that focus on family strengths while addressing the underlying conditions and contributing factors that impact child safety.<br>• Child safety is best achieved through active, collaborative and respectful engagement of parents, family, community and all other CPS stakeholders.<br>• Differential Response systems are designed to identify family needs and find creative solutions, including formal and informal supports and services to ensure child safety.<br>• Whenever possible, CPS agencies should respect family choices in the selection of services.<br>• When families cannot ensure child safety, it is necessary for the agency, courts, community, and/or extended families and kin to take appropriate action to provide protection. | • Newsletters: Quarterly Newsletters – Volume 1, Volume 2, Volume 3<br>• Brochure: N/A<br>• Videos: N/A<br>• Communication Plans: N/A |

| Jurisdiction | Website | Key Messaging Framework | Newsletters, Brochures, Videos and Communication Plans |
|---|---|---|---|
| | (2) Key components of DR, and<br>(3) Success story. | Also see Core Elements of DR | |
| **Oklahoma** | N/A | N/A | N/A |
| **Oregon** | Differential Response Homepage<br>Key elements:<br>(1) Vision of DR and what they hope to accomplish,<br>(2) High level research outcomes from other jurisdictions,<br>(3) A link to the video promoting family and community engagement.<br><br>Also contains three separate tabs to DR communications, contact us section, and information on implementation. | Oregon has developed a vision and principles for the implementation of their new practice model, which includes DR.<br><br>Vision: Safe Children – Strong, Supported Families<br><br>As a result of Oregon's implementation of DR, the following results will occur:<br>• Children will be kept safely at home and in their communities; using the Oregon Safety Model and its core concepts and tools to guide decision making.<br>• The community and Oregon DHS will work in partnership with a shared responsibility for keeping children safely at home and in their communities;<br>• Families will partner with Oregon DHS to realize their full potential and develop solutions for their challenges;<br>• Fewer children will re-enter the child welfare system through improved preventative and reunification services for families;<br>• Disproportionality will be reduced among children of color, and;<br>• Private agencies and community organizations will experience stronger partnerships with Oregon DHS on behalf of children and families.<br><br>Oregon also developed key principles to guide both traditional and alternative response:<br>• Both focus on safety and well-being of the child<br>• Both promote permanency within the family<br>• Both recognize the authority of CPS to make decisions about removal, out of home placement and court involvement, when necessary<br>• Both acknowledge that other community services may be more appropriate than CPS intervention in some cases | • Newsletters: DR Bulletins found on the Communication Page<br>• Brochure: N/A<br>• Videos: Family Engagement Video<br>• Communication Plans: N/A |
| **Tennessee** | Tennessee Multiple Response System Homepage<br>Key elements:<br>(1) Explanation of the approach,<br>(2) Explanation of the three tracks,<br>(3) Safety Concerns, and<br>(4) Rights of the Family. | Tennessee's website outlines the key components of the MRS.<br>Key components:<br>• Ensuring children are safe<br>• Avoiding negative labels for parents<br>• Setting aside the issue of fault<br>• Working in partnership with parents to identify the family's strengths and needs<br>• Asserting that families are the experts at solving their own problems. | • Newsletters: N/A<br>• Brochure: MRS Brochure<br>• Videos: N/A<br>• Communication Plans: N/A |
| **Virginia** | N/A | N/A | N/A |

| Jurisdiction | Website | Key Messaging Framework | Newsletters, Brochures, Videos and Communication Plans |
|---|---|---|---|
| **Washington** | Family Assessment Response Homepage<br><br>Key elements:<br>(1) Introduction,<br>(2) Differential Response explanation,<br>(3) Goals & Guiding Principles,<br>(4) Timeline, and<br>(5) Frequently Asked Questions. | Washington State developed key principles and goals for the implementation FAR.<br><br>Key Principles:<br>• Low to moderate risk neglect cases are best served through planning that includes parents as partners.<br>• Families want safety for their children.<br>• Families can meet their children's needs with supports and resources.<br>• Families are better able to care for their children when connections to communities are developed and strengthened.<br>• Communities want children to be safe and cared for.<br>• Family Assessment Response supports and enhances the agency's vision of increased family engagement, enhances the practice of solution based casework, assessment of family's needs and strengths, delivery of concrete and supportive services and focuses on child safety.<br>• Family Assessment Response is in line with and supportive to the Children's administration and strength based practice model.<br>• Family Assessment Response is closely connected and aligned with the implementation of evidence based practices to provide families and children with services that have shown to be successful.<br><br>Main Goals<br>• Provide Early Intervention to respond to low to moderate risk allegations with the possibility of preventing future high risk or unsafe situations.<br>• Increase Scope of Service Delivery to provide services and resources for low to moderate risk families. Opportunity to provide services not based on abuse or neglect, but on family need for sustained and supportive parenting of their children.<br>• Improve Family-Centered Practice by increasing the involvement of the family in assessment and identification of their strengths and needs, and the development of service plan to address issues relating to risk of abuse or neglect.<br>• Increase Resource Identification by reviewing service needs and resource availability for immediate and long term support outside the scope of abuse and neglect.<br>• Improve engagement and assessment by moving away from incident-based assessments to a comprehensive assessment of the family dynamics, strengths, issues and needs. | • Newsletters:<br>Fall 2013 Issue,<br>Summer 2013 Issue,<br>Spring 2013 Issue<br>• Brochure: FAR Brochure<br>• Video: Introducing FAR<br>• Communication Plans: FAR Project Plan Includes a brief Communication Plan |
| **Wyoming** | N/A | N/A | N/A |

# Evaluation Section

Core Section Components

- Evaluation Section: Narrative Analysis
- Evaluation Section: Matrix
- Document Library Folder: https://drive.google.com/folderview?id=0B26M5TMdNUWNeExZZmx4R0xxd3M&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhIVU1nOVE

Additional Tools/ Resources

- DR Outcomes Summary Matrix
- DR Evaluation Methodology Matrix

# Evaluation Section: Narrative Analysis

The evidence base for Differential Response has grown considerably in recent years. Numerous program evaluations have been conducted on DR systems throughout the United States, including several randomized-controlled trials, which are better able to balance differences between families receiving the DR and TR tracks, so that outcomes for the two groups can be compared. It is worth noting that DR systems vary widely across jurisdictions, and have important differences in terms of their structure, level of implementation, practice features between tracks, and available resources (among other differences). However, given those differences, all indicators of child safety have been equivalent or better, favoring families receiving the DR track (with the exception of Illinois' findings—discussed in greater detail below). Comparing families receiving the DR to TR tracks, the DR track has demonstrated improvements in family engagement, worker satisfaction, and community satisfaction and cooperation, while maintaining child safety.[xxix] For a concise summary of five outcomes of interest across the 16 surveyed jurisdictions, see the Outcomes Summary Matrix.

This section includes discussion on the following evaluation topics, collected from the 16 surveyed jurisdictions:

(1) Evaluators;
(2) Percentage of referrals assigned to the assessment track;
(3) Whether evaluations measured model fidelity;
(4) Child safety impacts/ outcomes (re-referral rates);
(5) Child safety impacts/ outcomes (removal rates); and
(6) DR costs and savings.

In addition to the perspectives gathered from jurisdictions, the discussion below includes some context and additional information gathered from the research literature.

## Evaluators

Among the 16 surveyed jurisdictions, 47% report an evaluation conducted by an external, entity, 38% had an analysis or evaluation that was conducted internally by the agency or department, and 13% report never having an evaluation conducted on their DR system. The research organizations providing external evaluation services included the Institute for Applied Research (IAR), the National Quality Improvement Center for Differential Response (QIC-DR), and local universities, among others. Internal evaluations were often completed by an auditor or research office located within the child welfare agency or county/ state government.

## Percentage of Referrals Assigned to the Assessment Track

The percentage of reports assigned to the multiple tracks varied considerably across jurisdictions. Among the surveyed jurisdictions where this information was available, 25% of jurisdictions sent more than 60% of all CPS referrals to the DR track (MN, NC, VA), 42% sent between 40% and 59% of referrals to the DR track (CO, HI, MA, MO, OH), and 36% sent less than 39% to the DR track (KY, LA, NV, NY). Note that data were not available in 4 jurisdictions. Respondents from several jurisdictions observed that the share of reports assigned to the assessment track generally varies with DR experience, such that over time, more cases are sent for assessments. This trend has especially been observed in states that phase in DR implementation in counties over time, whereby more cases are sent to the assessment track as infrastructure and service capacity are ramped up in individual counties. Participants believed that over time, workers making track assignment decisions at the hotline or field level gain trust in DR and become more comfortable sending cases to the assessment

track when they experience that child safety is not compromised. Subsequently, worker skill improves and discretionary criteria are employed more frequently, resulting in more reports assigned to the assessment track.[xxx]

## Measurement for Model Fidelity

Program evaluations are increasingly giving attention to the importance of maintaining fidelity to an articulated program model as an essential aspect of implementation. Among the 16 jurisdictions' evaluations, 40% included some type of measure or data collection process related to model fidelity (MA, MN, MO, NV, NY, OH). Several of these jurisdictions are younger DR systems, and within the DR field, model fidelity will continue to be an important issue to measure as DR systems mature and seek to become more sustainable over time.[xxxi] The QIC-DR cross-site study intended to include fidelity assessment as part of the evaluations.[xxxii] Although Colorado was unable to conduct a fidelity assessment as part of its evaluation, they developed a Fidelity Assessment Matrix,[17] which was designed to operationalize the practices and practice principles of Colorado's DR model to allow for an assessment of fidelity.[xxxiii] This matrix assesses the interplay between practices, practice principles, fidelity indicators, and data sources.

The lack of clearly articulated DR models of practice within jurisdictions has been a missing element in the DR field.[xxxiv] In response to this issue, Ohio invested considerable time and energy in developing their "Practice Profiles."[xxxv] The Practice Profiles seek to guide practitioners and supervisors in implementing DR effectively by providing a detailed description of the core activities associated with each function of Ohio's practice model. In specific, behaviorally-based terms, the Practice Profiles attempt to make the model learnable, doable, and teachable. The Practice Profiles offer clear guidance for workers, and can also fit within a quality improvement and performance management structure, not only guiding practice but also creating an accountability structure for sustaining effective practices over time.

