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Evaluating the Differential Response Approach in Child Protection: A Systematic Review of the Evidence

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Abstract

Evaluating the Differential Response Approach in Child Protection: A Systematic Review of the Evidence

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In U.S. Fiscal Year 2017, states responded to 2.4 million calls reporting child abuse or neglect, spanning from inadequate supervision to severe physical maltreatment (U.S. Children's Bureau, 2017). Since the mid-1990s, child welfare reformers have increasingly acknowledged that such a volume of reports warrants a wider, more flexible range of interventions than the standard fact-finding investigation. Today, the majority of states offer at least two distinct responses to child maltreatment reports through an approach known as Differential Response (DR). Despite the rapid proliferation of DR over the past two decades, critics have charged that it does not keep children as safe as traditional one-track systems, and some states have discontinued their pilot programs after mixed results. This report takes a systematic review approach to identify and assess the most rigorous published studies examining DR's impact on child maltreatment recidivism. The balance of evidence supports the claim that DR, and in particular the Alternative Response (AR) track, has kept children equally as safe, or safer, than their

counterparts served by the traditional investigative response. Qualitative research has also revealed that caregivers receive the Alternative Response intervention more positively than the traditional investigation. The report identifies key differences in jurisdictions' implementation of DR that have led to varying levels of success and offers policy and practice recommendations based on state and county practices that have yielded the best outcomes. Disparate research methodologies also contributed to different findings on child safety outcomes. The report recommends more consistent analytic strategies to make state DR evaluations comparable to one another and to build a stronger national consensus on the efficacy of the approach.

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Chapter 1: Introduction

The U.S. child welfare system is tasked with a dual mandate – investigate households to ensure child safety, but also support and engage families, providing and connecting them to resources to allow children to remain at home and prevent further maltreatment (Waldfogel, 2008). Some scholars have called this an "impossible imperative" due to the tensions involved in balancing the interrogative, adversarial aspects of an investigation with the social work principles of strengths-based client engagement (Berrick, 2018). Since the early 1990s, a child welfare reform movement known as Differential Response (hereafter "DR") has attempted to address this tension, reflecting a growing belief that more nuance is warranted in responding to the 2.4 million reports that are screened in[1] for a Child Protective Services (CPS) response each year (Berrick, 2018; U.S. Children's Bureau, 2017). In states with a DR system, accepted reports that meet state criteria for diversion do not receive a traditional investigative response ("TR") – the fact-finding pursuit to formally substantiate the report and identify a perpetrator and victim. Instead, these reports are met with an Alternative Response ("AR"), which involves a holistic family assessment, including considerations of risk, safety, and overall needs (DHHS Differential Response Issue Brief, 2008). The terms "AR" and "DR" are sometimes used interchangeably in the literature, but this report uses DR to refer to a two-track system and AR to refer to the non-investigative track within such a system.

DR has proliferated in county and state CPS systems since the mid-1990s. It is now implemented to some degree in 29 states and the District of Columbia and is championed

[1] Child welfare hotline calls can be "screened out" (receive no further formal response) if the description of the alleged maltreatment does not meet statutory definitions of child abuse and neglect, if there is insufficient information provided to locate the child, if the subject of the report is not a minor, or if the subject of the report is not yet born, among other possibilities (Yuan, 2005).

by large child welfare foundations such as Casey Family Programs (Casey, 2012). Despite wide embrace of the model, however, evaluators have measured outcomes in disparate ways and some scholars have challenged the robustness and generalizability of evaluation findings. As a result, DR is not yet considered an evidence-based intervention by the California Evidence-Based Clearinghouse for Child Welfare, which classifies child welfare programs based on the strength of existing evidence for their effectiveness (CEBC, 2019).

This report offers a systematic review of the existing literature on DR's effectiveness with a focus on the most rigorous published studies and public reports. It describes the magnitude of child maltreatment as a social problem in the U.S.; explains the development of the DR model, including the problems it was proposed to remedy; identifies DR's core components as a "promising practice"[2]; places the reform in the context of child welfare policy change over time; and examines evidence for key outcomes of concern to stakeholders, including DR's impact on child safety and its cost-effectiveness. In particular, the report attempts to account for the wide variation in safety findings through an examination of differences in DR implementation and outcome measurement in various jurisdictions. The final section offers recommendations to strengthen DR policy, practice, and research based on the findings reviewed. The DR approach has reduced maltreatment recidivism and improved child protection practice in a number of jurisdictions, but some have seen more success than others based on unique implementation decisions and resource availability. Furthermore, a more consistent approach to measurement of outcomes in state and county DR systems is warranted in order

[2] The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rates child welfare interventions on a scale of 1-5 based on the strength of published, peer-reviewed research. A score of 1 indicates that an intervention is "Well-Supported by Research Evidence," and a score of 5 indicates that a program is a "Concerning Practice." The Differential Response approach is currently rated 3 on the CEBC scale, suggesting that more research is needed to designate it as an evidence-based model.

to establish a stronger national consensus on its efficacy and to guide states considering future implementation.

Chapter 2: Background on Differential Response

RATIONALE FOR REFORM

Child maltreatment, both reported and unreported, persists as a grave social problem in the United States. According to the Children's Bureau, in Federal Fiscal Year (FFY) 2017, state Child Protective Services agencies received intake calls concerning 7.5 million children. Of these, 3.5 million children received a CPS investigation or intervention beyond the hotline call – amounting to almost five percent of the youth population (Children's Bureau, 2017). Three-quarters of the confirmed victims of maltreatment suffered neglect, about one-fifth were physically abused, nine percent experienced sexual abuse, and seven percent were victims of "other" maltreatment as coded by states.[3] States reported a total of 1,688 abuse/neglect-related child fatalities that year to the National Child Abuse and Neglect Data System (NCANDS) (Children's Bureau, 2017). In addition to the severe human toll, child maltreatment incurs social and economic costs to society at large. A study by Fang et al. (2012) estimated up to $200,000 in lifetime individual and societal losses per victim. In the state of Texas alone, a total of $55 billion in lifetime costs was estimated for the 63,000 confirmed victims of maltreatment in 2017 (TexProtects, 2019).

Research suggests that the official CPS statistics do not capture the full scope of child maltreatment, much of which goes unreported. Since 1974, the U.S. Department of Health and Human Services has periodically conducted a National Incidence Study of Child Abuse and Neglect ("NIS") to estimate the prevalence of maltreatment based on survey responses. The first three rounds found "significant under-detection of maltreatment known to professionals" (Trocmé, 2008, p. 20), and the most recent iteration corroborated this trend, finding that although physical and sexual abuse rates had declined overall, CPS

[3] About 15 percent of victims suffered some combination of the above, so the sum of the percentages exceeds 100.

investigated only between 30-40% of children who likely experienced harm or endangerment based on NIS survey results (U.S. DHHS, ACF, 2010).

