

differential *response*

Comparison of
Experiences in
Differential Response
(DR) Implementation:
*10 Child Welfare
Jurisdictions
Implementing DR*



APRIL 2012

differential *response*

This report provides a snapshot of considerations to help child welfare jurisdictions in planning and communicating the Differential Response (DR) approach to stakeholders. This report includes three parts: 1) Analysis of jurisdictions' implementation experiences, 2) A matrix comparing implementation experiences and additional information across 10 jurisdictions, and 3) Information regarding resources for jurisdictions considering DR or in the process of implementing DR.

The child welfare jurisdictions discussed below and highlighted in the matrix were chosen because they have considerable DR experience or because their implementation of DR has been tested in a rigorous evaluation. The choice of these jurisdictions is not intended to serve as an endorsement of the "best" DR jurisdictions, but instead to identify a sampling of diverse jurisdictions including large and small states, state vs. county administered child welfare systems, and various social and political environments. Information was gathered from informational requests from jurisdictions, conversations with agency managers and DR leaders from some jurisdictions, as well as publicly available literature and documents.

table of *contents*

Table of Contents

Discussion - Overview and Analysis	4
Communicating and Planning for DR Implementation	4
Basic DR System Components	7
Impacts to Child Safety.....	9
Funding and Costs of DR	10
Changes to DR Systems Over Time	12
Matrix	14
Table 1: DR Track Types and Assignment Processes	14
Table 2: DR Implementation Scope and Spread.....	16
Table 3: DR Impacts to Child Safety.....	17
Table 4: DR Privatization and Funding Sources	19
Table 5: Costs Upfront and Over Time for DR	21
DR Implementation Resources	23
References.....	28

differential *response*

Discussion

Traditional Child Protective Services (CPS) systems typically treat all screened-in reports of abuse and neglect in the same way—with forensically focused investigations to determine whether or not maltreatment occurred. By contrast, Differential Response (DR), also referred to as ‘alternative response,’ ‘multiple response,’ or ‘dual-track,’ provides child welfare agencies with an alternate way of responding that is proportionate to the severity of alleged child maltreatment and the family’s level of need.¹ DR allows agencies to focus upon the environmental context and the larger issue of family well-being through the use of partnership-based and family-centered approaches to meeting family needs. Due to the non-adversarial approach of DR, its focus on identifying root causes behind parenting difficulties, and provision of poverty related services, DR has demonstrated improvements in family engagement, child and family outcomes, and some cost savings over time.

Instead of a “one size fits all” approach to maltreatment reports, CPS systems with DR provide a response continuum that includes a traditional investigation pathway, a family assessment pathway, and sometimes a community services pathway for cases that would otherwise be screened-out. Expanded ways of responding to reports allow for more individualized treatment, better matching the intensity and type of services to family needs. DR systems seek to better meet underlying family needs which triggered the report in order to prevent traumatic and expensive services such as foster care, as well as future contact with child welfare systems. Nonetheless, once families are classified into a specific pathway, caseworkers can switch the family’s track in light of new information regarding child safety or to be more responsive to family needs.

Communicating and Planning for DR Implementation

Initiating a Philosophical Shift through DR

Agency managers and DR leaders speak of DR in terms of a true shift in philosophy, from incident-based responses towards a more holistic, family-centered service orientation. While DR is typically one component of a larger family-centered practice model, leaders commented that DR triggered new ways of approaching families and drove deeper, system-wide reforms. Simple changes can shift long-held beliefs and assumptions among caseworkers. For example, one manager reported that she used to answer the phone with “Investigations,” to which a caller asked if he had mistakenly called a police department. Now, she answers with more family-centered language, which changes the basis for initial interactions with families. Another manager asserted that for families who would previously have received no further contact, before ending the call caseworkers now ask a simple question: “What else can I do for you?” Under the traditional investigative approach, clients would rarely mention that they struggled with challenges such as feeding their children or maintaining housing. Under DR, families are sometimes more forthcoming in expressing their needs and identifying their struggles and goals. Until caseworkers are able to engage with families to get to know their needs and become advocates alongside families, managers stated that they cannot

¹ For more information on the core elements of Differential Response, see: 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>

meet families' needs or begin to align agency practice with service goals. Many DR caseworkers and agency managers said that implementing DR resulted in a significant cultural and practice transformation towards engaging families in deeper ways. One child welfare leader described DR as allowing social workers to do social work again.

In a discussion of the history of DR implementation, Siegel (2012) proposed an analogy of “rolling icebergs,” as a way to understand the ways that families come to the attention of child welfare agencies.¹ In this analogy, a child maltreatment report represents one point where the iceberg surfaces, indicating a problem with family functioning. Multiple reports on families over time tend to vary in type and nature, such that a specific type of report is not at all predictive of the type of future reports.² This seeming randomness among multiply-reported families indicated that the particular allegations in the report were often just the tip of the iceberg; other issues were often present, but hidden from view. Given that these families were reported for multiple reasons, Siegel makes the comparison to rolling icebergs, which surface and expose different tips or problems at different points in time. As a result, an agency response that narrows its focus to the single reported incident will likely miss important opportunities for serving these families. A more family-centered approach such as DR may be more likely to uncover deeper, hidden problems, and better meet the needs of these children and families.

Gaining Buy-In from Stakeholders and Strategic Allies

How agency managers communicate the design and purpose of DR to stakeholders can determine the ultimate success or failure of implementation. Eric Fenner, former Director of Franklin County Children's Services (Ohio), describes the most important information that needs to be shared about DR for judges and legislators:

When talking to the legislature and others that have a stake in how DR is rolled out, it's helpful for them to understand that serious cases of abuse are not going to the DR track. They tend to assume that DR is a replacement for the traditional investigative response. In fact, the Alternative or Family Assessment pathway is added onto the existing system, providing the agency with an alternate way of addressing low to moderate risk cases. The investigative pathway stays in place, but the agency is given an additional option for how to address these reports. Legislators and judges understandably have concerns about changes to child protective services systems, primarily around whether or not kids will be kept safe. Many judges that I talked to thought that nearly all cases came to court. They didn't realize that only 20 percent of cases are seen by a judge. What happened to all of those other cases, as well as calls that were screened-out? It might be helpful to show them data from these categories, in terms of who is in what track, and how they might think about how to meet the needs of these families. What DR allowed us to do, was to be responsive to the large majority of cases that came to our attention that traditionally would have been unsubstantiated—but still would have benefitted from services. Communicating that DR responds to cases that typically would be unsubstantiated and would not receive services helps to alleviate child safety concerns. If you give a presentation on DR, and haven't

² Siegel (2012) indicates that subsequent reports on families initially reported for educational neglect were more likely to involve other accusations and not include educational neglect 75% of the time. 81% of second and third reports that involved educational neglect concerned families whose initial report did not include this problem.

differential *response*

explained this in the first 15 minutes, you'll lose your audience, and they will start coming up with defensive questions around how to protect child safety. If you communicate this up front, most of the work will be done, which helps them to pay attention to what you're trying to communicate. This needs to come first: DR will not compromise the safety of children.ⁱⁱ

Another manager emphasized the importance of engaging with stakeholders from the beginning of the planning process and involving them throughout implementation. Just as DR seeks to involve families as partners in their own treatment, the partnership model must carry over to the planning and implementation process, involving caseworkers, community service providers, law enforcement officers, judges, legislators, and families. Managers remarked that such efforts can take considerable time and energy and can at times seem tedious; but gaining more buy-in from those who will be enacting new practices, presiding over cases, or voting on legislation, can remove significant barriers down the road.