## Re-Referral Rates of DR Families

Among the jurisdictions described here that measured re-referrals, nearly all were able to show either a reduction in re-referral rates for families assigned to the DR track compared to the investigative track, or were able to show no difference (non-statistically significant difference) between these two groups. Illinois was the single exception, as re-referral outcomes were observed to be worse for families initially assigned to the DR track (discussed in more detail below). The quality of program evaluations varied considerably, but among the some of the most rigorous (MN, MO, NC, OH), those jurisdictions reported statistically significant lower rates of re-referral for DR families. Two of these evaluations included randomized-controlled trials (RCTs) of DR (MN, OH). Minnesota's extended follow-up evaluation demonstrated significantly lower likelihood of new maltreatment reports among DR families, such that for every 10 families with a new report under AR over a 3-4 year period, about 13 similar families will receive a new report under the investigative track.[xxxvi] The initial Ohio evaluation found that subsequent reporting of families for child abuse and neglect declined in the largest way among the most impoverished families in the study.[xxxvii] A 2014 evaluation extension in Ohio measured child safety through multiple indicators, and consistently found the experimental AR group to have fewer safety concerns than the control

[17] For Colorado's Fidelity Assessment Matrix, see Winokur et al, 2014, Appendix L (Page 45), available here: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/QIC-DR/Documents/Program%20Evaluation%20of%20the%20Colorado%20Consortium%20on%20Differential%20Response%20-%20Final%20Report%20Appendices.pdf

TR group.[xxxviii] This Ohio evaluation found that 3.8% of experimental families received new accepted reports compared to 4.8% of control families, a difference which was statistically significant.[xxxix]

The National Quality Improvement Center for Differential Response (QIC-DR) recently released evaluations of three demonstration sites in Colorado, Illinois, and a 6-county consortium in Ohio, as part of its cross-site study.[xl] Each site conducted individual RCT evaluations, in which design elements were developed in coordination with the QIC-DR and the Federal Administration for Children, Youth, and Families (ACYF). In Colorado, there was no statistically significant difference between tracks on referral within 365 days of initial referral, as calculated through a stepwise regression model (44% of FAR families were re-reported compared to 45% for IR families).[xli] Ohio's 6-county consortium found no difference between tracks in the percentage of cases receiving a re-report (AR=28%, TR=28%).[xlii]

Illinois used an Intent-To-Treat (ITT) approach,[18] and survival analyses revealed higher accumulated risk of re-reports during the 18-month follow-up period for families in the DR group.[xliii] However, because 22% of the families that were randomly assigned to the DR group were switched to investigation after random assignment, additional survival analyses were conducted that compared child safety outcomes among four sub-groups of DR families:

- DR "switchers" consisted of families that were randomly assigned to DR but were switched to an investigation due to either safety concerns or a new maltreatment report. These families did not actually receive DR services (or received very little) and did receive an investigation.
- DR "refusers" were those families that declined DR services after the initial meeting and safety assessment with the DR caseworker. These families did not receive any DR services, nor an investigation.
- DR "withdrawers" were those families that were offered and initially accepted DR services but then voluntarily withdrew before services were complete.
- DR "completers" consisted of families who accepted and completed the DR services outlined in their service plans.[xliv]

After examining cumulative risk of re-report among DR sub-groups, both the DR "switchers" and DR "withdrawers" had significantly higher cumulative risk than families that received an investigation. However, risk of re-report among DR "refusers" and "completers" showed outcomes that were equivalent with investigated families.[xlv]

## Removal Rates under DR

Among all jurisdictions that measured child removal rates (LA County, KY, MN, MO, NV, NY, OH), removals were also shown to be lower among DR families compared to families who received a traditional investigation. For evaluations that utilized an RCT, randomly assigning cases to tracks such that the two groups are otherwise equivalent, Minnesota, New York, and Ohio were all able to demonstrate a statistically significant reduction in removal rates for DR families. For example, in Ohio's 2013 evaluation extension, the proportion of families in which one or more children were removed was 11.8% for control families and 9.8% for experimental DR families, a difference which was statistically significant. Additional states (HI, MA, NC) also showed reductions to their foster care populations at the aggregate-level, which could potentially be attributed to DR, but the design of these studies limits their ability to attribute these benefits to the introduction of DR. Other initiatives and internal or external factors could

[18] Intent-To-Treat (ITT) refers to including all families that were initially randomly assigned to the treatment group, regardless of whether they received the treatment or not.

also have led to reductions, but DR was believed to have had at least a small influence on those changes.

Among the QIC-DR cross-site evaluations, all states demonstrated equivalent or better child removal outcomes for families randomly assigned to the DR groups. In Colorado, a stepwise regression model indicated no significant difference between the tracks (FAR=6%, IR=6%).[xlvi] Illinois found no differences between the two groups in risk of child removal during the 18-month follow-up period (DR=2.6%, IR=2.4%).[xlvii] In Ohio, 4.5% of DR cases and 5.6% of TR cases had at least one child in placement either during the initial case episode or after case closure.[xlviii]

## DR Costs and Savings

Among jurisdictions that tracked start-up costs[19] for DR implementation, 6 out of 6 indicated that they had additional upfront costs associated with the implementation process (LA County, HI, MN, NV, NY, OH). All of these jurisdictions drew upon additional external funds for implementation and system maintenance over time. Half of these jurisdictions (LA County, MN, OH) indicated that they had access to foundation support. Jurisdictions utilizing external and expanded jurisdictional funds spent more dollars upfront, frontloading services at the beginning of a case in order to quickly connect families to poverty-related services. Generally, these jurisdictions anticipated cost savings on the back-end of cases by reducing the need for foster care.

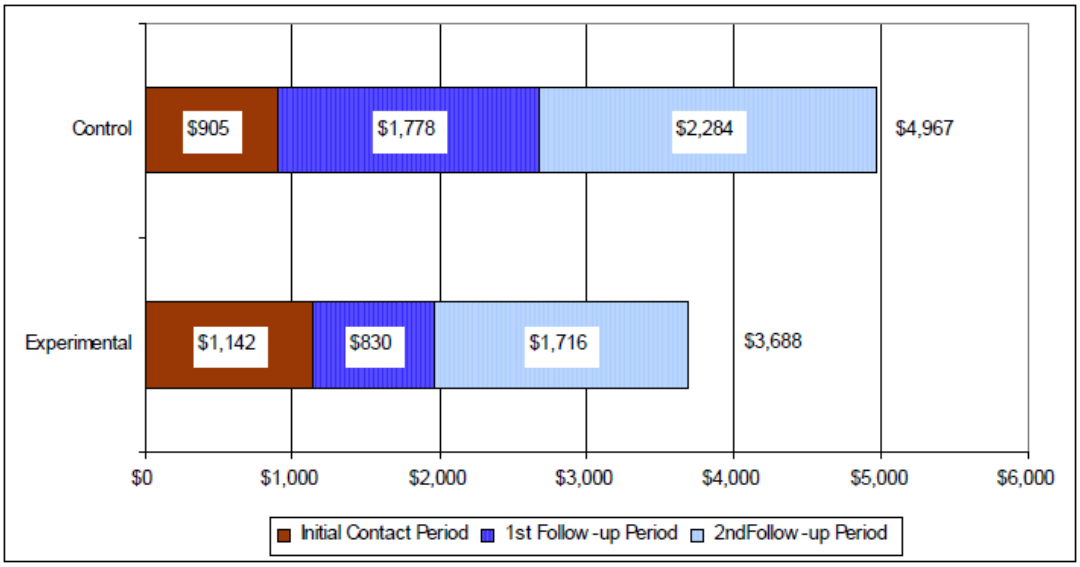
Until the QIC-DR cross-site evaluation, only Minnesota and Ohio had conducted cost analyses of DR using experimental data. Both Minnesota and Ohio were able to demonstrate lower total costs in the DR track compared to the TR track after an extended follow-up, although in the short-term, costs were higher for DR families. The Minnesota and Ohio cost analyses tracked costs across two categories: direct services costs (defined as expenditures for any service to any family member, including foster care payments) and indirect costs (worker time spent with and for each sample family) within CPS agencies.[xlix]

Consistent with Minnesota's DR resource formula: A+B=C (discussed in the Introduction section), it was anticipated that services would increase under DR, and as a result, the costs of services would increase in the short-term. It was also anticipated that worker time with families would increase, which would also lead to increased upfront costs. In Minnesota's initial contact period (from the point of initial contact with the family until CPS services ended), total costs averaged $1,142 per experimental DR family, compared to $905 for control families.[l] The evaluators noted that the $237 cost difference might be seen as the per-family investment cost of additional prevention services that were provided to experimental DR families.[li]

In Minnesota's follow-up period (the period after initial CPS services ended, which ranged from 39 to 56 months afterwards), costs were $2,547 per experimental DR family compared to $4,062 for control families.[lii] In total, across the life of the case, costs averaged $3,688 per DR family compared to an average of $4,967 per control family—amounting to a savings of $1,279 per family under DR (See Chart 1 for greater detail).[liii] In Minnesota's case, by investing in more services for families on the front-end of cases, costs were reduced on the back end, compared to equivalent families that were randomly assigned to the traditional investigative response.

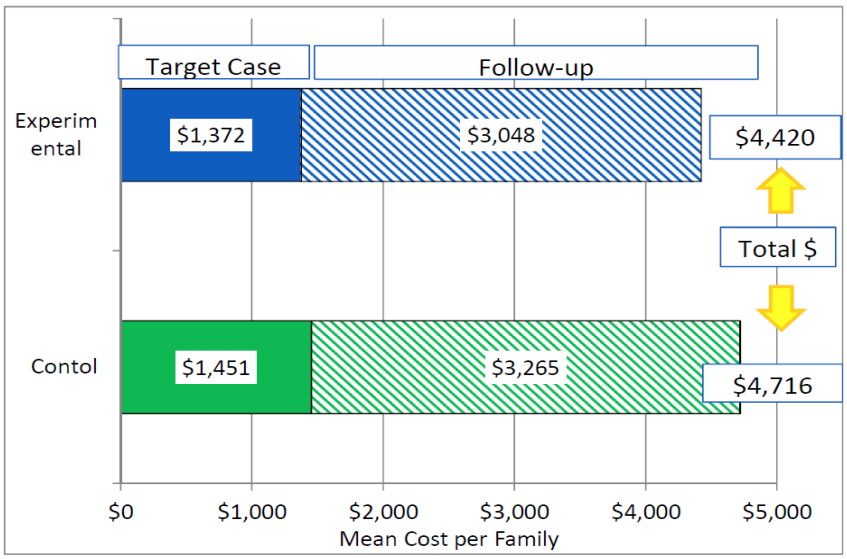
[19] Start-up costs typically included administrative, staff training, and data-system costs associated with DR implementation.