Many of the four million children who were reported but did *not* receive a response from CPS in FFY 2017 may nevertheless have had ongoing service needs or safety risks (Berrick, 2018). Child welfare agencies typically funnel their limited resources to cases that meet state statutory criteria for maltreatment. Some scholars have argued that CPS agencies in the United States are therefore narrowly centered on "child protection" from harm, rather than the promotion of holistic "child wellbeing" or "welfare," the paradigm around which some European countries have built their family safety nets (Berrick, 2018; Connolly, 2005; Ji & Sullivan, 2015; Schene, 1998).

Funding for child welfare in the U.S. has historically focused on those in most serious crisis to the detriment of upstream prevention efforts which could, according to some scholars, obviate those crises. Dr. Mark E. Courtney reports that in 1995, even prior to steep welfare cuts in the U.S., the federal government spent 11 times more on foster care than it did on income maintenance, such as the former Aid to Families with Dependent Children (AFDC) program, which could have supported impoverished families and potentially prevented some of the need for substitute care (Courtney, 1998; Roberts, 2002). It is well-established that poverty, although certainly not a necessary nor sufficient condition for child maltreatment, is a strong statistical predictor. The third NIS found that "the incidence of abuse and neglect is approximately 22 times higher among families with incomes below $15,000 per year than among families with incomes of more than $30,000 per year" (Courtney, 1998, p. 95; Sedlak & Broadhurst, 1996). Poverty can exacerbate

other risk factors and stressors and may also make it more likely that families will come into contact with mandated reporters such as social service providers[4] (Roberts, 2002).

However, many families who are investigated for poverty-related neglect, even some for whom maltreatment is substantiated, do not receive ongoing services that may prevent recurrence of similar reports. Multiple studies have found that up to 60 percent of such families "receive no subsequent services" and therefore remain at risk despite CPS intervention (English, 1998, p. 49; Yuan, 2005). A recent study of infants in California found that over 50 percent of those reported for maltreatment before age one were re-reported before age five (Berrick, 2018; Eastman, 2016). With respect to neglect in particular, at least one study has revealed that "children in families with allegations of neglect in their first report of child maltreatment are 30% more likely to experience a second report of confirmed child maltreatment than are children who are physically abused" because neglect often indicates an ongoing deficit in some resource (Ortiz et al., 2008, p. 60). This finding further supports the claim that many cases involving basic needs neglect, rather than physical abuse, are closed without corresponding services provided, increasing the risk of re-reports.

As the number of child welfare hotline calls grew in the late 1980s and early 1990s against a backdrop of substance use epidemics and fiscal austerity, many states began to rethink how they should best assess, prioritize, and respond to the large volume of intakes (Altstein & McRoy, 2000). In the early 1990s, a task force comprised of child welfare scholars, known as the Harvard Executive Session, convened to discuss possible policy reforms and recommendations for states to improve their CPS systems (Abner & Gordon, 2012; Waldfogel, 1998). The group identified five key issues, described below, that

[4] In some states, including Texas, all adults – regardless of profession – are mandated reporters of child abuse/neglect by law (Texas Family Code, 261.101).

informed the direction of future child welfare policy and provided the impetus for the spread of the Differential Response approach (Waldfogel, 1998, 2008):

Figure 1: Summary of Harvard Executive Session Findings, 1994-1997 (adapted from Waldfogel, 1998, pp. 107-109)

1. Overinclusion: CPS sometimes intrudes into the lives of families who arguably do not warrant an investigation. This includes disproportionate intervention into families of color, those in poverty, and those reported due to neighborhood or custody disputes (Dettlaff, et al., 2011). Meanwhile, some needy families are reported to CPS by concerned community members due to the perception "that families stand a better chance of getting services such as child care or therapy if they are identified as CPS cases" (Waldfogel, 1998, p. 107).

2. Underinclusion: Many children at risk of maltreatment fall through the cracks of CPS, either because they are not reported, they are screened out at the time of intake due to perceived low risk, or they are seen once for an investigation but have their cases closed without receiving the resources needed to prevent repeat maltreatment.

3. Capacity: The high volume of intakes at state CPS systems means that some investigations are done cursorily and many families do not receive the ongoing services and caseworker contact that might benefit them.

4. Service Orientation: Services tend to be oriented towards either child safety (in the form of removal) or family preservation (intensive in-home supports for those at risk for removal) rather than a more varied service array to meet the distinct needs of individual families who may not be at risk for removal.

5. Service Delivery: In many communities, services are unavailable, fragmented, or not accessible in the languages or cultural contexts that families need.

Primarily in response to the first two concerns, overinclusion and underinclusion, many state child welfare systems followed the leads of Florida and Missouri, which implemented the first DR pilot programs in 1993 and 1994 and laid the foundation for other states (Waldfogel, 1998). It may seem paradoxical that DR was designed to address both over- *and* underinclusion. However, Waldfogel and other scholars have described the goal of the DR approach as "narrowing-*plus*," to underscore the aim of narrowing the scope of

families who are met with a formal investigation while simultaneously broadening the range of clients who receive any services at all in response to a report (Waldfogel, 2008).

The goal is indeed to "differentiate" or tailor the CPS response based on the particular circumstances of each case. At its core, DR is a CPS approach in which screened-in reports are not met universally with a fact-finding investigation to confirm maltreatment and determine a perpetrator and victim, which was traditionally the case. Some families continue to receive this traditional response, but other families, typically those deemed lower-risk, are approached in an intentionally different manner. The core components that characterize the DR approach, and in particular the AR track, are discussed below.

CORE COMPONENTS OF DIFFERENTIAL RESPONSE

The Differential Response approach is implemented somewhat differently in each state (and often county) that has embraced it, and it is called by a variety of names ("Family Assessment Response" in Minnesota, "Multiple Response System" in North Carolina, and "Family Development Response" in some Canadian provinces, for example). However, a group of researchers working on behalf of the Child Welfare League of America and the American Humane Association proposed a set of criteria by which to judge a program's fidelity to the core components of Differential Response (Merkel-Holguin, Kaplan, & Kwak, 2006). The key criteria that allow a system to fall under the "DR umbrella" for evaluation and research purposes are summarized below, based on their review (pp. 10-11):

- There are two or more distinct CPS interventions for maltreatment reports that are screened in, and the use of multiple tracks is officially prescribed in statute or policy.