As discussed below (Jurisdictions Discontinuing DR), the primary roadblocks that can halt DR implementation and end initiatives result from the opposition of key stakeholders who question basic tenets of the DR approach. Other managers discussed the value of utilizing data and evaluations from other jurisdictions in communicating the efficacy of the approach, and that child safety should not be compromised—alleviating a primary concern about DR. Gaining judicial and legislative allies can be enormously helpful, as they can serve as advocates to others in their own profession.³ Managers discussed that judges and legislators are often more receptive when listening to one of their peers discussing the benefits of new approaches.

Gaining support among caseworkers should also be viewed as a key objective, according to DR leaders. One manager discussed the importance of finding creative ways for staff to become involved, which allows a greater sense of ownership in the process. Another discussed the importance of anticipating friction and resistance to change at various levels and stages, and taking actions to alleviate potential concerns early into the implementation process. Uncertainty about the approach can also occur among community service providers, and one manager emphasized the importance of engaging them in the process as well.

A critical element of Ohio's success was early and regular communication with all stakeholders throughout the process, at state and county levels. These stakeholders included judges, service providers, guardians ad litem/CASA volunteers, law enforcement officers, school staff, medical professionals and other community stakeholders. Managers found it critical to not only engage stakeholders in conversations at the beginning of implementation but to keep everyone informed about progress throughout implementation. Ohio created a quarterly newsletter to assist with this process at the state level, keeping stakeholders updated along the way.ⁱⁱⁱ

One manager commented that individuals will always struggle with change, even if it seems like a good idea, and even if data demonstrates that the new approach works. At a Shared Learning Collaborative convening (a collaborative model that engages experienced jurisdictions and jurisdictions planning implementation in peer-to-peer learning through structured and facilitated

³ For more information on communicating to Judges and Juvenile Officers on DR, see: 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.differentialresponseqic.org/resources/judgesguide.pdf>

discussions) on DR, “Participants emphasized the importance of bringing critics inside the process. When these individuals have ‘skin in the game,’ they can sometimes become an agency’s best allies and advocates for systems change.”^{4 iv}

Drawing upon Peer Expertise

When beginning to plan for DR implementation, one agency manager recommended investing considerable time upfront for gathering stakeholder support and drawing upon existing knowledge in articulating a DR model. Numerous jurisdictions with successful DR programs highlighted the value of peer-to-peer consultation (expert technical assistance from outside jurisdictions or internal pilot areas with more DR experience) in planning and spreading the DR model. These DR leaders built their systems on the shoulders of those who had gone before, capitalizing on important lessons learned, as well as barriers to avoid.

Several managers asserted that statewide implementation was achieved with the help of peer-to-peer guidance and county-county mentoring (in-state coaching from counties that were initially part of the DR pilot), which facilitated the spread of DR knowledge and experience statewide. One manager emphasized the importance of understanding the broader implementation science during planning stages.⁵ In regards to trainings, managers stated that one DR training for staff is not enough, and that caseworkers need to be immersed in the DR approach, through ongoing trainings, shadowing opportunities in the field, and peer-to-peer coaching, which should include managers in addition to workers. Such assistance was identified as an important way to change how agencies relate to families at a systems level, institutionalizing the DR approach.

Basic DR System Components

2-Track vs. 3-Track Systems

Differential Response CPS systems are designed to maintain the investigative pathway while adding one or more additional pathways, in order to respond to families with varying levels of need. Jurisdictions utilized the investigative pathway for severe or extreme cases, with track assignment criteria including the following: requiring the involvement of law enforcement; high-risk, immediate safety concerns; and the presence of imminent danger. Key variables determining track assignment often include: the level of severity, prior substantiated maltreatment reports, the type of alleged maltreatment, the relationship of the perpetrator to the child, and the age of the alleged victim, among others. The differential response pathway (usually referred to as the assessment, family assessment, or community response pathway) is typically utilized for low to medium risk cases, and especially for neglect cases that may be enmeshed with poverty.

Some jurisdictions discussed here (California counties, Hawaii, Minnesota, and Tennessee) also utilize a third pathway, which provides services to families who would otherwise be screened-out from services. Such families often have resource needs which lead them to be re-reported. When jurisdictions have incorporated a third pathway, these families are typically connected to voluntary

4 For more information on “gaining buy-in from strategic allies”, see Casey Family Programs’ “Shared Learning Collaborative on Differential Response” summary, listed in the references section below.

5 This Manager highly recommended the resources and services provided by the National Implementation Research Network (NIRN), found here: <http://www.fpg.unc.edu/~nirn/>

differential *response*

services, which can prevent future reports. In terms of implementation planning, jurisdictions do not typically implement a three-track DR system simultaneously, but phase-in these elements over time, building them as state and federal funding and other resources become available.

Track Assignment Decision Processes

The jurisdictions included in the matrix use one or more assessment tools for determining which pathway a family will be assigned to, and some of which have been tested for validity and reliability (such as Structured Decision Making (SDM) tools). SDM capacity to categorize investigated cases by risk level has been rigorously evaluated. The tools used by these jurisdictions were either modified or individualized based off of existing sets of instruments, developed in collaboration with academic research institutions, or were developed in-house by the agency.

The process for arriving at a track assignment decision has been put into practice in various ways. Some jurisdictions expect an individual hotline worker or caseworker to make this decision on their own. Others (L.A. County, Hawaii, Minnesota, and North Carolina) describe a more collaborative group or team process for arriving at a decision. North Carolina identifies a joint decision made between a supervisory-level staff member and the intake worker, and if the family is known to the agency, this decision may be extended to previous caseworkers to obtain their perspective as well. In L.A. County, the decision process for track assignment and necessary interventions involves a team, including a caseworker, supervisor, law enforcement officer, public health nurse, voluntary services provider, mental health service provider, the family, and extended family members.