Chart 1: Minnesota's 2006 Extended Follow-up Report: Mean Initial and Follow-up Costs of Experimental and Control Families[liv]




Ohio's 2010 preliminary cost analysis results initially indicated a cost increase for DR, after a short observation period (between 10 and 15 months after case closure). Combining service costs and costs calculated to average worker time[20], experimental DR families cost an average of $1,325 compared to $1,233 for control families that received investigations, in the short-term.[lv] However, examining costs over a longer follow-up period, Ohio's 2013 evaluation extension found average total costs at 5-year follow-up for AR families to be $4,420, compared to $4,716 for control families, an average cost savings of $296 per family (see Chart 2 for greater detail).[lvi]

Chart 2: Ohio's 2013 Final Extension Report: Mean Costs per Experimental and Control Family during Target and Follow-up and Total Mean Costs:[lvii]




[20] Note that Ohio's cost analysis was unable to track costs to individual cases, and therefore costs were estimated based on empirically-based case averages.

Findings from the QIC-DR cross-site evaluations provided mixed evidence on costs. In Colorado, over the course of approximately two years, the mean weighted cost per case for FAR cases was $1,212, compared to $954 for IR cases—however, given outliers, this difference was not statistically significant.[lviii] In Illinois, after combining initial and follow-up costs, the magnitude of service costs among investigation cases during the follow-up period led to significantly higher overall costs for investigation cases ($2,737) compared to DR cases ($725).[lix] Ohio had access to limited data on the use of agency resources, but cost analyses will be published in a forthcoming report.[lx]

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| **Los Angeles County, CA (2004)** | External evaluation (The Results Group) of 11-County pilot in California. | Not Available | Not measured | 22.6% of children of ARS families received a new referral within 12 months of case closing, compared to 29.4% for comparison group children.[lxi] | 1.9% of children of ARS families were subsequently removed within 12 months of case closing, compared to 3.5% for comparison group children.[lxii] | The state provided the county with a $1 million one-time grant to implement ARS. The Edna McConnell Clark Foundation provided $80,000 for the test pilot in the Compton office. When LA County initially began the pilot, they drew upon no additional county funding. They relied upon community organizing efforts to ask community-based organizations to provide additional services to develop capacity for DR implementation.[lxiii] | As of 2012, approximately $12 million have been spent on ARS since inception.[lxiv] |
| **San Francisco County, CA (2004)** | Not evaluated | Not Available | Not measured | Not measured | Not measured | Not measured | Not measured |
| **Santa Clara County, CA (2004)** | Not evaluated | Not Available | Not measured | Not measured | Not measured | Not measured | Not measured |
| **Colorado (2010)** | External evaluation (Quality Improvement Center for Differential Response (QIC-DR), Colorado State University, Westat, Walter R. McDonald and Associates (WRMA)) | During the pilot testing period in 2010, 48% of cases were eligible for FAR, and of those 60% were randomly assigned to FAR.[lxv] | The implementation fidelity assessment for the FAR track did not occur as planned due to resource and time limitations. Furthermore, the evaluation team did not explore whether IR caseworkers implemented the investigation response with fidelity. However, the Fidelity Assessment Matrix presented | Colorado observed no statistically significant difference between tracks on referral within 365 days of initial referral, as calculated through a stepwise regression model (44% of FAR families were re-reported compared to 45% for IR families). | A stepwise regression model indicated no significant difference between the tracks (FAR=6%, IR=6%).[lxvii] | The initial mean service cost per case for FAR cases was $807 ($238 for service costs, $259 for out-of-home (OOH) placement costs, and $310 for caseworker contact costs), compared to $540 for IR cases ($157 for service costs, $99 for OOH placement costs, and $284 for caseworker contact | The total mean cost per case for FAR cases was $1,212 ($807 for initial costs and $405 for follow-up costs), compared to $954 for IR cases ($540 for initial costs and $413 for follow-up costs). However, this difference was |

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| | | | in Appendix L of the evaluation could serve as a valuable tool for the ongoing evaluation of DR in Colorado as the practice is adopted by new counties.[lxvi] | | | costs).[lxviii] | not statistically significant.[lxix] |
| **Connecticut (2011)** | CT has a contract with the UCONN School of Social Work's Performance Improvement Center, and they are analyzing statewide data from the Community Support for Families Program that serves FAR families. CT is currently discussing expansion to evaluate the FAR experience. | No information | No information | No information | No information | No information | No information |
| **Hawaii (2005)** | Internal data analysis/ evaluation | As of 2012, 46% (including 31% referred for FSS, and 15% for VCM)[lxx] | Not measured | After implementing DR, recurrence of child abuse/ neglect at the state level decreased from 5.7% in FY 2004 to 3.9% in FY 2009.[lxxi] | From 2003 to 2010, children in out-of-home care decreased at the state level by approximately 44%.[lxxii] | After DR implementation, FSS was expanded from 3-6 weeks to 6 months of services, with a corresponding expansion of funding from $700,000 statewide to over $1 million per year (as of 2007). VCM was incorporated into the current comprehensive counseling contracts, which were to be funded at over $3 million per year (as of 2007). Enhanced Comprehensive Counseling and Supportive Services were to provide an additional $1 million per year | Not measured |

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| | | | | | | for expanded intensive home-based individual and family counseling, and other services.[lxxiii] | |
| **Kentucky (2000)** | Internal data analysis/ evaluation (implementation and outcomes) | 33.8% in 2008[lxxiv] | Not measured | Of FFY2007 intakes, 25.8% of first-time investigations and 26.3% of first-time FINSAs had a subsequent referral in FFY2007-2008, a difference that was not statistically significant.[lxxv] | Among chronically involved families with 4 or more referrals, 26.3% of FINSA families and 29.0% of investigative track families had one or more children enter out-of-home care at some time, a difference that was statistically significant. Note that families were assigned to tracks based on risk criteria, and so the researchers expected that investigative track families would be at higher risk for placement.[lxxvi] | Not measured | Not measured |
| **Louisiana (1999)** | Internal data analysis/ evaluation (descriptive data, not outcomes) | 35% as of 2010[lxxvii] | Not measured | Not measured | Not measured | Not measured | Not measured |
| **Massachusetts (2008)** | Internal data analysis/ evaluation (process measures and family outcomes) | 45.5% as of 2012. As of 2013, above 50%. | Yes, highlights of the Phase 1 Implementation Assessment:<br>* Strong and positive support for many elements of the new case practice model. | As of Dec. 2011, 9.7% of assessment cases had a re-referral within 6 months, compared to 9.6% for investigations. | At the state level, children in out-of-home placement decreased from 8,208 to 7,350, a | Not measured | Not measured |

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| | | | * The specific type of successes, challenges, training needs, and priorities included in reports were highly consistent across regions and areas.<br>* Regions/ areas reported considerable variation in implementation structures, use of data, and responses to identified challenges.<br>* Frustration that needed implementation supports and tools were not in place or, once identified, were too slow in being developed and provided.[lxxviii] | At the state level, children who remained safe from repeat maltreatment increased from 87.9% to 92.2%, a 4.9% improvement, over the period 2009-2012.[lxxix] | 10.5% reduction, over the period 2009-2012.[lxxx] | | |
| **Minnesota (2000)** | External, independent evaluation (Institute for Applied research (IAR)) | 71% as of 2013. | Yes, Practice Shift/Model Fidelity outcomes: Feedback from families and workers indicated that CPS practice changed consistent with the model during the demonstration. Compared with control families who received an investigation, experimental (DR) families were more likely to report that they were treated in a friendly and fair manner and that CPS workers listened to them and tried to understand their situation and needs. Experimental families more often reported that all | During the extended observation period from 2001 until 2005, a randomized controlled trial revealed that 37.5% of experimental FAR families received a new CPS report, compared to 39.8% of control families. Using a survival analysis, the relative risk of receiving a new referral under investigation is 28% higher for control families than FAR families, which was statistically significant | During the extended observation period from 2001 until 2005, a randomized controlled trial revealed that 16.9% of experimental FAR families had at least one child removed, compared to 18.7% for control families. This difference approached the standard level of statistical significance (p=0.077).[lxxxiii] | Minnesota did not provide implementation costs, but in their cost analysis, the initial contact period totaled average costs of $1,142 per experimental DR family, compared to $905 for control families.[lxxxiv] The authors note that the $237 cost difference might be seen as the per-family investment cost of additional prevention services that were provided to experimental DR families.[lxxxv] | The Minnesota FAR evaluation included a rigorous cost analysis, which demonstrated that FAR was both cost effective and cost beneficial. Average cost of open cases for experimental FAR families was $1,142, and $905 for control families. For costs incurred over 3 to 5 years, average costs for experimental FAR families was $3,688 compared to $4,967 for |

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| | | | matters important to them were discussed, that they were more involved in decision making, that workers helped them obtain services they needed and connected them to various community resources.[lxxxi] | (p=0.016).[lxxxii] | | | control families.[lxxxvi] |
| **Missouri (1994)** | External evaluation (IAR) | 43% as of 2011[lxxxvii] | Not explicitly, although the evaluation included assessment of worker-family relations, family satisfaction, and delivery of timely and appropriate services.[lxxxviii] | Using a quasi-experimental design, from baseline through the demonstration period, subsequent CA/N reports increased at a slower rate in pilot FAR counties (36.0% to 37.7%), compared to comparison counties (35.7% to 40.4%), meaning that there was a relative decline in hotline recidivism in the pilot areas, which was statistically significant (p = 0.016).[lxxxix] | No statistically significant difference was found between Pilot FAR and comparison areas in families with children placed outside their homes. The proportion of families with a child placed was 14.0% for demonstration FAR areas, compared to 15.6% for comparison areas.[xc] | Not measured | Not measured |
| **Nevada (2007)** | External evaluation (IAR) | An average of 13% of total cases were initially assigned to the DR track during the 3 year pilot period ending in 2010. Individual counties ranged from 5.9% to 26.7%, with lower rates in | Yes, feedback from families and FRC case workers indicate that the DR program has been implemented with model fidelity, that is, as designed, both in terms of the protocol—the manner in which families are approached in response to a report of child maltreatment—and in terms of | Using a quasi-experimental design, comparing DR families to comparison families, DR families had a more extensive history of past reports (52.6%) than comparison families (45.4%). Among DR families during the follow- | Prior to the pilot DR program, 7.6% of DR families had one or more children removed compared to 6.8% of comparison families. The percent of DR families with a child removal after the | In the first year of the pilot, a total of $214,000 was spent on staff and travel for the first 2 sites (in southern NV). | Not measured |