- The reports are assigned to their respective tracks based on level of risk, with the alternative track typically characterized by circumstances of low or moderate risk. The risk threshold is determined by state statute and/or agency policy.
- Cases can be re-assigned to a different track based on the discovery of additional evidence of maltreatment or risk after the initial track assignment.
- Families on the AR track can decline services after the assessment with no consequences.
- There is no formal substantiation or finding of maltreatment on the AR track, no perpetrators/victims are formally identified, and no names are entered into a state's Central Registry for Child Abuse and Neglect.

Other features of many, though not all, DR systems include the following:

- An AR caseworker's initial visit is not unannounced, as in traditional investigations. Instead, the caseworker will call the family ahead of time and schedule a visit based on the family's availability.
- On the AR track, children are not interviewed out of the presence of their caregivers as is traditional in an investigation – rather, there is a joint family interview involving all parties.[5]

[5] Two of the earliest DR implementers, Missouri and Minnesota, currently approach this differently: Missouri policy states that "Children should be interviewed alone whenever possible when conducting a family assessment…[but] [t]he private interview with the child does not preclude him/her from the family interview session" (Missouri Child Welfare Manual, Intake, 2017, p. 1). Meanwhile, Minnesota leaves the choice up to the caseworker and his/her supervisor: "The decision as to how to first contact a child requires critical thinking and analysis of a specific child's and family's context….The decision…is best made in consultation with a multi-disciplinary team…" (Minnesota's Best Practices for Family Assessment and Family Investigation, 2016, p. 5).

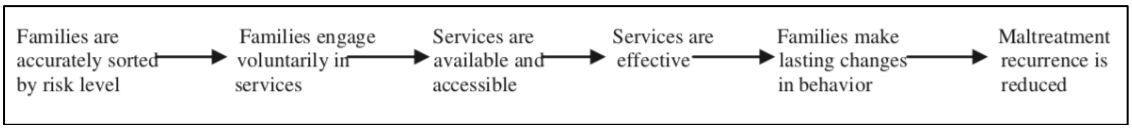
- Families on the AR track have greater access to funds for basic needs/concrete services than their TR counterparts.
- There are separate caseworker units for AR and investigative response.
- The public agency refers families to, or officially contracts with, community-based organizations to provide services to AR families.

The wide variation in DR implementation across states and counties will be further explored in Chapter 5, with a discussion of the challenges this variation poses for a conclusive evaluation of DR's impact on child safety compared to systems with a single investigative response. Even when certain components are officially mandated by state or county policy, contextual constraints and competing demands often preclude caseworkers from adhering to them, affecting fidelity to the DR model and jeopardizing the validity and generalizability of research findings.

LOGIC MODEL

Based on the above criteria and prior research, scholar Kathryn Piper developed a logic model showing the sequence of steps that would drive the theory of change on the AR track in a successful DR system (Piper, 2017).

Figure 2: Differential Response Logic Model. Reprinted with permission from "Differential response in child protection: How much is too much?" by Kathryn Piper, 2017, *Children and Youth Services Review*, Vol. 82, 69-80, p. 70.



Other researchers have described the model slightly differently. Gary Siegel, who co-led evaluations of DR in Minnesota, Missouri, Nevada, Maryland, and Ohio as part of the Institute of Applied Research (IAR), focuses on two key inputs – caseworker approach and basic needs assistance, especially for families in poverty facing reports of neglect (Siegel, 2012):

> a) The unique caseworker approach under DR consists of "approaching a family from the start as a unit and in a respectful, supportive, friendly and non-forensic manner consistent with sound family-centered practice, focusing broadly on strengths and needs, and involving family members in decisions about what to do" (Siegel, 2012, p. 18). The assumption is that this will lead to voluntary family engagement in services and will, in turn, lead to more sustainable change than the mandated services that may accompany a traditional investigation.[6] The Washington, D.C. Differential Response Program Guide asserts the rationale that "…less severe allegations usually indicate a struggling family who will benefit more from a helping hand than a pointing finger" (CFSA of Washington D.C., n.d., p. 1).
>
> b) Offers of basic needs assistance (help with rent and utilities, food, and transportation, for instance) are more common in DR systems, especially on the AR track, and differ from services traditionally offered after investigations, which tend to focus on addressing family interpersonal dynamics and individual needs, such as

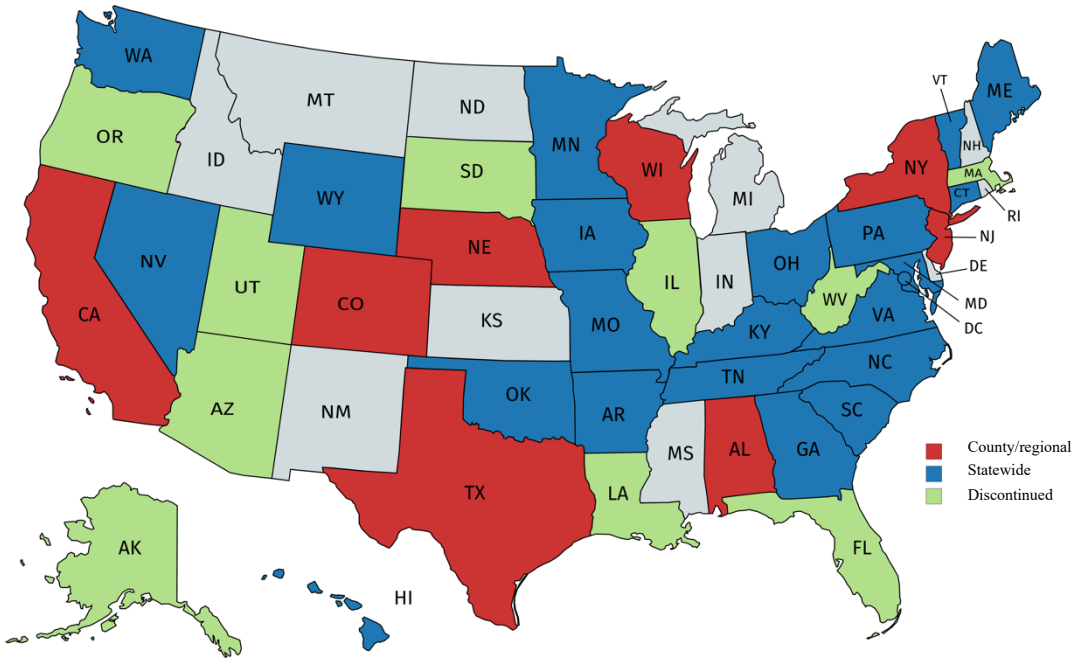
[6] At least one qualitative study offers evidence to the contrary, finding that families referred to services through DR show significantly lower engagement (as rated by caseworkers) than self-referred and even mandated clients. The authors suggest that the DR service process may be better understood as a quasi-voluntary or even non-voluntary one in practice, based on these results (Navarro, 2014). Chapter 6 offers further exploration of qualitative findings on caregiver perceptions.

parenting skills, substance use treatment, counseling, therapy, etc.