Olmsted County, Minn., developed the RED Team model (Review, Evaluate, and Direct), in which track assignment decisions are made as a collaborative team decision-making process. The RED Team serves as a collaborative review team that shares the burden and accountability for these important decisions. Based upon the assumption that “no one of us makes decisions better than all of us together,” the RED Team approach creates more consistent track assignments within a team environment. Utilizing the “Consultation & Information Sharing Framework,” the RED Team typically includes a supervisor, intake worker, assessment workers, investigative workers, and ongoing workers.⁶

The percentage of reports assigned to the multiple tracks varies considerably across jurisdictions. Managers from several jurisdictions noted 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 has especially been observed for 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. Over time, workers experience increased comfort with the assessment track, and the notion 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.

⁶ 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>

Privatization of DR Functions

The majority of jurisdictions identified here do not privatize any DR functions, although some have in the past or plan to in the future. Roles that have been privatized include assessment, case management, and comprehensive service provision functions. Privatized functions are typically relied upon to build capacity for new functions required by the DR approach, or to expand existing capacity beyond what can be provided by the public agency alone. Jurisdictions not accessing additional funds for DR implementation avoided privatized functions, while some jurisdictions which had access to expanded funding chose to utilize privatized components.

The Illinois child welfare system is largely privatized, with over 80 percent of services delivered to children and families by private agencies under purchase of service (POS) contracts with the Department of Children and Family Services (DCFS).^v Oversight for DR in Illinois was provided by the Differential Response Project Steering Committee established under the Illinois Child Welfare Advisory Committee (CWAC). CWAC was created in 1995 to provide a forum for collaboration between the public and private child welfare agencies. The identified purpose of CWAC is to advise the department regarding “programmatically and budgetary matters related to the provision of purchase of child welfare services.”^{vi} CWAC subcommittees and work groups include representatives from both the public and private sectors. Departmental leadership determined that it was a necessary first step to expose existing DCFS CPS staff, child welfare staff, and local community stakeholders, to DR in order to embed DR as part of the department’s larger vision of child welfare reform. These stakeholders were included in the process in order to increase interest, mobilize support, and to allay fears and clear up misconceptions. A series of town hall meetings were held throughout the state in which the DCFS director and DR project director presented the proposed DR model, answered questions, and received comments from the community.⁷

Impacts to Child Safety

Re-Referral Rates of DR Families

Among the jurisdictions described here, all were able to show either a reduction in re-referral rates for families assigned to the family assessment track compared to the investigative track, or were able to show no difference (non-statistically significant difference) between these two groups.⁸ The quality of program evaluations that DR implementation received varied considerably, but among the most rigorous (Minnesota, Missouri, New York, and Ohio), these jurisdictions reported lower rates of re-referral for DR families, and some of these reductions were statistically significant. The two evaluations which were able to conduct randomized-controlled trials (RCTs) of DR (Minnesota and Ohio) reported a statistically significant difference in re-referral rates. Minnesota’s extended follow-up evaluation demonstrated that the risk of receiving a new referral under investigation is 28 percent higher, such that for every 10 families with a new report under DR, about 13 similar families will receive a new report under the investigative track.^{vii} The Ohio evaluation found that subsequent reporting of families for child abuse and neglect declined in the largest way among families of color, the most impoverished families in the study.^{viii} The evaluation of Contra Costa and Alameda counties

7 For more information on Illinois’ privatization of DR responsibilities, see: Kearney, K.A., Fuller, T.L., Jones, W., and McEwen, E. (2012). Putting It All Together: Lessons Learned from the Planning and Development Phases of Implementing Differential Response in Illinois. Protecting Children, 26: 8-20. Available at: <http://www.differentialresponseic.org/assets/docs/protecting-children-2012.pdf>

8 With the exception of Illinois, as they are awaiting the results of their evaluation, forthcoming in 2013.

differential *response*

Calif. highlighted the relevance of family engagement in services in order to achieve successful outcomes.^x In Contra Costa County, 28 percent of children from Path 1 families (otherwise screened-out cases) who were offered and engaged in services were re-referred for maltreatment one year after the initial referral compared to 30 percent of children from families who did not engage in services.

Removal Rates Under DR

Child removal rates among these jurisdictions were also shown to be lower among DR families compared to families served through investigations. Several evaluations lacked the ability to compare outcomes of DR and investigation families, but some showed a trend over time of reduced child removals or juvenile petitions that coincide with the time of initiation of DR (Hawaii, North Carolina, and Tennessee). It is important to note that other initiatives and internal / external factors could also have led to decreased removals, but DR was believed to have had at least a small influence on these numbers. For evaluations that allowed for an adequate comparison between families receiving DR or investigations, Minnesota, New York, and Ohio were all able to demonstrate a statistically significant reduction in removal rates for DR families.

Funding and Costs of DR

Jurisdictions Accessing External Funds

Most jurisdictions examined here drew upon additional external funds for implementation and system maintenance over time. L.A. County, Contra Costa County, New York, Illinois, Minnesota, and Ohio were able to use funds from outside the county/state, including foundation grants/technical assistance, federal Title IV-B Promoting Safe and Stable Families (PSSF) funds, and two states (Illinois and a consortium of six counties in Ohio) received a federally funded grant from the Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR). Several jurisdictions (LA County, Contra Costa County, Hawaii, Illinois, Minnesota, New York, North Carolina, and Ohio) were able to access expanded funding from state and county sources, or through the establishment of dedicated revenue streams. These sources were used both for upfront implementation and ongoing costs. Jurisdictions utilizing external and expanded state/county funds spent more dollars upfront, frontloading services at the beginning of a case to quickly connect families to poverty-related services. Generally, these jurisdictions expected to receive cost savings on the backend of cases by reducing the need for expensive and less effective services such as residential treatment for children.

Minnesota described 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, and strengthening the family’s ability to take care of itself.^x

Jurisdictions Seeking to Implement Cost-Neutral DR

Three jurisdictions, Missouri, North Carolina and Tennessee, did not have access to expanded funding, or believed that DR should be implemented and maintained in a cost-neutral way compared to the existing system. 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 investigations. These jurisdictions reported that the lack of additional funds required greater creativity among caseworkers in working with community organizations to locate external sources of service provision to meet case specific needs of children and families.^{xi} Without the establishment of stronger ties to resources within the community to assist children and families, implementation and resulting outcomes in these jurisdictions likely would not have been as successful. Whether through additional funding or through expanded access to community services, all jurisdictions discussed in the matrix were able to provide families with greater access to services in the course of DR implementation.

Jurisdictions Demonstrating Cost Savings

Only Minnesota and Ohio conducted a rigorous cost analysis of DR, although Illinois is planning to examine the costs incurred in developing, implementing, and sustaining DR, including estimates for staffing costs, service costs, and short-term and longer-term costs.^{xii} Minnesota and Tennessee were able to demonstrate some degree of cost savings over time which was associated with DR implementation. Minnesota's analysis indicated that DR was both cost effective and cost beneficial, with an average cost incurred over three to five years of \$3,688 for DR families compared to \$4,967 for control families.^{xiii} A Tennessee preliminary evaluation reported that a cost savings estimate could be calculated given the reduced numbers of children entering custody. For 2004 and 2005, the cost for each day for all children in custody was \$349,641, compared to \$269,190 in 2008 and 2009.^{xiv} While cost savings coincided with DR implementation, other factors could have influenced this reduction in entries into care and cost savings.