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| | | urban counties and higher rates in rural counties.[xci] | the assistance and services provided to them, often to address basic needs.[xcii] | up period, 25.6% had one or more new reports compared to 31.9% of comparison families. Assuming the families were roughly comparable, researchers would have expected the percentage for DR families to have been 37.0% (52.6 / 45.4 * 25.6), a difference which was statistically significant ($p < 0.001$).[xciii] | demonstration period was 0.5% compared to 1.1% for comparison families, a difference that was not statistically significant ($p=0.074$).[xciv] | | |
| **New York (2008)** | Internal evaluation (implementation and outcomes) | Experienced counties range from 28.2% to 65.5%; 2.8% of all cases statewide, as of 2011.[xcv] | Not explicitly, although the evaluation assessed: Family Engagement and Satisfaction (strong evidence was found that families were more positive about the FAR approach than they were about the investigative response); Access to Services (the FAR approach increased, expanded, and expedited families' access to appropriate services, especially services to meet basic family needs, such as food, housing, and utilities); Broader Community Involvement (FAR caseworkers broadened the involvement of the community in meeting family service | No significant differences were found between the FAR and investigated control groups in the likelihood of having a subsequent report six months after intake or case closure. In Tompkins County, the percentage of families with subsequent reports within six months of intake was somewhat higher in FAR than in the control group (34.8% vs. 28.8%), but this difference was not statistically significant. In Onondaga County, the percentage of families | The FAR approach led to a decrease in the need for family court involvement. The percentage of families on whom a petition was filed in family court within six months after the initial report was significantly lower for FAR families than for investigated control group families in Onondaga County (1.9% compared to 4.4%) and trending lower in Tompkins County (2.6% compared to 4%).[xcviii] | The AHA training contract was initially approximately $250,000 to begin implementation. No additional funding allocation was attached to DR legislation, and so the child welfare agency had to shift some funding around to reflect its priorities for DR. Overall, DR was implemented on a cost-neutral basis. | The training contract with Butler Institute now averages approximately $550,000 per year. Support from Casey Family Programs has provided additional resources to support internal capacity development, training and quality assurance activities. |

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| | | | needs); and Caseworker Perspectives (FAR workers were more likely than investigative workers to believe that a majority of families on their caseload view the CPS agency as a source of support and assistance (53% vs. 21%), and that a majority of families would feel they were better off because of their involvement with CPS (24% vs. 11%)).[xcvi] | with a subsequent report within six months of intake was slightly higher in FAR than in the control group (25.5% vs. 24.0%).[xcvii] | | | |
| **North Carolina (2001)** | External evaluation (Duke University) | 74.3% as of 2012[xcix] | Not measured (although model fidelity to Child and Family Team Meetings was assessed) | Compared to matched control counties, MRS was found to have a beneficial impact on child safety from a decline in the rates of substantiations and re-assessments, including a shift in the trajectory of substantiation rates over time. From 2002 until 2005, 6,534 cases of substantiated maltreatment were estimated to have been prevented across 9 MRS counties, as well as 1,149 cases of repeat maltreatment reports.[c] | Removal rate into foster care could not be found. However, beginning in 2006, juvenile petitions as a proportion of the total number of CPS assessments show a pattern of decline. The evaluation noted that it is unlikely that MRS is the single cause of this reduction, which may be influenced by a variety of internal and external factors.[ci] | In the short run, all MRS counties were able to re-allocate staff members and resources to accommodate the needs of MRS without additional funds or a change in turnover rates. Actual cost information is unavailable, as they do not have resources to adequately track costs.[cii] | Because no additional funds had been allocated for the implementation of MRS, the "official" costs of implementing MRS were the same. As a proxy for costs incurred over time, MRS counties were able to re-allocate staff members and resources to accommodate MRS without additional funds or a change in turnover rates.[ciii] |
| **Ohio (2007)** | External evaluation (IAR, QIC-DR, Human Services Research Institute, | 51.7% (Percent of referrals assigned to the AR track during | Not explicitly, although the evaluation assessed AR practice, including: Changes in | Children were found to be as safe under AR as under traditional | In the 2013 evaluation extension, the proportion of | Ohio provided participating counties with additional funding for AR, including a | OH's 2013 evaluation extension demonstrated cost |

| Evaluation Section: Matrix | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jurisdiction (Year of Inception)** | **Evaluator** | **Percentage of Referrals Assigned to Assessment Track** | **Measured Model Fidelity** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Upfront Costs for DR Implementation** | **Costs over Time** |
| | WRMA) | Ohio's 18-month AR pilot across the 10 pilot sites.) As of the beginning of 2014, about 40% of all child abuse or neglect reports statewide are served through AR. Statewide implementation has not yet been completed, and OH anticipates this percentage will continue to rise as OH completes the statewide rollout. | Family Engagement and Attitudes (there was evidence of improved family engagement and satisfaction under AR; initial emotional reactions were more positive and less negative; families were more satisfied with their workers and felt that they had more say in decisions that were made), and Changes in Services (workers reported feeling better able to intervene effectively with AR families than with other families; service referrals were more frequent among workers involved with alternative response; workers felt that reactions of alternative response families to assistance were more positive than the reactions of other families).[civ] | approaches. Using a randomized-controlled trial, in the first study year, 11.2% of experimental families had a new report, compared to 13.3% of control families, and this difference was statistically significant. A 2014 evaluation extension consistently found the experimental AR group to have fewer safety concerns than the control TR group.[cv] This Ohio evaluation found that 3.8% of experimental families received new accepted reports compared to 4.8% of control families, a difference which was statistically significant.[cvi] | families in which one or more children were removed and placed out-of-home during and after the target case was 11.8% for control families and 9.8% for experimental AR families, a difference which was statistically significant (p=0.015).[cvii] | financial reimbursement of $1,000 to pilot counties for every family with a Family Service Plan in place to meet a service need. In addition, Casey Family Programs provided an extra $50,000 per year for each site. The average cost for providing direct services for each AR family was $194, compared to $99 for each traditional response family.[cviii] | savings for DR. Using random assignment, measured costs over the course of 5 years including $4,420 per experimental AR family, and $4,716 per control family, an average cost savings of $296 per family. Note that data were not collected at the level of the individual case, but were instead based on averages which were empirically-based or reasonably estimated. The primary limitation of this method is that it may not reflect unknown variations across cases.[cix] |
| **Virginia (1997)** | Internal data analysis/ evaluation (implementation and outcomes). After statewide implementation, an evaluation by an outside evaluator was conducted and program changes were made as necessary. | 70% since statewide implementation in 2002. | Not measured | Among DR Families in 2008, 24% of high-risk families had a subsequent referral, as well as 18% of moderate-risk families. Note that DR outcomes were not compared to traditional response outcomes.[cx] | Not measured | Not measured | Not measured |

# DR Outcomes Summary Matrix

## Code Key:

### Percentage of Referrals Assigned to Assessment Track

| | |
|---|---|
| • High (above 60%) | * |
| • Moderate (40-59%) | + |
| • Low (under 39%) | - |

### Maintained Fidelity during Implementation

| | |
|---|---|
| • Fidelity was achieved | + |
| • Did not achieve | - |

### Child Safety Impacts/ Outcomes (Re-Referral Rate)

| | |
|---|---|
| • Better outcomes for DR (and statistically significant) using equivalent comparison groups | * |
| • Equivalent outcomes (non-significant) | + |
| • Worse outcomes (and significant) | - |

### Child Safety Impacts / Outcomes (Removal Rate)

| | |
|---|---|
| • Better outcomes for DR (and statistically significant) using equivalent comparison groups | * |
| • Equivalent outcomes (non-significant) | + |
| • Worse outcomes (statistically significant) | - |

### Achieved Cost Savings over Time

| | |
|---|---|
| • Savings were achieved using a rigorous method of calculation, and cost differences were statistically significant. | * |
| • Savings were achieved using non-rigorous method of calculation, or cost differences were not statistically significant. | + |
| • DR cost more than the traditional approach. | - |

| DR Outcomes Summary Matrix | | | | | |
|---|---|---|---|---|---|
| | **Percentage of Referrals Assigned to Assessment Track** | **Measured Fidelity and Maintained during Implementation** | **Child Safety Impacts/ Outcomes (Re-Referral Rate)** | **Child Safety Impacts/ Outcomes (Removal Rate)** | **Achieved Cost Savings over Time** |
| **LA County (CA)** | Not available | Not measured | + | + | Not measured |
| **SF County (CA)** | Not available | Not measured | Not measured | Not measured | Not measured |
| **Santa Clara County (CA)** | Not available | Not measured | Not measured | Not measured | Not measured |
| **Colorado** | 48% were eligible for FAR | Not measured | + | + | + |
| **Connecticut** | Not available | Not measured | Not measured | Not measured | Not measured |
| **Hawaii** | 46% | Not measured | + | + | Not measured |
| **Kentucky** | 34% | Not measured | + | + | Not measured |
| **Louisiana** | 35% | Not measured | Not measured | Not measured | Not measured |
| **Massachusetts** | 45% | + | + | + | Not measured |
| **Minnesota** | 71% | + | * | + | * |
| **Missouri** | 43% | + | * | + | Not measured |
| **Nevada** | 13% | + | + | + | Not measured |
| **New York** | 28-65% | + | + | * | Not measured |
| **North Carolina** | 74% | Not measured | * | + | Not measured |
| **Ohio** | 52% | + | * | * | * |
| **Virginia** | 70% | Not measured | Not measured | Not measured | Not measured |
| % * | 25% | NA | 36% | 18% | 66% |
| % + | 42% | 40% | 64% | 82% | 33% |
| % - | 33% | Not Measured: 60% | 0% | 0% | 0% |