Scope of Implementation

As of 2019, the majority of U.S. states implement DR to some degree, whether statewide or on a county or regional level. Texas, for example, has rolled out the approach on a regional basis since 2014 and aims to achieve statewide implementation after Houston is incorporated in 2019 (Martin, 2019; Texas DFPS, Alternative Response Resource Guide, 2018).

Figure 3: State Implementation of Differential Response as of June 2019



(See Appendix A for more information and individual state sources. Map created using mapchart.net)

As shown in Figure 3, 21 states (and Washington, D.C.) implement DR statewide, eight have optional county or regional-level programs, and 10 states have discontinued DR programs after previously implementing them. Eleven other states do not have formal DR programs or policies available for review, but many are considering implementation. Florida, which was the DR pioneer in 1993 with a specific mission to develop closer ties with community-based organizations and eliminate use of the Central Registry for employment screening, has since privatized its child welfare system in a way that no longer accommodates Differential Response (Casey, 2012; Waldfogel, 2008). A review by Casey Family Programs notes that "child safety concerns caused a judicial group to recommend that Florida return to the use of a protective investigation for all reports" (Casey, 2012, p. 12). Massachusetts experienced a similar situation in 2015 after several child fatalities occurred in families who had originally been assigned to the AR track (Scharfenberg, 2015). However, many DR leaders in the Bay State felt that the program should have been "improved rather than eliminated" and could have been successful with greater investment and support from state leadership (Scharfenberg, 2015, p. 1). Oregon recently eliminated its DR program through Senate Bill 942 after agency leaders determined that the state did not have the staff capacity to implement the AR track with sufficient fidelity while also serving families with thorough investigations (Blackburn, 2019; Geiser, 2017). Appendix A contains more information on each state's DR implementation status.

Chapter 3: Placing Differential Response in Historical Context

The development of Differential Response is best understood and critiqued in the context of a history of policy reforms in child welfare that have sought to balance, and sometimes prioritize, the ostensibly conflicting aims of child safety and family preservation. Although the two goals are not mutually exclusive, and are sometimes described as a false dichotomy, they represent the two primary ideological foundations for many new child welfare policies. Some scholars have characterized the trajectory of child protection policy as a "pendulum" alternating in a reactive way between the two poles (Dumbrill, 2006a). It is important to assess DR in the context of this history because the interpretation of research findings can vary depending on the lens through which an author or evaluator views the aims of child protection.

THE PENDULUM OF CHILD SAFETY AND FAMILY PRESERVATION

The challenge of balancing child safety and family preservation has been called "the oldest debate in child welfare" (Berrick, 2018, p. 55; Schene, 1998). One of the earliest foster care proponents, Charles Loring Brace, developed the Children's Aid Society in 1853, infamous for sending over 150,000 poor youth from the urban East Coast to farming homes in the Midwest, where he felt they would receive a more "virtuous" upbringing. Public concern over the separation of these children from their home communities, often immigrant or religious minority enclaves, was a precursor to today's debates around the benefits and harms of transracial and transcultural foster and adoptive placements (Altstein & McRoy, 2000).

The modern child protection system in the United States, however, did not develop until after the animal welfare movement. A high-profile child abuse incident spurred the creation of the New York Society for the Prevention of Cruelty to Children in 1874,

modeled after the American Society for the Prevention of Cruelty to Animals. Similar organizations began to grow in other states, bolstered by legislation defining and formally outlawing child abuse (Markel, 2009). As momentum on behalf of child safety grew, social reformers including Jane Addams and Mary Richmond touted the importance of preserving families when possible. In 1909, a convening of social policy leaders at the White House Conference on the Care of Dependent Children echoed this sentiment, promulgating the principle that "except in unusual circumstances, the home should not be broken up for reasons of poverty…" (Altstein & McRoy, 2000, p. 6).

Despite this early recognition of the need to support families, especially poor families, prior to the last resort of a child removal, the pendulum swung towards an increasing, and arguably excessive, use of out-of-home care (Roberts, 2002). For example, research in the 1960s disseminated the idea that abuse and neglect were the result of "intergenerational pathological problems" from which children could only escape by being permanently removed from their home environments early on (Altstein & McRoy, 2000, p. 6). The federal child welfare funding streams, primarily Titles IV-E and IV-B of the Social Security Act, also increasingly incentivized removal by offering states uncapped funds for foster care, with smaller, fixed amounts for family preservation and prevention services.

THE PENDULUM SWINGS: LEGISLATION 1974 – PRESENT

After the federal Child Abuse Prevention and Treatment Act (CAPTA) was passed in 1974, setting nationwide minimum definitions for abuse and neglect and establishing a system of mandated reporting, intake calls to county and state child welfare agencies increased, requiring more funding and investigative capacity. Between 1976 and 1993, abuse and neglect reports rose by 347%, and from 1987-1992, the number of children in

foster care rose by over 50% (Altstein & McRoy, 2000; Schene, 1998). Growing recognition of the prevalence and consequences of child maltreatment helped protect thousands of previously vulnerable children. However, the jump in investigations and removals led to worries of over-reporting and over-intervention in families' lives.

These concerns informed the development of the Adoption Assistance and Child Welfare Act (AACWA) of 1980. This law required that states make "reasonable efforts" to keep children with their families of origin when possible, and when infeasible, to keep children in the most "family-like" foster care setting that could meet their needs (Kawam, 2014). AACWA temporarily reduced the number of children in foster care, but the "reasonable efforts" clause was never well-defined and was thus subject to variations in state interpretation and enforcement.

In 1997, the Adoption and Safe Families Act (ASFA), signed by President Bill Clinton, sought to "reaffirm the focus on child safety," including putting pressure on states to terminate parental rights more quickly and find permanent homes for children who had been in foster care for long periods of time (Golden et al., 2009, p. 5). Although the law authorized increased funding for prevention and family preservation measures, it was viewed as reinforcing the "child safety" pole of the continuum at the expense of family reunification. Some caregivers did not feel they were fully informed about the new timelines and requirements for avoiding the termination of parental rights, and the law offered only vague language that states must make "diligent efforts" to restore parents' fitness to care for their children (Golden et al., 2009).