Minnesota was able to separate out and compare costs from two periods: 1) the initial period of contact with the family until CPS services ended, and 2) the period after CPS services ended. Total costs from this first period were \$1,132 for experimental FAR families compared to \$593 for control families. Total costs from second period were \$804 for experimental FAR families compared to \$1,537 for control families.^{xv} Consistent with the basic design of the DR model, more services were provided upfront for DR families, which appeared to drive costs down later on; this was the opposite of investigation services. Paralleling this increased service intensity upfront, some jurisdictions also reported that more caseworker time is required at the beginning of DR cases than investigation cases, in order to coordinate and connect families to services and supports more quickly, which can be helpful for jurisdictions to keep in mind as they plan for implementation.

Cost Increase Under DR

The only other jurisdiction to complete a rigorous cost analysis besides Minnesota was Ohio, which demonstrated a slight cost increase compared to control families after a short observation period.

differential *response*

Combining direct and indirect costs in Ohio, experimental DR families cost an average of \$1,325 compared to \$1,233 for control families receiving investigations.^{xvi} Anecdotally, Ohio expects that DR costs will decrease over time, an expectation supported by the initial evaluation. Ohio managers anticipate that the extended evaluation, which will track costs later into the implementation process, will demonstrate cost savings over the traditional approach. This evaluation will be available in January 2013, and will also report on updated child safety outcomes.^{xvii} Because DR tends to frontload services, some managers reported that states should expect an initial increase in costs, followed by a reduction in placement rates, which can save significant costs on the back end given a sufficient amount of time for savings to accrue.

Changes to DR Systems Over Time

Jurisdictions Discontinuing DR

While the jurisdictions discussed above experienced success in implementing and maintaining system changes over the course of several years, implementing a DR poses many challenges. Numerous barriers can stall or derail the implementation of DR. Several jurisdictions initiated DR or DR-like pilot programs which are no longer operational, including Alaska, Arizona, Delaware, Florida, Texas, Washington, and West Virginia. Major barriers that can halt implementation include the lack of funding, child safety concerns among powerful stakeholders, and inconsistent implementation (as a result of funds management issues, or equity issues for how resources are drawn upon across communities).

Florida provides a useful example. Despite generally positive findings reported in a 1996 outcome evaluation, difficulties identified during the evaluation had a negative effect on the community support for the DR initiative.^[j] Intense judicial concern with the inconsistent implementation of DR and child safety concerns caused a judicial group to recommend that Florida return to the use of a protective investigation for all reports.

In 1999, Texas caseworkers participated in a pilot named “Flexible Response.”^{xix} A program evaluation demonstrated promising outcomes. Staff felt that the process was beneficial to families and helped staff gain greater job satisfaction. Families were surveyed and expressed that the program was helpful and improved their parenting. However, the pilot was costly, and at that time Texas did not have the funding or resources to move forward with full implementation.

The examples of Florida and Texas point to the importance of gaining strategic allies and communicating clearly and often to stakeholders about the basic design of DR systems. Note that several states that discontinued DR (Arizona, Florida, Texas, and Washington) are currently planning new DR initiatives, as system improvements commonly go through fits and starts. Such can be the evolutionary life cycle of DR, whereby a pilot gains traction, encounters barriers, ends, and then after sustained focus from agency managers, DR is granted new energy.

System Changes Over Time

Over time, DR systems change and adapt in various ways. A learning organization can incorporate feedback from caseworkers, families, and stakeholders, as well as research findings, to improve practices and create more efficient processes. In response to concerns regarding inconsistencies around in track assignment decisions made at the field-level, Missouri centralized and streamlined this process through a centralized intake unit. This decision resulted in a higher percentage of cases being assigned to the assessment track. For Missouri, the biggest change over time involved technology; they were able to integrate assessment tools into their SACWIS system, and more broadly take advantage of technology's ability to provide greater efficiencies, which other jurisdictions also mentioned.^{xx}

Fidelity to the DR practice model was identified as a “constant issue” to focus on and manage over time, for North Carolina and other jurisdictions, especially as the model expanded into new counties and touched more families and community partners.^{xxi} Jurisdictions with more DR experience have placed particular importance on fidelity, as a means of building more consistent practices across geographical and cultural space. Several of these jurisdictions highlighted the value of coaching and mentoring to standardize practice to a greater degree, and credit peer T/A for significantly improving implementation processes overall. As more funding became available for expansion, managers pointed towards the utility of investing in coaching and mentoring to embed practice changes deeper into their organizations.

In the course of expansion, another issue that was identified as deserving attention was making available a comprehensive service array across offices, such that families' needs can be met equally regardless of where their case is being served. When additional resources become available, they recommended ensuring that families are never left without assistance, and that families be provided a wider service array, and offered an expanded period of service provision. Expanded services were said to include poverty-related services such as housing assistance, cash aid, Supplemental Nutrition Assistance Program (SNAP), and additional resources to meet basic household needs.

As discussed above, implementation of DR can encounter challenges that slow or stop the initiative. Challenges present an opportunity to learn and adjust the trajectory of implementation. While not all barriers can be predicted and avoided, leaders recommend gaining the insight of peers and utilizing existing knowledge, which can refocus efforts towards achieving the long-term objectives of DR.

differential *response*

Matrix

Table 1: DR Track Types and Assignment Processes

Jurisdiction (Year of Inception)	Multiple Track Types	Staff Responsible for DR Track Assignment Decision	Track Assignment/ Assessment Tools
Contra Costa County (CCC), CA (2004)	3-Track approach including (1) Community Response (for screened-out reports in which a family can benefit from community services), (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). CCC is currently not utilizing Path 1 due to lack of impact on future entry into care.	Caseworker	Comprehensive Safety Assessment System including the Comprehensive Assessment Tool (CAT) (developed by the Sphere Institute), which includes Structured Decision Making (SDM) elements.
Los Angeles County, CA (2004)	3-Track approach including (1) Community Response (for when allegations are unfounded and the risk is low), (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). Path 1 is still in the implementation process throughout the county.	Team decision, often involving assessment worker, case manager, supervisor, service providers, law enforcement officer, public health nurse, and family members.	A set of Structured Decision Making (SDM) tools, including Hotline, Safety Assessment, Family Risk Assessment, and Family Strengths and Needs Assessment tools.
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	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.
Illinois (2010)	2-Track approach including (1) investigation (allegations of abuse or severe neglect) or (2) assessment response (for cases where allegations only include neglect concerns).	Hotline worker, then information is entered into randomizer for experimental evaluation	The Illinois Child Endangerment Risk Assessment Protocol (CERAP) is used for all reports. IL also conducts a strengths and needs assessment for assessment cases.
Minnesota (1997)	3-Track approach including (1) Investigation (criminal or severe allegations), (2) Family Assessment (low to moderate risk cases), or (3) Family support intervention (for screened-out cases) (Not all counties employ a 3-track approach).	Varies by county. Some counties rely upon a team process, such as the RED team (Review, Evaluate, and Direct).	Structured Decision Making (SDM) tools that assesses for substantial child endangerment, and checks for 16 categories including criminally chargeable actions and risk factors.