# DR Evaluation Methodology Matrix

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
|---|---|---|---|---|---|---|---|
| **Current DR States** | | | | | | | |
| **California** | Eleven-County Pilot Project Evaluation Report[22] | 2008 | Natural experiment: Comparisons were made between the 11 pilot counties and the 47 non-pilot Counties. | • Review of the process by which the strategies have been implemented<br>• An assessment of the programmatic changes implemented in each county<br>• Accomplishments, challenges and lessons learned in the course of implementation. | • Recurrence of Maltreatment<br>• Entries as a % of Substantiations<br>• Re-entry Less than 12 Months Following Reunification | • Recurrence of maltreatment was prevented.<br>• The pilot strategies support improved decision-making.<br>• Families are more involved and take greater responsibility for achieving positive outcomes.<br>• CWS has shifted to a more collaborative, rather than enforcement, approach to working with families and community organizations.<br>• CWS caseloads are shifting to families with greater needs and more difficulty achieving success.<br>• The pilot strategies require CWS staff to spend more time working with families, especially those with greater needs. | http://www.childsworld.ca.gov/res/pdf/11CountyPilot2008.pdf |
| **Colorado** | Program Evaluation of the Colorado Consortium on Differential Response: Final Report | 2014 | Randomized controlled trial (RCT): Families were randomly assigned to either an experimental or a control group. | • Family Engagement Outcomes<br>• Caseworker Satisfaction Outcomes<br>• Community Buy-in Outcomes | • Child Safety Outcomes<br>• Family Well-Being Outcomes<br>• Initial Costs<br>• Follow-up Costs<br>• Overall Costs | • No significant differences between the FAR and IR tracks on all of the safety outcomes examined.<br>• According to caseworker perceptions, FAR families were more likely to have material needs and mental health needs met than were IR families. There were no statistically significant differences between the tracks in the improvement of family needs, given that a specified need was met.<br>• The findings suggest that FAR makes a difference in engaging families and enhancing their experience with CPS. Based on findings from the family exit survey, FAR families reported feeling more engaged than did IR families.<br>• There was no significant difference between the | http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/QIC-DR/Documents/Program%20Evaluation%20of%20the%20Colorado%20Consortium%20on%20Differential%20Response%20- |

[21] For a discussion of research design strategies, such as understanding the difference between natural experiments from quasi-experimental designs, see P. 31-32 of: Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR] (2011) *Differential Response in Child Protective Services: A Literature Review, Version 2.* Washington DC: Children's Bureau, US Department of Health and Human Services. Available at: http://www.differentialresponseqic.org/resources/qic-dr_lit_review-version-2.pdf

[22] Note that California's evaluation was intended to test three combined strategies (including differential response) to improve outcomes for children and families served by the child welfare system.