With its passage coming soon after federal welfare reform in 1996, which was widely viewed as putting poor families at greater risk, ASFA similarly concerned advocates for vulnerable families (Roberts, 2002). The 1996 law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), turned AFDC into Temporary

Assistance for Needy Families (TANF), a more restrictive block grant that required states to attach time limits and work requirements to public assistance receipt. According to some scholars, the reform sent "contradictory messages…[W]hile child welfare laws punish[ed] poor mothers for neglecting their children, welfare reform push[ed] these same mothers into paid employment without the supports needed to properly care for them" (Roberts, 2002, p. 196). The conclusions regarding PRWORA's effects on families' economic well-being (particularly those headed by single mothers) are mixed, however, with some scholars emphasizing that overall family income rose due to women's increased labor market participation (Daly & Burkhauser, 2009; Fang & Keane, 2004).

It was not until passage of the Family First Prevention Services Act, in February 2018, that significant federal funding was made available to states through Title IV-E of the Social Security Act for prevention and family strengthening services for youth at risk of being placed in substitute care. Previously, this funding stream only reimbursed states for services *after* removal (Texas DFPS Family First Act Summary, 2019). The Family First Act is in the early stages of implementation, so it remains to be seen how it will affect the child welfare landscape.

The development of federal child welfare policy in the 20th century can be understood as an ongoing attempt to set more uniform national standards and guidelines for child safety while also offering family preservation and prevention services on a more limited basis, including allowing for state experimentation. The Differential Response reform movement is a largely state-led innovation aimed at more carefully and intentionally balancing the two ideals based on the specific context and circumstances of each child maltreatment incident (Kyte et al., 2013). DR also aims to broaden the range of families who receive services to increase protective factors and prevent more intensive involvement with CPS.

Chapter 4: Methodology

GOAL OF THE REVIEW

The purpose of this review was to systematically examine and critique existing research on the impact of the Differential Response approach in United States child welfare systems in order to offer objective and informed policy, practice, and research recommendations. At least one systematic literature review has been conducted on DR in the recent past (Hughes et al., 2013). The current report seeks to expand on existing work and incorporate more recent studies, including randomized controlled trials that were not included in the prior review, and to synthesize outcome and process findings to a greater degree. After the 2013 review, some scholars called for "a more systematic and clear use of key informant data and presentation of the literature" on Differential Response due to limitations identified in the prior review (Fluke et al., 2013, p. 547; Winokur et al., 2015). Although the current review does not offer original key informant data, it attempts to contribute to the field by describing and analyzing the contemporary landscape of DR research in an objective and critical manner.

The key independent variable of interest was case assignment to either the Alternative Response (AR) or Traditional/Investigative Response (TR) track, and the primary outcome analyzed was child safety, measured by comparing rates of screened-in subsequent reports after an initial screened-in report ("index report") during a study's data collection period. A second outcome examined was cost, measured by initial costs (defined as the period from the index report to assessment closure or case closure if a formal service case was opened), follow-up costs (costs incurred after closure of the index case), and overall costs of AR cases compared to TR cases. In addition to safety and cost outcomes, additional process and implementation findings were examined to determine what factors

drive or mediate success in Differential Response systems. These included staffing structures and policies, funding availability and sources, the formality of relationships with community-based agencies, and family and caseworker reception of the approach.

SAFETY MEASURES USED IN CHILD WELFARE AND DR RESEARCH

A child welfare intervention's impact on safety outcomes can be measured in a variety of ways (Fuller et al., 2013, 2017). Safety can be examined at the child level, family level, or perpetrator level, and a follow-up period after the intervention must be chosen, commonly between 60 days to two years after the index report or after the assessment/investigation period. Some studies examine how scores change on validated family safety and risk assessments, such as the Structured Decision-Making (SDM™) tool (Loman & Siegel, 2004). Other studies examine the nature, rather than quantity, of subsequent reports to determine whether the seriousness of the allegations increases or decreases (Fuller et al., 2017).

As discussed above, one of the defining features of the Differential Response reform is that no official disposition is assigned to indicate whether a maltreatment report was substantiated or unsubstantiated. Although caseworkers complete a safety and risk assessment in AR cases, often the same as those used by investigators, they do not attempt to substantiate reports in AR cases. Therefore, evaluations of the approach typically use *re-reports* or recidivism rates as the safety outcome that can be compared between index cases that receive an AR assessment and those met with a traditional investigation. This method has been criticized by scholars as a poor measure of safety for a number of reasons. Some have argued that re-reports might simply reflect a "surveillance bias" – the possibility that a family in contact with community-based social services (which occurs more often with AR families) will have more exposure to mandated reporters as a result of service

engagement. At least one study (Ortiz et al., 2008) has indeed found a correlation between increased service receipt and higher re-reports for families on the AR track. A quasi-experimental study in Tompkins County, New York, also found strong evidence that the surveillance effect inflates AR re-reports during the assessment period before case closure, whereas other studies have found minimal impact of the surveillance effect (Piper, 2016; Piper, 2017). It is, however, an important bias to keep in mind and attempt to control for when operationalizing child safety as a reduction in re-reports.

Some scholars have noted that the federal government defines child maltreatment recurrence as a *substantiated* report following a previously substantiated report, so any alleged maltreatment that receives an AR will not count as part of a family's, or state's, full history of maltreatment because no finding is made or entered into the federal data system (Bartholet, 2015). Ortiz et al. (2008) concur that "[re-reports] may not fully capture a child's subjective experience of safety," but they and others explain that this measure is commonly used in DR research and has been used in the federal Child and Family Service Reviews (CFSRs) as an "indicator" or proxy for safety, if not a direct measure (Jones, 2013; Ortiz et al., 2008, p. 68). Loman, Filonow, and Siegel (2010a) caution that measuring child safety in terms of re-reports is a valid but "limited criterion of the success or failure" of an Alternative Response and that re-reports must be analyzed along with "other, more proximate changes" that the approach can produce, including an increase in services provided and a decrease in family fear of the agency (p. 135). Despite these limitations, studies of DR (including those by Loman and Siegel) almost universally use *re-reports at the family level* as the primary outcome measure to capture the approach's impact on child safety.