Jurisdiction (Year of Inception)	Multiple Track Types	Staff Responsible for DR Track Assignment Decision	Track Assignment/ Assessment Tools
Missouri (1995)	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)	Hotline worker	Structured Decision Making (SDM) tools including the Safety Assessment tool and Family Risk Assessment tool.
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	Each district uses its own tool for screening into FAR. 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 and more severe cases) or (2) Assessment response (for dependency cases and some cases of neglect)	Multiple staff are involved including intake workers, caseworkers, supervisors, and previous caseworkers, if the family is known to the agency.	Structured Intake Tool used at intake for track assignment, which is a Structured Decision Making (SDM) tool.
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)	Varies by county	The Pathway Assignment Tool (developed with AHA)
Tennessee (2006)	3-Track approach including (1) Investigation (intentional injuries / high risk of harm), (2) Assessment (lower risk cases), or (3) Resource Linkage (screened-out cases)	Hotline worker	Structured Decision Making (SDM) tools, including Intake Assessment, Safety Assessment, Family Risk Assessment tools.

differential *response*

Table 2: DR Implementation Scope and Spread

Jurisdiction	State / County System	Current Scope of Implementation	Number of Cases Served in DR track	Percentage of Referrals Assigned to Assessment Track
Contra Costa County (CCC), CA (2004)	State Supervised / County Administered	DR has been targeted towards populations and communities with identified need.	In CY2011, 337 families were served in Path 2 and 21 in Path 1. Note that CCC stopped serving Path 1 as of July 2011 due to budget cuts. ⁱ	Not Available
Los Angeles County, CA (2004)	State Supervised / County Administered	Implemented county-wide, although still developing Path 1 in all county locations.	From 2005 until 2010, 5,955 families were served in Path 2 (including 12,682 children). ⁱⁱ	Not Available
Hawaii (2005)	State Administered	Statewide	From 2005 until 2007, 2,447 families were referred for FSS services, and 1,188 families were referred for VCM services ⁱⁱⁱ	46% (including 31% referred for FSS, and 15% for VCM) ^{iv}
Illinois (2010)	State Administered	All 102 counties initiated DR at the same time in Nov. 2010	In FY 2011, approximately 3,750 families were expected to receive services through DR. ^v	For DR eligible cases, 50% are sent to DR, as part of the evaluation's randomization process). ^{vi}
Minnesota (1997)	State Supervised / County Administered	Statewide	In 2010, 16,172 children received FAR. ^{vii}	64% ^{viii}
Missouri (1995)	State Administered / Strong County Discretion	Statewide	39,552 children were served through Family Assessment Track in FY 2011. ^{ix}	43% ^x
New York (2008)	State Supervised / County Administered	Regional/ Local Pilot Site	In 2010, 7,944 children received FAR. ^{xi}	Experienced counties range from 28.2% to 65.5%. ^{xii} 2.8% of all cases statewide. ^{xiii}
North Carolina (2001)	State Supervised / County Administered	Statewide	In 2011, 52,371 cases were referred to the family assessment track. ^{xiv}	74.3% ^{xv}

Jurisdiction	State / County System	Current Scope of Implementation	Number of Cases Served in DR track	Percentage of Referrals Assigned to Assessment Track
Ohio (2007)	State Supervised / County Administered	As of April 2012, 40 of 88 counties will be providing DR	In 2011, 12,116 cases were served in Ohio's DR pathway. (In CY 2011, 33 Ohio counties were implementing DR for all or a portion of the year). ^{xvi}	51.7% ^{xvii} (Percent of referrals assigned to the AR track during Ohio's 18-month AR pilot)
Tennessee (2006)	State Administered	Statewide	In 2011, 36,385 cases referred for assessment, and 448 referred for resource linkage. ^{xviii}	58% to Assessment, 0.7% to Resource Linkage. ^{xix}

Table 3: DR Impacts to Child Safety

Jurisdiction	Child Safety Impacts/ Outcomes (Re-Referral Rate)	Child Safety Impacts/ Outcomes (Removal Rate)
Contra Costa County (CCC), CA (2004)	28% of children from Path 1 families who were offered and engaged in DR services were re-referred for maltreatment within 1 year following the initial referral. 30% of children were re-referred among families not engaged in services. (Children referred to Path 2 were not included in this analysis). ^{xx}	3% of children from Path 1 families who were offered and engaged in DR services were removed within 1 year following the initial referral. 12% of children were removed among families not engaged in services, as well as 4% of children for cases where no services were offered due to program capacity limitations. (Children referred to Path 2 were not included in this analysis). ^{xxi}
Los Angeles County, CA (2004)	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. ^{xxii}	1.9% of children of ARS families were subsequently removed within 12 months of case closing, compared to 3.5% for comparison group children. ^{xxiii}
Hawaii (2005)	After implementing DR, recurrence of child abuse/neglect decreased from 5.7% in FY 2004 to 3.9% in FY 2009. ^{xxiv}	From 2003 to 2010, children in out-of-home care decreased by approximately 44%. ^{xxv}
Illinois (2010)	The forthcoming Illinois evaluation will be a randomized control trial (RCT) experiment examining outcomes for families who are randomly assigned to either an investigation or non-investigation pathway. ^{xxvi}	Forthcoming in statewide evaluation, expected in 2013