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
|---|---|---|---|---|---|---|---|
| | | | | | | two tracks on overall costs. | %20Final%20Report.pdf |
| **Kentucky** | Program Evaluation of the Multiple Response System | 2009 | Quasi-experimental with sub-study of matched families: The 20,965 cases included in the 2003 evaluation are matched to cases with recurrence of maltreatment in NCANDS data to estimate subsequent referrals. | • Implementation experiences such as regional variation in using FINSA or Investigation<br>• Perceived effectiveness of Families in Need of Service Assessment (FINSA) track<br>• Worker satisfaction with FINSA | • Percent of first referrals with a subsequent referral<br>• Risk ratings on first and subsequent referrals<br>• Racial distribution for track and findings<br>• Differences across tracks for multiply-referred families | • The rate of using the FINSA track for cases that meet criteria increased from 26% in 2001 to 33.8% in 2008.<br>• There is marked variation in regional patterns of using the FINSA track with a low of 12.4% to a high of 54.4% of referrals meeting criteria using this track.<br>• Risk ratings and substantiations in the case are independent concepts. A case may have low risks and be substantiated or high risks and be unsubstantiated.<br>• Regardless of the track of the case, about 26% of all first time referrals, have subsequent referrals that meet acceptance criteria. This 26% tend to become chronically involved with CPS, comprising 71% of the point-in-time case work.<br>• The FINSA track is used more often in early referrals. Accepted referrals are mostly taken (85.7%) as an investigation in subsequent referrals.<br>• Cases tracked as an Investigation are more likely to be substantiated in subsequent referrals than cases tracked as a FINSA. | http://chfs.ky.gov/nr/rdonlyres/ba81ef9b-572d-4c59-ab4e-597eee3b0935/0/evaluationofthemultiplerespon sesysteminkentucky_09.pdf |
| **Louisiana** | Jefferson Parish Review | 2004 | Natural experiment: Case review of 30 cases from Jefferson Parrish, comparing West Jefferson and East Jefferson offices. | • Appropriateness of the worker for AR track<br>• Appropriateness of services for family needs<br>• Extent of service provision<br>• The length of time between the acceptance of a report and initial case contact<br>• The length of time to case closure | None | • One-fifth to one-quarter of all sample cases had a history of prior valid investigation.<br>• Most referrals that were assigned to assessment were neglect cases, although in West Jefferson, physical abuse accounted for 40% of assessment cases. | LA Evaluation could not be found, but some information available here: http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential- |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
|---|---|---|---|---|---|---|---|
| | | | | | | | response.pdf |
| **Minnesota** | Extended Follow-up Study of Minnesota's Family Assessment Response (FAR) | 2006 | Randomized controlled trial (RCT): Families were randomly assigned to either an experimental or a control group. | • Family satisfaction with FAR<br>• Family financial need and types of services provided<br>• Worker views and attitudes of FAR<br>• Perceived effectiveness of FAR<br>• Perceptions of child safety under FAR<br>• Perceived reaction of families<br>• Perceived attitudes of key community stakeholders<br>• Factors that hindered implementation of FAR<br>• Effect of FAR on CPS workload and job-related stress | • Subsequent reports to CPS based on the use of FAR<br>• Service cases/ reception of services<br>• Later removal and placement of children<br>• Costs for purchased services<br>• Costs for social worker time<br>• Initial Costs<br>• Follow-up period costs | • FAR families continue to have fewer subsequent child maltreatment reports.<br>• The approach to families (the protocol) under FAR—family friendly, non-adversarial, participatory and voluntary—led to reduced levels of future reports, regardless of whether services were or were not offered to families.<br>• The FAR protocol and the provision of services each led, independent of the other, to increased positive attitudes among families.<br>• The FAR approach led consistently to increased services to families. This was particularly the case with financially-related services—such as financial assistance, food services, clothing assistance, housing assistance, utilities assistance and job-related help.<br>• Subsequent removal and placement of children was reduced under FAR. This finding of the original 2004 evaluation was reconfirmed for the longer follow-up period.<br>• The large majority of workers reported a positive or very positive attitude toward FAR. Most workers reported that it positively impacted their practice with families.<br>• While costs during the initial contact period were greater for FAR families, follow-up costs were greater for control families.<br>• When all costs are included and combined, mean costs for control families were $4,967 and $3,688 for FAR families. | http://www.iarstl.org/papers/FinalMNFARReport.pdf |
| **Missouri** | Differential Response in Missouri after Five Years | 2004 | Quasi-experimental design: Outcomes for families and offices in the demonstration area as a whole were compared to outcomes in a comparison | • Utilization of community resources<br>• Cooperation of families<br>• Family satisfaction and involvement in decision-making | • Child safety threats and response time<br>• Recurrence of CA/N reports<br>• Removal of children from homes | • The percentage of reported incidents in which some action was taken increased.<br>• Child safety was not compromised, and in certain types of cases was improved.<br>• In cases where child safety was threatened, children were made safer sooner. | http://www.iarstl.org/papers/MODiffResp2004a.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
|---|---|---|---|---|---|---|---|
| | | | area. The comparison area was composed of 14 small and medium-sized counties across the state and selected zip code areas in St. Louis City and County. The entire comparison area closely matched the demonstration area in population and DFS caseload characteristics. | • Worker perceived effectiveness of (Family Assessment Response) FAR<br>• Community satisfaction with FAR<br>• Reported incidents in which some action was taken<br>• Timeliness for delivering needed services<br>• Types of families assisted under the FAR approach<br>• Types of families not assisted under the FAR approach<br>• Characteristics of chronic CA/N families | • CA/N recurrence after five years | • Recurrence of CA/N reports decreased.<br>• Removal of children from homes neither increased nor decreased.<br>• Needed services were delivered more quickly.<br>• There was greater utilization of community resources.<br>• Family cooperation improved.<br>• Families were more satisfied and felt more involved in decision-making.<br>• Workers judged FAR to be more effective.<br>• Community representatives preferred FAR.<br>• There was evidence that investigations were enhanced. | |
| **Nevada** | Differential Response in Nevada: Final Evaluation Report | 2010 | Quasi-experimental design: The study began 9 months after the start of the pilot project. The study had two main parts, an examination of the implementation of the DR-family assessment track within the state's child protection system and an analysis of program outcomes. The research design for the study of program outcomes was quasi-experimental, using family a comparison group. These families were selected through a group matching procedure. | • Child well-being<br>• Caregiver stress, isolation and support<br>• Family functioning: Views of workers<br>• Family satisfaction<br>• Family engagement from the perspective of workers<br>• Family reports of services received<br>• Worker perceptions of assistance to families<br>• Worker job satisfaction and workload<br>• Worker understanding of DR<br>• Training needs<br>• Worker attitudes towards DR | • One or more past and subsequent reports of any kind<br>• One or more past investigations and one or more subsequent investigations or DR family assessments | • Nearly all families who receive a family assessment express satisfaction with the way they are treated and with the help they receive or are offered. Most feel their families are better off for the experience. The response of Nevada families has been as positive as families in other states who participated in similar evaluations of DR programs.<br>• Many of the families who receive a family assessment are poorer and less educated than other families in the state. Many describe being stressed, for emotional and financial reasons or because they are socially isolated with few people to turn to for help.<br>• Importantly, families who receive services through DR tend to be those experiencing significant problems related to the well-being of their children, who often live in poverty, and with problems that are sometimes acute and often chronic in nature. | http://www.iarstl.org/papers/NevadaDRFinalReport.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
|---|---|---|---|---|---|---|---|
| | | | | | | • Feedback from families and Family Resource Center (FRC) case workers indicate that the DR program has been implemented with model fidelity, that is, as designed, both in terms of the protocol—the manner in which families are approached in response to a report of child maltreatment—and in terms of the assistance and services provided to them, often to address basic needs.<br>• Both FRC-DR workers and CPS case workers express a need for more DR training. | |
| **New Jersey** | | | Natural Experiment: DYFS Continuous Quality Improvement (CQI) Unit evaluated the effectiveness of new systems introduced into practice. | None | • The number of children re-abused after becoming known to the system<br>• The number of cases reopened after case closure<br>• The percent of children open for services who are removed and placed out of home<br>• The number of cases successfully closed without removal<br>• The length of time children remain in placement<br>• The percentage of cases closed after investigation | Unknown | NJ Evaluation could not be found, but some information available here: http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential-response.pdf |
| **New York** | Differential Response in Child Protective Services in | 2011 | RCT and Quasi-experimental: The impact study compares the outcomes for Family Assessment Response | • Organizational, staffing and practice changes made to implement FAR<br>• How cases were identified and screened for | • Percentage of families provided or referred to services that address their needs | • Strong evidence was found that families were more positive about the FAR approach than they were about the investigative response.<br>• FAR caregivers were significantly less likely than investigated caregivers to report feeling annoyed, | http://www.ocfs.state.ny.us/main/reports/CPS%20Differential%20Response%20E |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
|---|---|---|---|---|---|---|---|
| | New York State. Implementation, Initial Outcomes and Impacts of Pilot Project | | (FAR) families to the outcomes for control groups consisting of similar families who met the FAR eligibility criteria but who received the traditional CPS investigative response. The impact study is limited to two Round 1 counties—Onondaga and Tompkins—where it was possible to establish control groups. In Onondaga County, a randomized control trial was used to assign FAR-eligible families to receive the FAR intervention or to a control group to receive the traditional CPS investigation. In Tompkins County, a control group was constructed by using a multi-stage process to identify FAR-eligible families reported to CPS in 2007 and then applying propensity score pairing to select control group families who matched the demographic and child welfare characteristics of families who entered the FAR track during the evaluation sampling period. | assignment to the FAR track<br>• How caseworkers engaged families<br>• Service Provision under FAR track<br>• Family engagement with services and follow-through on service referrals<br>• Family perceptions for how they were treated<br>• Family satisfaction with help received<br>• Caseworker attitudes of FAR<br>• Caseworker satisfaction with FAR<br>• Number of children for whom petitions are filed in the family court<br>• Utilization of formal child welfare services<br>• Utilization of natural and community resources to meet family needs<br>• Characteristics and child welfare histories of families assigned to the FAR track | • Prevalence of subsequent reports of child abuse and neglect | stressed, irritated, angry, and worried by the end of the first home visit.<br>• No significant differences were found between the FAR and investigated control groups in the likelihood of having a subsequent report by six months after intake, or by six months after case closure. | valuation%20Final%20Report_%20Jan%202011.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
|---|---|---|---|---|---|---|---|
| **North Carolina** | Multiple Response System (MRS) Evaluation Report to the North Carolina Department of Social Services (NCDSS) | 2009 | Natural Experiment: To control for changes not related to MRS, the 10 pilot counties were compared with 9 matched controls. A second set of analyses examined pilot counties and 10 wave 2 counties to determine if MRS changes in pilot counties were replicated in wave 2 counties. | • Timeliness of response<br>• Timeliness of case decision<br>• Implementation of Child and Family Teams<br>• Collaboration between child welfare agency and Work First<br>• Shared parenting activities<br>• Feedback from families | • Case distribution across tracks<br>• Rates of new assessment<br>• Rates of repeat assessment | • There was a significant shift over time in the use of the Family Assessment track in both pilot and wave 2 counties with the sharpest increases occurring in the first twelve months of MRS implementation.<br>• Child safety, as measured by overall rates of assessment and rates of substantiated maltreatment, have not been adversely affected by the implementation of MRS.<br>• MRS temporarily disrupted the time to initial response in pilot counties. However, the slowed responding was minimal and short-lived, and has subsequently returned to previous levels.<br>• Timeliness of case decision for all counties has declined in recent years regardless of the date of MRS implementation.<br>• Consistent with the findings in the 2006 report, increased levels of frontloaded services reduced the likelihood of a re-assessment within six months.<br>• Families expressed more positive feelings about their overall interaction with CPS later in the process as compared to initially. This may indicate that negative perceptions about the role of CPS are beginning to change. | http://www.ncdhhs.gov/dss/mrs/docs/2009%20MRS%20Report.pdf |
| **Ohio** | Ohio Alternative Response (AR) Pilot Project Evaluation: Final Report | 2010 | Randomized controlled trial (RCT): Families determined to be appropriate for alternative response had a 50/50 chance of receiving an experimental alternative response family assessment or a control traditional response assessment (investigation). | • Worker attitudes and perceptions of alternative response<br>• Family engagement<br>• Family satisfaction<br>• Community response to AR implementation<br>• Racial differences in later accepted reports | • Short-term child safety from the time of the original report until final contact with families<br>• Subsequent accepted reports of child maltreatment<br>• Out-of-home placement rates<br>• Direct service costs (expenditures for any | • A little more than half of child abuse and neglect reports were appropriate for an alternative response family assessment rather than a traditional response investigative assessment.<br>• Families assigned to the alternative response pathway were among the poorest in Ohio.<br>• There was evidence of improved family engagement and satisfaction under alternative response.<br>• Workers reported feeling better able to intervene effectively with alternative response families than with other families. | http://www.iarstl.org/papers/OhioAREvaluation.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
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| | | | | | service to any family member, including foster care payments)<br>• Indirect costs (worker time spent with and for each sample family, by collecting worker time records and utilizing State-cost allocation records to determine average hourly costs by quarter in each pilot county) | • Alternative response cases were kept open for slightly longer periods. The number of contacts of various kinds with and for families increased under alternative response.<br>• Provision of poverty-related services of various kinds increased under alternative response, such as food and clothing, help with utilities, and money to pay rent.<br>• Families served through alternative response were more frequently connected to counseling and mental health services.<br>• Alternative response families were more satisfied with services received.<br>• Children were as safe under alternative response as under traditional approaches.<br>• Removals and out-of-home placements of children declined.<br>• The cost study showed that full indirect costs measuring worker times were slightly more expensive for alternative response by the end of the evaluation period.<br>• Combining direct and indirect costs, experimental AR families cost an average of $1,325 compared to $1,233 for control families in traditional investigations.<br>• The 2013 evaluation extension measured costs over the course of 5 years and found average costs for DR families to be $4,420, compared to $4,716 for control families, an average cost savings of $296 per family. Note that data were not collected at the level of the individual case, but were instead based on averages which were empirically-based or reasonably estimated. | |
| **Tennessee** | Tennessee Department of Children's Services: | 2010 | Natural experiment: The plan for the current evaluation was to follow-up on the counties | • Community involvement<br>• Stakeholder perspectives<br>• Service provision<br>• Service utilization by type | • Re-referral rates<br>• Commitments for dependency and neglect cases | • Reduced rates of dependency and neglect commitments were observed in most of the regions examined.<br>• A majority of Administrators and slightly over half | https://drive.google.com/folderview?id=0B26M5TMdNUWNXzg4 |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
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| | Multiple Response System (MRS). 2010 Preliminary Evaluation | | included in the initial pilot evaluation. Additional counties were identified for inclusion in the present study. | • Worker perceptions of child safety<br>• Worker perceptions of service provision<br>• Worker satisfaction and support of MRS | • Average daily cost for a child in state custody<br>• Daily cost for custody of foster care population | of CPS Workers and Family Service Workers (FSWs) agreed that children are kept safe under MRS.<br>• Many DCS Case Workers and Administrators perceived that MRS increased identification and provision of resources/services.<br>• CPS Worker job satisfaction was significantly associated with more positive views of MRS.<br>• The Evaluation indicated cost savings due to reduced numbers of children entering custody. For 2004 and 2005, the cost for each day of children in custody was $349,641, compared to $269,190 in 2008 and 2009. MRS, in conjunction with other state initiatives, was believed to reduce the amount of money paid for custodial care. | RGVlVU9EY1E&usp=sharing&id=0B26M5TMdNUWNTnFTNHhIVU1nOVE |
| **Virginia** | Evaluation of the Differential Response System | 2008 | DSS staff prepared data extracts from OASIS (data system) that were used by Virginia Tech in the analyses presented in this report. Analyses are based on 28,757 valid referrals for suspected abuse or neglect accepted from January through December of 2007. This report includes data from case reviews of ongoing service cases. The case reviewer examined 117 high and moderate risk family assessments and founded investigations with ongoing CPS service cases. | • Types of referrals assigned to each track<br>• Track assignment and number of types of abuse or neglect<br>• Track assignment and safety assessment<br>• Appropriateness of initial track assignment<br>• Number of investigations and number of founded investigations<br>• Identifying service needs<br>• Trends in risk assessments<br>• Service needs, disposition and type of abuse or neglect<br>• Regional and local differences in identification of service needs<br>• Specific services needed<br>• Number of families | • Prevention of foster care<br>• Incidence of foster care | • There has been a steady increase in the use of the family assessment track by local departments of social services (LDSS). The statewide percentage of family assessments increased from 55% in 2002 to 70% in 2007. Trends varied in different parts of the state, but there was an overall trend in all areas toward greater use of the assessment track.<br>• As in previous years, a little over one-third of families had identified service needs and the large majority of them received at least some services.<br>• The trend toward more high and moderate risk and fewer low risk families receiving services appears to be primarily the result of the changes in risk assessment that occurred in SDM agencies. As more families were evaluated as high or moderate risk, the percentage of services going to those families naturally increased.<br>• The special topic for this year's report was an evaluation of ongoing service cases. The data from those cases suggest that ongoing services are effective in reducing the risk of future abuse or | http://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2008/differentialresponsesystem_evaluation_annualreport_2008_12-08.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
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| | | | | receiving services<br>• Sources of services<br>• Ongoing CPS and foster care services<br>• Services needed and services received<br>• Services during the investigation or family assessment<br>• Appropriateness of services to reduce assessed risk<br>• Services for substance abuse and domestic violence<br>• Case closure<br>• Services to prevent foster care | | neglect. The percentage of families at high risk decreased from 67% to 17%. In addition, while initially there were no families at low risk, almost half (48%) were found to be low risk when they were reassessed.<br>• Seventy-eight percent of the families, including 73% of high risk and 82% of moderate risk families, did not have another referral during the year and a half between January of 2007 and the time of the case review. Considering that 58% had at least one other valid CPS report before January of 2007, these data suggest that intervention by the LDSS may indeed have contributed to preventing additional abuse or neglect. The recurrence rate was lower in families where services fully addressed the families' service needs than in families where services only partially addressed those needs, supporting the impression that services properly tailored to family needs have played a role in reducing later abuse or neglect. | |
| **Discontinued DR States** | | | | | | | |
| **Alaska** | | 2001 | Quasi-experimental (matched site) and pre-post comparison: Comparison of recidivism rates in Wasilla to another site both before and after the program from June 1997 to May 1999 and June 1999 to May 2001. | • Number of cases referred to the DR program<br>• Percentage and number of cases where contact was made within 7 days of receiving the report<br>• Number of families that successfully completed case plans<br>• Number of cases that went past 90 days<br>• Types of services provided to families<br>• Client satisfaction with services | • Percentage and number of cases returned to OCS for refusal of services<br>• Percentage and number of cases returned to OCS because of further allegations<br>• Percentage and number of cases returned to OCS because of heightened risk factors | • The study showed that there was significantly less recidivism during the program period; families who participated in DR had fewer re-reports. | AK Evaluation could not be found, but some information available here: http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential-response.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
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| | | | | • Attitudes about program effectiveness and satisfaction | | | |
| **Arizona** | State of Arizona Office of the Auditor General, Performance Audit: Family Builders Program | 2001 | Natural Experiment: To assess the impact of Family Builders on subsequent CPS reports, evaluators examined three groups of families referred to Family Builders: service plan completers, service plan non-completers, and families assessed only. They also analyzed families investigated by CPS. | • Number of referrals to the program<br>• Number of families served<br>• Services delivered<br>• Client satisfaction<br>• The extent to which program goals and objectives are met | • Risk of future child maltreatment<br>• Subsequent CPS reports | • Although the services provided to families differ, Family Builders and CPS had similar outcomes related to subsequent CPS reports. Family Builders offers more services to low-risk families than CPS does.<br>• The proportion of families served by Family Builders who received subsequent CPS reports was comparable to the proportion of families investigated by CPS who received subsequent reports.<br>• Families who completed the program had fewer subsequent CPS reports than families who did not complete the program. Further, families receiving program services experienced a slight reduction in their risk for child abuse and neglect, as measured by the caseworker-completed Family Risk Scale. | http://azmemory.azlibrary.gov/cdm/ref/collection/statepubs/id/19227 |
| **Florida** | Evaluation of Florida's Family Services Response System (FSRS) | 1996 | Natural Experiment: comparison of 2 implementation groups | • Family functioning<br>• FSRS status and implementation progress<br>• Client satisfaction level<br>• Review of each district's strategic plan<br>• Level of development in implementation of FSRS--including strengths and needs<br>• Perceptions of reducing risk to children<br>• Partnership with local formal and informal supports | • Agreement in out of home placements between interim and final placements.<br>• Placement stability<br>• Effects of FSRS on children, families, and local communities<br>• The degree to which cases were diverted from judicial involvement<br>• The degree that cases were handled by less restrictive, community-based | • As an indication of decreased unnecessary child removal, high implementing districts showed significant improvement in the match between the initial decision to remove a child from the home during the investigation and what the court later decided for out-of-home placement.<br>• FSRS was generally accepted and supported by investigators, districts, and community stakeholders.<br>• Protective Investigators' support and ownership of FSRS was related to the degree of support experienced from supervisors and administrators, and the degree of flexibility permitted in the work environment in support of FSRS.<br>• Families reported that they were generally treated with courtesy and respect during investigations.<br>• High-implementing districts demonstrated shared | http://centerforchildwelfare.fmhi.usf.edu/kb/trdiver/1996%20Evaluation%20of%20Floridas%20Family%20Services%20Response%20System.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
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| | | | | | service providers | ownership of FSRS that increased access for community-based services and supports for families, both after a child abuse investigation and as a preventive measure. | |
| **Illinois** | Differential Response in Illinois: Final Evaluation Report | 2013 | Randomized controlled trial (RCT): IL integrated a randomizer into their SACWIS system. When family information is entered into the system, they are automatically assessed for AR eligibility and for those that are eligible, the randomizer assigns them to either the experimental or control condition. | • Caseworker turnover<br>• Worker and agency caseload<br>• Family satisfaction<br>• Caseworker satisfaction<br>• The conditions in which DR works best<br>• The mechanisms through which the positive outcomes associated with DR are achieved<br>• Effect of the non-investigation pathway on families of different socio-demographic backgrounds<br>• Worker-family interactions and services<br>• Characteristics of service provision (e.g. number of contacts with the family and adherence to service recommendations) | • Children remaining safely in their homes<br>• Percentages of families re-reported<br>• Substantiated maltreatment allegations after receiving a non-investigation<br>• Cost Analysis | • More DR parents reported feeling hopeful, comforted, encouraged and thankful after their initial visit.<br>• More DR parents reported that their worker listened to them carefully and understood their family's needs well.<br>• Using an Intent-To-Treat approach, survival analyses revealed higher accumulated risk of maltreatment re-reports during the 18-month follow-up period for families in the DR group. However, because 22% of the families that were randomly assigned to the DR group were switched to investigation after random assignment, additional survival analyses were conducted that compared child safety outcomes among four sub-groups of DR families.<br>• After examining cumulative risk of re-report among DR sub-groups, both the DR "switchers" and DR "withdrawers" had significantly higher cumulative risk than families that received an investigation. However, risk of re-report among DR "refusers" and "completers" showed equivalent outcomes to investigated families.[cxi]<br>• No differences were found between the DR and investigation groups in risk of child removal during the 18-month follow-up period (DR=2.6%, IR=2.4%).<br>• After combining initial and follow-up costs, the magnitude of service costs among investigation cases during the follow-up period led to significantly higher overall costs for investigation cases ($2,737) compared to DR cases ($725). | http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/QIC-DR/Documents/Illinois%20DR%20final%20report%20January%202014.pdf |