SYSTEMATIC REVIEW PROCESS AND CRITERIA FOR INCLUSION

Initial Review

This review employed a systematic search process to identify a sample of primary research studies examining Differential Response and its impact on child safety and agency cost. Using the search terms and databases below, a total of 43 original studies were identified for initial review (see Appendices B and C for further details):

Figure 4: Search Methods for Initial Review

- Search Terms:
    - "differential response" AND (child welfare OR child protection)
    - "alternative response" AND (child welfare OR child protection)
    - "family assessment response" AND (child welfare OR child protection)
    - "differential response" OR "alternative response" in title and "child" in text
- Databases and Journals:
    - Google Scholar, *Children and Youth Services Review, Child Maltreatment*
    - *Child Abuse and Neglect, Research on Social Work Practice, Journal of Social Work Research, Social Service Review*
    - ProQuest, including Dissertations & Theses
    - EBSCO Host searching: ERIC, Family Studies Abstracts, PsycARTICLES, PsycINFO, SocINDEX with Full Text
    - *JSTOR*
    - Cochrane Library, Campbell Collaboration
    - Citations in articles found through the above methods (snowball method)

Inclusion Criteria

A set of inclusion criteria was applied to the full sample of 43 studies to identify a smaller sample to serve as the main source of evidence for safety and cost measures. Studies were included in the final "Safety Sample" if they met all of the following criteria:

- Included quantitative analyses of child safety that examined re-reports as a function of path assignment (as documented in administrative data, rather

than surveys); included measures of cost-effectiveness; or included both safety and cost measures

- Were published no earlier than 1993 (when the first U.S. state implemented Differential Response)
- Studied a jurisdiction in the U.S.
- Used a sample size of at least 500 families for quantitative analysis
- Were published by a peer-reviewed journal, government agency, or university (including doctoral dissertations that met all other criteria)
- Used an experimental, quasi-experimental, or comparison-group design with rigorous statistical controls

When these six criteria were applied, 20 studies were identified for inclusion in the Safety Sample (see Appendix B). Most of the 23 excluded studies measured safety in a non-comparable manner or primarily yielded qualitative findings through analysis of survey data, interviews, or focus groups (see Appendix C). It is important to note that the 23 studies were not excluded because of deficiencies in rigor or research quality – most represented high-quality research on DR and produced important findings. Rather, the goal was to identify studies whose outcomes could be compared to one another based on similarities in methodology and the dependent variables examined.

Limited Author Diversity in the Safety Sample and in DR Research

Multiple studies by the same authors were included in the Safety Sample if the jurisdictions of focus were different or if the studies presented unique analyses with longer observation periods than prior studies. It is important to note that fully 30% of studies in the Safety Sample (6 of 20) involved evaluators Gary Siegel and L. Anthony Loman, who are members of the Institute of Applied Research ("IAR"). The IAR is "an independent

research and consulting organization" based in St. Louis, Missouri that provides research and technical assistance to states and non-profits on child welfare and other social policy issues (IAR Website, n.d., p. 1). Some critics have argued that Loman and Siegel engage in "advocacy research" dedicated to results that promote DR rather than objectively analyze it (Bartholet, 2015, p. 603). However, the IAR research uses more rigorous designs than most DR studies – four of the six IAR studies included in the Safety Sample used random assignment, accounting for half of the eight analyses in the sample that did. Additionally, two of the studies included in the Safety Sample, by Fluke et al. (2016 and 2018), examined the same six states and used the same administrative dataset to draw conclusions. However, they are discussed and presented in this study as separate analyses because the authors offer somewhat different findings in each iteration and the implications of both are worth considering independently.

Another key organization that sponsored three of the eight randomized studies is the National Quality Improvement Center on Differential Response (QIC-DR). Now based at the University of Colorado – Denver, the QIC-DR was created in 2008 with a grant from the federal Children's Bureau in order to select three sites to implement pilot DR programs and to evaluate them from inception (Illinois, Colorado, and six counties in Ohio). In the course of its efforts to implement and evaluate the programs, the QIC-DR collaborated with the IAR and other organizations, including the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect and Walter R. McDonald & Associates, Inc. (Fuller et al., 2017). The findings from the three QIC-DR sites are more mixed than those yielded by Loman and Siegel, and the evaluators differed for each study as well (Fuller et al., 2013; Murphy et al., 2013; Winokur et al., 2015). The credibility of DR research could benefit from increasing diversification of evaluators and sponsoring organizations, and it is important to consider the possibilities of author bias and publication bias that may result

from a lack of author diversity. However, findings should not be discounted based on a study's author, and experience with multiple studies may provide authors such as Loman and Siegel with a deeper understanding of the DR approach and the challenges involved in evaluating such a flexible and varied intervention.

Chapter 5: Results

SAFETY OUTCOMES – RE-REPORTS AND SUBSTANTIATION

One of the reasons that the Differential Response approach is not yet considered an evidence-based model by the California Evidence-Based Clearinghouse for Child Welfare is that evaluations have found inconsistent results with respect to its impact on child safety and maltreatment recidivism. For example, Lawrence et al. (2011) found in a study of North Carolina's DR system that the approach significantly reduced maltreatment recidivism: they estimated that without the new approach, "an additional 1149 children would have returned for a repeat assessment within 12 months of an earlier maltreatment assessment" and "6534 additional children ages 0-17 would have experienced a maltreatment substantiation in the nine [AR] counties between mid-2002 and the end of 2005"[7] (p. 2360). Researchers in Illinois, meanwhile, found that within 18 months of case closure, 18.8% of families on the AR track experienced at least one re-report, compared to 14.7% of TR families (a statistically significant difference). The likelihood of substantiation upon re-report was also *higher* for families initially receiving an AR (6.1% vs. 4.7% for TR).

However, the majority of studies examined in the sample (15 out of 20) found either that the AR track produces improvements in child safety or produces no statistically significant difference when AR cases are compared to investigated cases. In addition, qualitative analyses almost universally revealed positive, statistically significant increases

[7] In North Carolina's DR system, AR cases *do* receive "findings" such as "Services Needed" or "Services Recommended," which may be considered comparable to investigative dispositions (without the same negative consequences). Therefore, the prevention of 6534 substantiations is not simply a result of the definitional elimination of formal dispositions in the DR model, but rather indicates a real safety improvement for many children.

in caregiver reception to CPS intervention under the AR approach; the implications of these and other qualitative findings are discussed in Chapter 6.

The studies were grouped into the following four broad categories: those that found that DR systems improve child safety by reducing system re-involvement for those routed to an Alternative Response, those that found that DR compromises child safety by increasing re-reports for AR families compared to their counterparts receiving a traditional investigation, those that found no statistically significant or consistent differences in safety between AR and traditional cases, and those that found that re-reports depend on the *rate* of diversion to AR within a jurisdiction. Many of the studies measured safety in multiple ways, such as examining screened-in re-reports and then examining *substantiated* re-reports. Some yielded different results based on how safety was operationalized, so there are limitations to classifying each study according to a single safety finding. For example, studies of Oregon and Maryland found no differences on re-reports, but they did find that the DR approach made a significant difference for subsequent substantiation rates (Fuller et al., 2017; Shipe, 2017). In Figure 5, the studies are grouped using re-reports as the key safety indicator, and those that used random assignment and a true experimental design are italicized for reference.