differential response

Jurisdiction	Child Safety Impacts/ Outcomes (Re-Referral Rate)	Child Safety Impacts/ Outcomes (Removal Rate)
Minnesota (1997)	During the extended observation period from Feb. 2001 until Dec. 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 risk of receiving a new referral under investigation is 28% higher for control families than FAR families. ^{xxvii}	During the extended observation period from Feb. 2001 until Dec. 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 approaches the standard level of statistical significance ($p=.077$). ^{xxviii}
Missouri (1995)	A detailed examination of 5 child safety areas revealed no reduction in child safety that might be attributed to the Family Assessment demonstration, including: basic life needs, supervision and care of children, less serious physical and verbal abuse, very serious physical and verbal abuse, and sexual abuse. ^{xxix}	No 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. ^{xxx}
New York (2008)	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. ^{xxxi}	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%). ^{xxxii}
North Carolina (2001)	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, with 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. ^{xxxiii}	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. ^{xxxiv}
Ohio (2007)	Children were found to be as safe under DR as under traditional approaches. 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. Subsequent reporting of families for child abuse and neglect declined under AR, particularly among minority families, the most impoverished families in the study. ^{xxxv}	Removals and out-of-home placements of children declined under DR. 1.8% of experimental AR children were removed, compared to 3.7% of control group children, a statistically significant difference. AR appeared to reduce the number of child removals and out-of-home placements. ^{xxxvi}
Tennessee (2006)	Within 6 months, there were no statistically significant differences for new reports or for indicated reports. 18.6% of assessment families received a new report in this time frame, compared to 16.8% for investigation families. 2.3% of assessment families were indicated for maltreatment, while 2.7% of investigated families were indicated. ^{xxxvii}	For children entering custody, rates from pre-MRS implementation were not significantly different than the average post-MRS rates. However, a declining trend in dependency and neglect commitments was found in most regions following MRS implementation. Other initiatives may have contributed to these differences, but the authors note that MRS may well have played a significant role in reducing the number of children entering custody. ^{xxxviii}

Table 4: DR Privatization and Funding Sources

Jurisdiction	Privatization of DR Functions	Funding Sources for DR Implementation and Ongoing Operations
Contra Costa County (CCC), CA (2004)	CCC contracts with community and faith based agencies to provide Path 2 case management services. County workers conduct initial assessment and if Path 2 is appropriate, the worker invites the community case manager to meet the family. The county then closes the referral and is no longer involved.	Statewide startup funds were provided by the Foundation Consortium for California's Children & Youth, Casey Family Programs, and the Marguerite Casey Foundation, which provided TA to develop and begin implementing DR. CCC operating costs are paid from Title IV-B PSSF, state Child Welfare Services Outcomes Improvement Project (CWSOIP), State Family Preservation (SFP), and county funds. ^{xxxix}
Los Angeles County, CA (2004)	Currently, no ARS functions are privatized. However, depending upon renewal, LA County plans to use their Title IV-E waiver to contract out the first responder function, which will allow community agencies to be first responders on certain referrals, instead of DCFS.	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 is 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 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. ^{xl}
Hawaii (2005)	These DR services are contracted out to private agencies: 1) FSS (assessment, service planning, short-term counseling and intervention and development of family resources, up to 6 months); 2) VCM (assessment, case planning, monitoring and counseling, up to 12 months).	Hawaii is currently utilizing Title XX TANF Transfer funds, and state general funds. ^{xli}
Illinois (2010)	Upon initial visit to the home, a DCFS staff accompanies a private agency worker (Pathways to Strengthening and Supporting Families (PSSF) caseworker) who continues to work with the family on a voluntary basis.	Implementation planning included Peer-to-Peer Technical Assistance Match sponsored by Casey Family Programs held with Minnesota representatives. Illinois received a QIC-DR grant to supplement the demonstration. The majority of funding was drawn from state DCFS funds. ^{xlii}
Minnesota (1997)	Some FAR functions are privatized, depending upon the county. Case management functions are primarily done by public agency workers. Large counties are more likely to contract out some functions.	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 funds. ^{xliii}
Missouri (1995)	No FAR functions are privatized. Missouri law requires that the state: "Shall be the sole provider of child abuse and neglect hotline services, the initial child abuse and neglect investigation, and the initial family assessment."	A goal of the FAR demonstration was to make it cost-neutral to the traditional system. 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 able to assist children and families. ^{xliiv}

differential *response*

Jurisdiction	Privatization of DR Functions	Funding Sources for DR Implementation and Ongoing Operations
New York (2008)	Nearly all counties retain responsibility for FAR within public agencies. During implementation, one small county initiated its program by contracting out the strengths and needs assessment function; the private agency caseworker then worked with the family once the county worker completed the initial safety assessment.	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 pay 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. ^{xlv}
North Carolina (2001)	No MRS functions are privatized.	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. ^{xlvi}
Ohio (2007)	Assessment and Case-management functions are the responsibility of county agencies. Some counties use private agencies for post-assessment functions/ services.	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). ^{xlvii} Additionally, 6 counties are also receiving funds from the QIC-DR for their demonstration project. ^{xlvii}
Tennessee (2006)	No MRS functions are privatized.	Funding for MRS was provided entirely from the state DCS budget. ^{xlviii}

Table 5: Costs Upfront and over Time for DR

Jurisdiction	Upfront Costs for DR Implementation	Costs Over Time
Contra Costa County (CCC), CA (2004)	The state provided the county with a \$1 million one-time grant to implement DR. ^{xix}	During a 3-year period from 2007-2009, average annual expenditures totaled \$891,324, and average annual cost per family was \$2,858. ⁱ
Los Angeles County, CA (2004)	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 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. ⁱⁱ	Approximately \$12 million have been spent on ARS since inception. ⁱⁱⁱ
Hawaii (2005)	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 for expanded intensive home-based, individual and family counseling, and other services. ⁱⁱⁱ	Actual costs over time were not available, but see initial costs (left) for 2007 annual projections.
Illinois (2010)	Upfront costs have not yet been analyzed, but a forthcoming evaluation will include a cost analysis to examine the costs incurred in developing, implementing, and sustaining DR in Illinois. ^{iv}	The forthcoming evaluation will include a cost analysis to examine the costs incurred in developing, implementing, and sustaining DR in Illinois. Estimates will be developed for both staffing costs and service costs, and for both short-term and longer-term costs. ^{iv}
Minnesota (1997)	Minnesota did not provide implementation costs, but separated out costs involved from Period 1 (the time of initial contact with the family until CPS intervention was discontinued), and Period 2 (beginning the day after period 1 and extended throughout the follow-up period). Total costs from Period 1 were \$1,132 for experimental FAR families compared to \$593 for control families. Total costs from Period 2 were \$804 for experimental FAR families compared to \$1,537 for control families. ^{vi}	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 control families. ^{vi}

differential *response*

Jurisdiction	Upfront Costs for DR Implementation	Costs Over Time
Missouri (1995)	Cost information is unavailable because the DR demonstration was intended to be cost-neutral, and FAR-specific funds were not tracked.	Cost information is unavailable because the FAR demonstration was intended to be cost-neutral, and FAR-specific funds were not tracked.
New York (2008)	The AHA contract was initially approximately \$250,000 to begin implementation, and is now approximately \$400,000 per year. ^{lviii}	Funding was not made available for cost analysis.
North Carolina (2001)	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. ^{lix}	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. ^{lx}
Ohio (2007)	Ohio provided participating counties with additional funding for DR, including a 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. ^{lxi}	Combining direct and indirect costs, experimental DR families cost an average of \$1,325 compared to \$1,233 for control families in traditional investigations. ^{lxii}
Tennessee (2006)	Tennessee reported no upfront costs for MRS implementation. ^{lxiii}	Tennessee reported no additional costs over time to maintain MRS compared to the traditional approach. An 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. ^{lxiv}