| | Evaluation Title | Year | Research Design[21] | Process Measures | Outcome Measures | Findings | Link to Evaluation |
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| **Texas** | Flexible Response (FRS) Evaluation | 1999 | Quasi-experimental design (matched site): The study was designed to test the effectiveness of two types of intervention: investigation and assessment. In addition to comparing the types of intervention to each other in the pilot region (8), Region 11 was chosen as a comparison area for examining current investigation practices. Harris County in Region 06 also served as a control area with regard to some risk assessment dimensions which remain to be analyzed. | • Case seriousness<br>• Worker timeliness and efficiency<br>• Caseworker satisfaction<br>• Family satisfaction<br>• Child safety<br>• Worker timeliness and efficiency<br>• Caseworker satisfaction<br>• Family satisfaction<br>• Assessment of fidelity | • Child safety (re-entry) | • More serious cases were routed to investigations<br>• The seriousness of a case was the driving force that led to the decision to investigate or assess, with 58% to investigations and 42% to assessments.<br>• Investigations can be completed in fewer days than assessments (61 days vs. 68 days respectively).<br>• There was no difference in satisfaction ratings between investigations and assessments.<br>• Children were equally safe under assessment as in an investigation and the satisfaction level of FRS was high among families and workers.<br>• However, due to the size of Texas, implementing the program statewide would be costly and this was considered to be a large drawback for further implementation. | https://drive.google.com/folderview?id=0B26M5TMdNUWNbGpORFVybVk5UDA&usp=sharing&tid=0B26M5TMdNUWNTnFTNHhlVU1nOVE |
| **Washington** | Alternative Response Systems (ARS) Program Progress Report | 2005 | Natural Experiment | • Family engagement rates in services<br>• Length of services provided<br>• Regional service differences<br>• Model fidelity<br>• Worker satisfaction<br>• Client satisfaction<br>• Client engagement | • Outcomes for families at 6 months post service | • Statewide, an average of 68% of the families received face to face contact with an ARS service provider, with some regions being well below this mark.<br>• Services were offered to 70% of the referred families, 49% of the families referred participated in services, and 22% completed services.<br>• Outcomes at six months post service were as follows: 18% of the ARS-referred families had a re-referral to CPS within six months of the end of ARS services. Looking at families who participated in services only, the re-referral rate is 17% (and 20% for families who were not located or contacted).<br>• The overall placement rate is 3%. This rate ranges from 2% for families who participated in services to 6% for families who were returned to | http://www.dshs.wa.gov/pdf/ca/ARS_FY04.pdf |

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| | | | | | | CPS as higher risk. | |
| **West Virginia** | West Virginia Family Options Initiative (FOI), Final Pilot Evaluation Report | 1998 | Natural Experiment | • Worker job satisfaction<br>• Community view of CPS<br>• Community Service Capacity<br>• Client satisfaction<br>• Client engagement | • Re-report rate | • FOI was found to work well, with clients, community members, and staff finding the service beneficial.<br>• However, there were some pieces of FOI that did not work out as well, such as the ongoing tracking component. | WV Evaluation could not be found, but some information available here: http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential-response.pdf |

# Additional Resources

## General DR Resources:

1. The National Quality Improvement Center for Differential Response in Child Protective Services (QIC-DR) includes links to QIC-DR literature reviews, QIC-DR cross-site evaluations (CO, IL, OH), and additional publications on DR research and implementation efforts: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/QIC-DR/Pages/QIC-DR.aspx

2. The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect website includes additional publications on DR: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/Pages/DiffResp.aspx

3. Child Welfare Information Gateway, Differential Response webpage: http://www.childwelfare.gov/pubs/issue_briefs/differential_response/

4. Institute of Applied Research (IAR), includes DR evaluations across multiple states, Powerpoint presentations, and special papers: http://www.iarstl.org/

5. National Implementation Research Network (NIRN) seeks to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices: http://nirn.fpg.unc.edu/

6. National Resource Center for Child Protective Services (NRCCPS) Decision-Making Tools Library, which provides updated child protection decision-making resources currently in use in states and territories, including screening, safety assessment, risk assessment, and differential response track assignment tools: http://nrccps.org/information-dissemination/1249-2/

7. National Child Welfare Workforce Institute and the Child Welfare Information Gateway: Online Resource to Support Leadership Academy for Middle Managers (LAMM) Change Initiatives: Differential Response: http://www.ncwwi.org/files/LAMM_Change_Initiatives_Online_Resources_Philadelphia_11-10-10.pdf