Figure 6 offers a brief statement of each study's findings on both re-reports and substantiation upon re-report, but re-reports are the outcome of focus in this study because substantiation is not an equally likely outcome for families within and across jurisdictions, so it is less useful to compare. There are policy reasons – exogenous to the effectiveness of the AR intervention – that some families may be more likely than others to have a substantiated re-report after an Alternative Response. For example, some states, but not all, *require* that a family re-entering the CPS system after an AR receive an investigation rather than another AR, and some require that a family re-reported after an investigation receive

another investigation rather than being eligible for an AR. In such states, including New York (Ruppel et al., 2011), cases assigned to the control group were at higher risk for substantiation upon re-report than cases in the treatment group simply because of eligibility policy rather than because of any real safety differences. In addition, this poses difficulties for comparisons across systems. A family in one jurisdiction may receive a disposition of "substantiated" upon re-report whereas a family with similar circumstances in another jurisdiction may receive a second AR instead, precluding a substantiation.[8] Therefore, substantiation offers another frame through which to view DR's impact on child safety, but the findings of each study with respect to substantiation cannot be generalized beyond the particular jurisdiction(s) of focus.

[8] For example, in Piper's 2016 study, the author describes state differences in the proportion of AR cases that get re-assigned for an AR (and are thus ineligible for substantiation upon recurrence): "[i]n Vermont, 36.71% of the 2010 AR index cases that were re-reported were reassigned to the AR track. In Tennessee, 69.61%, and in Louisiana, 35.92% of the re-reported AR cases were re-assigned to the AR. This makes the comparisons of the AR group to the control groups on [substantiation] outcome measures meaningless. Thus, the only reliable outcome available for comparison purposes is the re-reporting variable" (p. 91).

Figure 5: Safety Sample Studies by Safety Trend (Reduction in Re-Reports)

DR Increases Safety	**DR Decreases Safety**	**No Significant Difference, or DR Does Not Compromise Safety**	**Safety Depends on Rate of Diversion in a DR System**
Fluke et al., 2016 *Loman & Siegel, 2015* (Follow-up to original Ohio study) *Loman & Siegel, 2012* (Follow-up to original Minnesota study) Lawrence et al., 2011 (North Carolina) *Loman, Filonow, & Siegel, 2010a* (Ohio) Loman, Filonow, & Siegel, 2010b (Nevada) Ortiz et al., 2008 *Loman & Siegel, 2004* (Minnesota)	*Fuller et al., 2013* (Illinois) Jones, 2013 (Minnesota)	Shipe, 2017 (Maryland) Fuller et al., 2017 (Oregon) *Winokur et al., 2015* (Colorado) *Murphy et al., 2013* (Ohio) *Ruppel et al., 2011* (New York State) Shusterman et al., 2005 Loman & Siegel, 1997 (Missouri)	Fluke et al., 2018 Piper, 2017 Piper, 2016

Figure 6: Key Findings by Study (Re-Reports and Substantiated Re-Reports)

Study	Findings
Fluke et al., 2018	• Each 1% increase in county AR utilization rates was associated with a 3% decrease in *overall* re-reports, but with a 1% increase in re-reports among families on the AR track. • No findings on substantiation upon re-report.
Piper, 2017	• In states with AR diversion rates exceeding 33%, families on the AR track were re-reported at higher rates than those who received an investigation. The opposite was true below 33%. • No findings on substantiation upon re-report.
Shipe, 2017 (MD)	• Track assignment (AR/TR) did not significantly predict re-reports. • Families who had an unsubstantiated TR were over twice (2.15 times) as likely to have a substantiated re-report as were families who initially received an AR.
Fuller et al., 2017 (OR)	• Track assignment (AR vs. AR-matched investigated families in non-DR counties) did not significantly predict re-reports (15.5% vs. 15.4%). • AR families had lower rates of substantiated re-reports than matched families in non-DR districts (3.4% vs. 4.7%).
Fluke et al., 2016	• There were 18% fewer re-reports in counties with AR utilization rates above the median compared to those below the median. • There were 37% fewer substantiated re-reports in counties with AR rates above the median compared to those below.
Piper, 2016 (LA, VT, TN)	• In the state with the lowest diversion rate of the three examined, AR cases were 25% less likely than TR cases to be re-reported. In the state with the highest diversion rate, AR cases were 44% more likely to be re-reported than TR cases. In the state with the median diversion rate, AR cases were 33% more likely to be re-reported than TR cases. • No findings on substantiation upon re-report (see Footnote 8 on p. 27 of this report).
Loman & Siegel, 2015 (OH)	• AR families were less likely to be re-reported than control families (48.3% vs. 49.5%), which was a modest but statistically significant reduction in recidivism. Past CPS history was found to be a stronger predictor than DR track; 59% of families with at least one past report were re-reported compared to 39% of families with no prior CPS history. • No findings on substantiation upon re-report.
Winokur et al., 2015 (CO)	• Track assignment did not significantly predict re-reports or substantiation upon re-report (44% vs. 45% for AR and TR respectively). Past CPS history did significantly predict recidivism. • Survival analysis revealed that AR families were 18% less likely than TR families, over time, to have a high-risk re-report rather than a low-risk re-report.

Figure 6 cont.