DR Implementation Resources

General DR Resources

American Humane Association, Differential Response webpage. Includes links to Program Evaluations, Training Evaluations, the AHA Annual Conference, Webinar Series, and other Publications. <http://www.americanhumane.org/children/programs/differential-response/>

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

Institute of Applied Research (IAR), includes DR evaluations, Powerpoint presentations, and special papers: <http://www.iarstl.org/>

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. Their purposes is to advance the science of implementation across domains, inform the transformation of human services, and ensure that the voices and experiences of diverse communities and consumers influence and guide implementation efforts. <http://www.fpg.unc.edu/~nirn/>

National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR). Includes details on the 3-state, Cross-Site DR evaluation (CO, IL, OH), which will end in 2012. <http://www.differentialresponseqic.org/>

DR Bibliography: <http://www.differentialresponseqic.org/resources/annotated-bibliography-pdf.pdf>

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/>

Literature Reviews / Surveys

American Humane Association (2012). Differential Response in Child Protective Services: Research and Practice Advancement (Issue Title). *Protecting Children*, 26: 3. Available at: <http://www.differentialresponseqic.org/assets/docs/protecting-children-2012.pdf>

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>

differential *response*

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>

Child Welfare Institute (2005). *A Review of the Literature on Alternative Response, Risk Safety & Family Assessment*. Tallahassee, FL: Florida Department of Children and Families. Available at: http://centerforchildwelfare.fmhi.usf.edu/kb/tridiver/ARS%20Review%20of%20Literature_2005.pdf

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>

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.differentialresponseqic.org/assets/docs/qic-dr-findings-report-jun09.pdf>

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.differentialresponseqic.org/assets/docs/qic-dr-lit-review-sept-09.pdf>

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

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

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

Bazon 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: Bazon Center for Mental Health Law. Available at: <http://www.bazon.org/LinkClick.aspx?fileticket=-ELUn7dsyVQ%3D&tabid=104>

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>

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>

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

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>

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

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

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>

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

differential *response*

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

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

Florida Department of Children and Families (no date). *Alternative Response System Pilot Policy and Procedures Manual*, Available at: <http://centerforchildwelfare.fmhi.usf.edu/kb/trdiver/ARS%20Procedures%20Manual%20Final.doc.pdf>

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=OCCMQFjAA&url=http%3A%2F%2Fdcs.co.la.ca.us%2Fpolicy%2Fhndbook%2520cws%2F0070%2F007054802v0909.doc&ei=B017T6a-K4fjiAL408A_&usq=AFQjCNGzFxxut4Mv0LuSZ17BXEzuu6-1Nw

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>

Minnesota Department of Human Services (Jan. 2009). *Social Services Information System (SSIS) Version 5.2, Training Module: Structured Decision Making (SDM)*. Available at: http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs16_139169.pdf

Minnesota Department of Human Services (July 2007). *Structured Decision Making® Updated Risk Assessment and Risk Reassessment Policy and Procedures*. Available at: http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs16_138720.pdf

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

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.differentialresponseqic.org/resources/judgesguide.pdf>

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.differentialresponseqic.org/assets/docs/differential-response-in.pdf>

National Conference of State Legislatures, Differential Response: State Enacted Legislation: <http://www.ncsl.org/?tabid=17800>

The National Child Welfare Resource Center on Legal and Judicial Issues: <http://apps.americanbar.org/child/rcjji/>

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

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

Jurisdictional Pages

Florida's Center for the Advancement of Child Welfare Practice, provides tools, resources and publications: <http://centerforchildwelfare.fmhi.usf.edu/kb/trdiver/Forms/AllItems.aspx>

Ohio Alternative Response Pilot Project, also includes Alternative Response Quarterly periodical (Archive on right hand column): <http://www.americanhumane.org/children/programs/differential-response/current-projects/ohio-alternative-response.html>

National Center for Adoption Law and Policy, Ohio Differential Response page: <http://law.capital.edu/adoption/ar2/>

New York Family Assessment Response (FAR), includes implementation videos: <http://www.ocfs.state.ny.us/main/cfsr/far.shtm>

North Carolina's Multiple Response System (MRS) page, includes MRS Evaluations and Reports, MRS County Resources, MRS Training Information, and MRS! Newsletter Issues: <http://www.ncdhhs.gov/dss/mrs/index.htm>

Tennessee Multiple Response Approach to Child Maltreatment Concerns: <http://www.tennessee.gov/youth/services/multrespapproach.htm>

differential *response*

References

- i. Personal communication, Contra Costa County Children and Family Services Bureau, December 13, 2011.
- ii. Personal communication, Los Angeles County Department of Children and Family Services, January 27, 2012.
- iii. Personal communication, Hawaii Department of Human Services, January 13, 2012.
- iv. Ibid
- v. Illinois Governor's Office of Management and Budget, Fiscal Year 2011 Budget.
- vi. Personal communication, Illinois Department of Children and Family Services, December 15, 2011.
- vii. U.S. Department of Health and Human Services (US DHHS), Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). Child Maltreatment 2010. Available at: http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can
- viii. US DHHS, 2011, cited above.
- ix. Personal communication, Missouri Children's Division, February 8, 2012.
- x. Ibid
- xi. US DHHS, 2011, cited above.
- xii. Ruppel, J., Huang, Y., and Haulenbeek, G. (2011). Differential Response in Child Protective Services in New York State, Implementation, Initial Outcomes and Impacts of Pilot Project, Report to the Governor and Legislature. Albany, NY: Office of Children and Family Services. Available at: http://www.ocfs.state.ny.us/main/reports/CPS%20Differential%20Response%20Evaluation%20Final%20Report_%20Jan%202011.pdf
- xiii. US DHHS, 2011, cited above.
- xiv. Personal communication, North Carolina Department of Health and Human Services, January 30, 2012.
- xv. Ibid
- xvi. Personal communication, Ohio Department of Job and Family Services, December 21, 2011.
- xvii. Loman, L.A., Filonow, C.S., and Siegel, G.L. (2010). Ohio Alternative Response Evaluation, Final Report. St. Louis: Institute of Applied Research. Available at: <http://www.iarstl.org/papers/OhioAREvaluation.pdf>
- xviii. Personal communication, Tennessee Department of Children's Services, January 19, 2012.