## Literature Reviews / Surveys:

8. American Humane Association (2012). Differential Response in Child Protective Services: Research and Practice Advancement (Issue Title). *Protecting Children, 26: 3. Available at:* http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/General%20Resources/docs/protecting-children-2012.pdf

9. American Humane Association (2008). Exploring Differential Response: One Pathway Toward Reforming Child Welfare (Issue Title). *Protecting Children,* 23: 1 & 2. Available at: http://www.americanhumane.org/assets/pdfs/children/differential-response/pc-23-1-2.pdf

10. American Humane Association (2005). Differential Response in Child Welfare (Issue Title). *Protecting Children,* 20: 2 & 3. Available at: http://www.americanhumane.org/assets/pdfs/children/differential-response/pc-20-2-3pdf.pdf

11. Merkel-Holguin, L., Kaplan, C., and Kwak, A. (2006). *National Study on Differential Response in Child Welfare*. Englewood, CO: American Humane Association and Child Welfare League of America. Available at: http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential-response.pdf

12. Morley, L. and Kaplan, C. (2011). *Issue Brief #3: Formal Public Child Welfare Responses to Screened-Out Reports of Alleged Maltreatment*. Englewood, CO: Quality Improvement Center on Differential Response in Child Protective Services. Available 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

13. Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR] (2009). *Online Survey of State Differential Response Policies and Practices, Findings Report.* Washington DC: Children's Bureau, US Department of Health and Human Services. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/General%20Resources/docs/qic-dr-findings-report-jun09.pdf

14. Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR] (2009) *Differential Response in Child Protective Services: A Literature Review.* Washington DC: Children's Bureau, US Department of Health and Human Services. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/General%20Resources/docs/qic-dr-lit-review-sept-09.pdf

15. Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR] (2011) *Differential Response in Child Protective Services: A Literature Review, Version 2.* Washington DC: Children's Bureau, US Department of Health and Human Services. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/QIC-DR_Lit_Review%20version%20%202.pdf

16. Richardson, J. (2008). *Differential Response: A Literature Review.* Urbana, IL: Children and Family Research Center, University of Illinois School of Social Work. Available at: http://www.state.il.us/DCFS/docs/DRLitreview_11.21.09.pdf

17. U.S. Department of Health and Human Services, Children's Bureau (2003). *National Study of Child Protective Services Systems and Reform Efforts, Findings on Local CPS Practices*. Washington DC: Children's Bureau, US Department of Health and Human Services. Available at: http://aspe.hhs.gov/hsp/CPS-status03/CPS-practices03/index.htm

## Financing Guides:

18. Bazelon Center for Mental Health Law (2003). *Mix and match: Using federal programs to support interagency systems of care for children with mental health care needs.* Washington DC: Bazelon Center for Mental Health Law. Available at: http://www.bazelon.org/LinkClick.aspx?fileticket=-ELUn7dsyVQ%3D&tabid=104

19. Harbert, A., Dudley, D. (2009) *Differential Response - Effective Prevention and Intervention Models; Implementation and Financing*. San Diego, CA: Southern Area Consortium of Human Services (SACHS). Available at: http://theacademy.sdsu.edu/programs/SACHS/literature/Differential%20Response-SACHS%202009.pdf

20. Lind, C., Crocker, J., Stewart, N., Torrico, R., Bhat, S., and Schmid W. (2009). *Finding Funding: Supporting making connections core result that children are healthy and prepared to succeed in school*. New York: The Finance Project. Available at: http://www.financeproject.org/publications/findingfunding-supportingmakingconnections.pdf

21. Schmid, D., Freundlich, M., and Greenblatt, S. (2010). *Funding Permanency Services: a Guide to leveraging federal, state, and local dollars.* Baltimore, MD: Annie E. Casey Foundation. Available at: http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={F818604B-BF1E-4DA3-9A5B-513E9EE3011D}

## Implementation Guides / Readiness Assessments:

22. Berrick J. D., Bryant, M., Conley, A., de Elizalde, L., Garcia, V., and Geer, A., (2009). *Differential response and alternative response in diverse communities: An empirically based curriculum*. Berkeley: University of California at Berkeley, California Social Work Education Center. Available at: http://www.csulb.edu/projects/ccwrl/Differential%20Response%201023.pdf

23. California Department of Social Services (2010) *The California Child Welfare Improvement Activities, Differential Response Guidelines and Resources for Implementation.* Sacramento, CA: California Department of Social Services. Available at: http://www.childsworld.ca.gov/res/pdf/DR_Guidelines.pdf

24. Carpenter, Carla (2012). *Ohio Differential Response County Planning Guide.* Columbus, Ohio: Ohio Department of Job and Family Services. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/Documents/DR%20Online%20Material_TOTAL/Facilitated%20Discussion

%20of%20Ohio%20DR/Differential%20Response%20Implementation%20County%20Planning%20Guide%20August%202012.pdf

25. Casey Family Programs (2007) *Implementing Differential Response in California: Promising Practices and Lessons Learned.* Seattle, WA: Casey Family Programs. Available at: http://www.casey.org/Resources/Publications/BreakthroughSeries_DifferentialResponse.htm

26. National Technical Assistance and Evaluation Center for Systems of Care (2010). *Systems of Care Implementation Case Studies.* Washington DC: U.S. Department of Health and Human Services, Children's Bureau, National Technical Assistance and Evaluation Center for Systems of Care. Available at: http://www.childwelfare.gov/management/reform/soc/communicate/initiative/evalreports/reports/ImplementationCaseStudies.pdf

27. Ohio Department of Job and Family Services (2010). *Alternative Response Implementation Readiness Assessment: For use by Ohio counties in determining preparedness for launching an alternative response system.* Available at: http://law.capital.edu/uploadedFiles/Law_Multi_Site/NCALP/2010_Readiness_Assessment.pdf

28. Sphere Institute (2006). *Implementing Differential Response: An Assessment of Community Organizations' Capacity and Interest.* Burlingame, CA: Sphere Institute. Available at: http://www.sphereinstitute.org/publications/DR_Report_FINAL.pdf

## Procedural Manuals / Practice Guides:

29. Children's Research Center (May 2008). *Structured Decision Making, Policy and Procedures Manual, California Department of Social Services.* Madison, WI: Children's Research Center. Available at: http://www.childsworld.ca.gov/res/pdf/SDM_Manual.pdf

30. Los Angeles County Department of Child and Family Services (Sept. 2009). *Procedural Guide, 0070-548.02, Point of Engagement: Alternative Response Services (ARS).* Available at: http://www.google.com/url?sa=t&rct=j&q=procedural%20guide%20%200070-548.02&source=web&cd=1&ved=0CCMQFjAA&url=http%3A%2F%2Fdcfs.co.la.ca.us%2Fpolicy%2Fhndbook%2520cws%2F0070%2F007054802v0909.doc&ei=B017T6a-K4fjiAL408A_&usg=AFQjCNGzFxxut4Mv0LuSZ17BXEzuu6-1Nw

31. Minnesota Department of Human Services (no date). *Family-centered Practice Guide Engaging, Assessing and Building Strengths with Families.* Available at: https://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4938-ENG

32. Minnesota Department of Human Services (July 2007). *Structured Decision Making® Updated Risk Assessment and Risk Reassessment Policy and Procedures*. Available at: http://nrccps.org/wp-content/uploads/Minnesota-SDM-Policy-and-Procedures-Manual-052012.pdf

33. M & B Consulting (Nov. 2003). *Standards of Professional Practice For Serving Children and Families: A Model of Practice.* Nashville, TN: Tennessee Department of Children's Services. Available at*:* http://tennessee.gov/youth/dcsguide/DCS_PracticeModel11.24.03.pdf

## Legal and Judicial Resources:

34. National Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR] (2011). *Differential Response in Child Protective Services: A Guide for Judges and Judicial Officers.* Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/resources/judgesguide.pdf

35. National Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR] (2009). *Differential Response in Child Protective Services: A Legal Analysis.* Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/General%20Resources/docs/differential-response-in.pdf

36. The National Child Welfare Resource Center on Legal and Judicial Issues: http://www.americanbar.org/groups/child_law/what_we_do/projects/rclji.html

37. The National Council of Juvenile and Family Court Judges: http://www.ncjfcj.org/

38. The National Center of State Courts: http://www.ncsc.org/

[i] Quality Improvement Center on Differential Response in Child Protective Services [QIC-DR] (2011) *Differential Response in Child Protective Services: A Literature Review, Version 2.* Washington DC: Children's Bureau, US Department of Health and Human Services. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/QIC-DR_Lit_Review%20version%20%202.pdf

[ii] Ibid, Also see:

Siegel, G.L. and Loman, L.A. (2006). *Extended Follow-up Study of Minnesota's Family Assessment Response.* St. Louis: Institute of Applied Research. Available at: http://www.iarstl.org/papers/FinalMNFARReport.pdf

Loman, L.A. and Siegel, G.L. (2014). *Ohio Alternative Response Evaluation Extension: Final Report.* St. Louis: Institute of Applied Research. Available at: http://www.iarstl.org/papers/OhioARFinalExtensionReportFINAL.pdf

[iii] As described in:

Siegel, G.L. (2012). *Lessons from the Beginning of Differential Response: Why it Works and When it Doesn't*. St. Louis: Institute of Applied Research. Available at: http://www.iarstl.org/papers/DRLessons.pdf

[iv] Children's Research Center (2008, updated 2012). *Structured Decision Making, Policy and Procedures Manual, California Department of Social Services.* Madison, WI: Children's Research Center. Available at: http://www.childsworld.ca.gov/res/pdf/SDM_Manual.pdf

[v] Social Work Research Center (2012). *Colorado Year 1 Site Visit, Final Report*. Fort Collins, CO: Social Work Research Center, Colorado State University. Available at: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/Documents/Year%201%20Site%20Reports/coloradoyear1.pdf

[vi] Connecticut Department of Children and Families (2012). *Differential Response System (DRS): The Family Assessment Response Notebook.* Hartford, CT: Department of Children and Families, State of Connecticut. Available at: http://www.ct.gov/dcf/lib/dcf/drs/docs/family_assessment_response_notebook_030112.doc

[vii] Hawaii Child Welfare Services Branch (2006). *Child Welfare Services Differential Response Procedures Manual.* Honolulu, HI: Child Welfare Services Branch, Department of Human Services, State of Hawaii.

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