- xix. Ibid
- xx. 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>
- xxi. Berrick et al., 2009, cited above.
- xxii. Personal communication, Los Angeles County Department of Children and Family Services, January 27, 2012.
- xxiii. Ibid
- xxiv. Walters, J., and Costello, T. (2010). Hawaii's Differential Response System Practical Implementation Strategies that Led to Successful Outcomes. Powerpoint Presentation.
- xxv. Walters and Costello, 2010, cited above.
- xxvi. Illinois Department of Children and Family Services (2009). Application for Funding from the National Quality Improvement Center on Differential Response in Child Protective Services. Springfield IL: Illinois Department of Children and Family Services. Available at: http://www.state.il.us/DCFS/docs/IL_QIC_DR_Application.pdf
- xxvii. 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>
- xxviii. Ibid
- xxix. Siegel, G.L. and Loman, L.A. (1997). Missouri Family Assessment and Response Demonstration: Final evaluation report. St. Louis: Institute of Applied Research. Available at: http://www.iarstl.org/papers/MO_FAR_Final_Report-for_website.pdf
- xxx. Siegel & Loman, 1997, cited above.
- xxxi. Ruppel, Huang, & Haulenbeek, 2011, cited above.
- xxxii. Ibid
- xxxiii. Lawrence, C.N., Rosanbalm, K.D., and Dodge, K.A. (2011). Multiple Response System: Evaluation of Policy Change in North Carolina's Child Welfare System. Children and Youth Services Review, 33, 2355-2365.
- xxxiv. Center for Child and Family Policy (2011). Multiple Response System (MRS) Evaluation Report to the North Carolina Division of Social Services (NCDSS): Review of Juvenile Petitions. Durham, NC: Center for Child and Family Policy, Duke University. Available at: <http://www.ncdhs.gov/dss/mrs/docs/MRS%20Report%202011.pdf>

differential response

- xxxv. Loman, Filonow & Siegel, 2010, cited above.
- xxxvi. Ibid
- xxxvii. Hilker, K. (2010). Tennessee Department of Children's Services: Multiple response system, 2010 preliminary evaluation. Murfreesboro, TN: Tennessee Center for Child Welfare, Middle Tennessee State University.
- xxxviii. Hilker, 2010, cited above.
- xxxix. Harbert, A. and 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>
- xl. Ibid
- xli. Personal communication, Hawaii Department of Human Services, January 13, 2012.
- xlii. Personal communication, Illinois Department of Children and Family Services, December 15, 2011.
- xliii. Personal communication, Minnesota Department of Human Services, December 6, 2011.
- xliv. Siegel & Loman, 1997, cited above.
- xlv. Personal Communication, New York Office of Children and Family Services, December 14, 2011.
- xlvi. Personal communication, North Carolina Department of Health and Human Services, January 30, 2012.
- xlvii. Personal communication, Ohio Department of Job and Family Services, December 21, 2011.
- xlviii. Personal communication, Tennessee Department of Children's Services, January 19, 2012.
- xlix. Harbert & Dudley, 2009, cited above.
- I. Personal communication, Contra Costa County Children and Family Services Bureau, December 13, 2011.
- ii. Personal communication, Los Angeles County Department of Children and Family Services, January 27, 2012.
- lii. Ibid
- liii. Walters, J., and Costello, T. (2007). Hawaii's Differential Response System: Practical Implementation Strategies that Led to Successful Outcomes. Powerpoint Presentation.
- liv. Illinois Department of Children and Family Services, 2009, cited above.

- iv. Ibid
- vi. Loman, L.A. and Siegel, G.L. (2004). Minnesota Alternative Response Evaluation, Final Report. St. Louis: Institute of Applied Research. Available at: <http://www.iarstl.org/papers/ARFinalEvaluationReport.pdf>
- vii. Siegel & Loman, 2006, cited above.
- viii. Personal Communication, New York Office of Children and Family Services, December 14, 2011.
- lix. Center for Child and Family Policy (2004). Multiple Response System (MRS) Evaluation Report to the North Carolina Division of Social Services (NCDSS). Durham, NC: Center for Child and Family Policy, Duke University. Available at: <http://www.ncdhhs.gov/dss/publications/docs/MRSReport.pdf>
- lx. Center for Child and Family Policy, 2004, cited above.
- lxi. Loman, Filonow & Siegel, 2010, cited above.
- lxii. Ibid
- lxiii. Personal communication, Tennessee Department of Children's Services, January 19, 2012.
- lxiv. Hilker, 2010, cited above.
- lxv. 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>
- lxvi. Casey Family Programs (2012a). Casey Practice Digest Interview: A Conversation with Eric Fenner, Former Director of Franklin County Children's Services, Ohio, on DR Implementation. Casey Practice Digest, (1) 5-6.
- lxvii. Personal communication, Ohio Department of Job and Family Services, December 21, 2011.
- lxviii. Casey Family Programs (2012b). Shared Learning Collaborative on Differential Response. Seattle, WA: Casey Family Programs.
- lxix. Kearney, K.A., Fuller, T.L., Jones, W., and McEwen, E. (2012). Putting It All Together: Lessons Learned from the Planning and Development Phases of Implementing Differential Response in Illinois. *Protecting Children*, 26: 8-20.
- lxx. Illinois Administrative Code § 428.50
- lxxi. Siegel & Loman, 2006, cited above.
- lxxii. Loman, Filonow, & Siegel, 2010, cited above.
- lxxiii. Berrick et al., 2009, cited above.

differential *response*

- lxxiv. As described in Siegel, 2012, cited above.
- lxxv. Casey Family Programs, 2012b, cited above.
- lxxvi. Illinois Department of Children and Family Services, 2009, cited above.
- lxxvii. Siegel & Loman, 2006, cited above.
- lxxviii. Hilker, 2010, cited above.
- lxxix. Loman & Siegel, 2004, cited above.
- lxxx. Loman, Filonow & Siegel, 2010, cited above.
- lxxxi. Personal communication, Ohio Department of Job and Family Services, December 21, 2011.
- lxxxii. The Florida Senate Committee on Children, Families, and Elder Affairs (Oct. 2010). Differential Response to Reports of Child Abuse and Neglect. Interim Report 2011-10
- lxxxiii. Personal communication, Texas Department of Family and Protective Services, February 3, 2012.
- lxxxiv. Personal communication, Missouri Children's Division, March 29, 2012.
- lxxxv. Personal communication, North Carolina Department of Health and Human Services, January 30, 2012.

casey family *programs*

Casey Family Programs is the nation's largest operating foundation whose work is focused on safely reducing the need for foster care and building communities of hope for all of America's children and families. We work in partnership with child welfare systems, families and communities across the nation to prevent child abuse and neglect and to find safe, permanent and loving families for all children. We believe every child deserves a family of their own and a community of hope. We are committed to our 2020 Strategy for America's Children – a goal to safely reduce the number of children in foster care and improve education, employment and mental health outcomes for all children. We bring decades of front-line experience serving vulnerable children and families and are committed to helping states, counties and tribes implement effective child welfare practices. We provide nonpartisan research and technical expertise to child welfare system leaders, members of Congress and state legislators so they may craft laws and policies to better the lives of children in foster care, children at risk of entering the system and their families. The foundation, established by United Parcel Service founder Jim Casey in 1966, is based in Seattle.