Study	Findings
Fuller et al., 2013 (IL)	• AR-assigned families were significantly more likely to experience at least one re-report in the 18 months following case closure: 18.8% for AR compared to 14.7% for TR-assigned families. • AR-assigned families were significantly more likely than TR families to have a substantiated re-report within 18 months of case closure: 6.1% vs. 4.7%.
Jones, 2013 (MN)	• For six of the seven years examined, AR families were re-reported at higher rates than TR families. The difference diminished over time. • No findings on substantiation upon re-report.
Murphy et al., 2013 (OH)	• Track assignment (AR/TR) did not significantly predict re-reports (37% compared to 36% for AR and TR respectively). • No findings on substantiation upon re-report.
Loman & Siegel, 2012 (MN)	• Track assignment significantly predicted re-reports (with a lower likelihood on the AR track) only for families with no prior CPS history. Survival analysis revealed that within the AR group, receipt of material services predicted a lower likelihood of re-report. • No findings on substantiation upon re-report.
Lawrence et al., 2011 (NC)	• DR counties saw significantly fewer repeat assessments over time than control counties. • No findings on substantiation *specifically upon re-report*, but the authors did see fewer substantiations overall in DR counties compared to non-DR counties (see Footnote 7 on p. 25 of this report).
Ruppel et al., 2011 (NY, Onondaga County)	• Track assignment (AR/TR) did not significantly predict re-reports by six months after case closure (26.4% for AR compared to 27.3% for TR). • AR cases were less likely to see a substantiated re-report than TR cases (4.1% compared to 7.5% - but eligibility policy affected this.)
Loman, Filonow, & Siegel, 2010a (OH)	• AR families were significantly less likely to be re-reported than TR families (11.2% compared to 13.3%). Survival analysis revealed that both track assignment and prior CPS history significantly predicted re-reports. • No findings on substantiation upon re-report.
Loman, Filonow, & Siegel, 2010b (NV)	• AR families were significantly less likely to be re-reported than TR families (25.6% vs. 31.9%). A survival analysis controlling for follow-up period length and past report history confirmed the significance of this finding. • No findings on substantiation upon re-report.
Ortiz et al., 2008	• TR families were 9% more likely to be re-reported than AR families. • No findings on substantiation upon re-report.

Figure 6 cont.

Study	Findings
Shusterman et al., 2005	• Track assignment (AR/TR) did not significantly predict re-reports in five of the six states examined. Only Oklahoma showed fewer re-reports on the AR track within six months of intake. • State findings differed, but all six states showed lower rates of substantiation upon re-report for cases originally assigned to AR compared to TR. (KY: 3% vs. 5%; MN: <1% vs. 4%; MO: 1% vs. 5%; NJ: 3% vs. 4%; OK: 2% vs. 5%; WY: 2% vs. 5%).[9]
Loman & Siegel, 2004 (MN)	• Families on the AR track had significantly fewer re-reports over two years than investigated families (27.2% compared to 30.3%). When analyzed using a survival analysis, this difference was only significant among families with no prior reports. • Substantiation upon re-report was found to be lower for AR families than TR families, but the difference was not statistically significant.
Loman & Siegel, 1997 (MO)	• Recidivism increased in both DR counties and non-DR counties after implementation, but the increase was smaller in DR counties. DR counties performed significantly better than control counties in reducing re-reports in specific categories – basic needs neglect, educational neglect, and inadequate supervision. Families with three or more children also saw fewer re-reports under the DR system. • No findings on substantiation upon re-report.

SAFETY OUTCOMES – CHILD REMOVALS

Child removals are a third possible safety outcome of interest in addition to re-reports and substantiation upon re-report. However, because the families eligible for the AR track (or in the case of the randomized controlled trials, *all* sample families) were low-risk, the vast majority were never at risk for removal, so examining this outcome does not reveal much. Just 13 of the 20 studies examined removals or outcomes related to removals (such as the filing of family court petitions). Five studies found no significant differences in the rate of child removals, with both the AR and investigative tracks having very low removal rates, typically between 2-5%, with the exception of Missouri, in which 14-15%

[9] Shusterman et al. (2005) did not report these percentages directly. They were derived from the data presented on pp. 26, 32, 39, 45, 52, and 58 of that study (Figures A-2, B-2, C-2, D-2, E-2, and F-2, respectively).

of families in both DR counties and non-DR counties experienced removals (Fuller et al., 2013; Fuller et al., 2017; Loman & Siegel, 1997; Murphy et al., 2013; Winokur et al., 2015). Again, with the exception of Missouri, these studies were either randomized controlled trials or quasi-experimental studies with matched focal families, so the groups were equivalent and the findings therefore credible in terms of measuring DR's true impact on child removals into foster care. Seven studies found that families on the AR track experienced significantly fewer child removals than investigated families (Jones, 2013; Loman, Filonow, & Siegel, 2010a, 2010b; Loman & Siegel, 2004, 2012, 2015; Shusterman, 2005). However, two of these studies compared groups with different initial risk profiles (Jones, 2013; Shusterman, 2005), as they did not use randomized or quasi-experimental group designs, so their findings are less telling. In other words, in an uncontrolled setting, it is not surprising that investigated families would experience more removals than AR families, given that they were investigated precisely because they were determined to be at higher risk upon intake. The final study did not examine removals but instead family court petitions, and it found that families randomized to the AR track experienced significantly fewer petitions than their investigated counterparts – almost half as many (Ruppel et al., 2011). Less family court involvement likely led to fewer removals in the long run.

ACCOUNTING FOR THE VARIATION IN SAFETY FINDINGS

It is difficult to generalize findings from any one of the DR studies to a judgment of the approach as a whole because of differences in the DR model across jurisdictions, the number and size of jurisdictions examined in each study, the design and rigor of study methodology, including sample size and equivalence of groups compared, and the length of the observation period, among other factors. These issues are addressed below with a

discussion of how these factors may drive child safety findings in the positive or negative direction, which may be useful for jurisdictions considering implementation or modification of their existing programs. Specific studies and their jurisdictions of focus are highlighted in each section to illustrate these variables.

Differences in the DR Model

The reauthorization of the federal CAPTA legislation in 2010 formally endorsed DR as "an eligible use of basic state grant funds for improving child protective services" and acknowledged flexibility in DR implementation as a "state or community-determined formal response that assesses the needs of the child or family without requiring a determination of risk or occurrence of maltreatment" (Fluke et al., 2016, p. 2). As such, DR is implemented differently by each jurisdiction depending on local CPS practices, culture, politics, and connections to community-based agencies. It is therefore more accurately called an "approach," "philosophy," or "orientation" rather than a formal "model" (Fuller et al., 2017; Shipe, 2017).

Targeting the AR Track: Who Gets an Alternative Response?

Differences in Diversion Rates, Risk Thresholds, and Criteria

One of the most striking, easily-compared differences in DR practice across jurisdictions is the proportion of cases diverted from traditional investigations to an Alternative Response (AR). Almost every state examined in the Safety Sample[10] reserves

[10] States covered by at least one study in the Safety Sample are the following: Colorado, Illinois, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Vermont, Virginia, Washington, and Wyoming. Data from additional states (e.g. Indiana and Wisconsin) are examined in control groups but not as treatment cases.

AR for lower-risk (or sometimes "moderate risk") cases, but each state defines this threshold in its own way.

Some states, such as Minnesota, have explicitly written in state statute that the AR track is the "preferred response" or the default track for screened-in cases *unless* certain exclusionary criteria are met, such as reports of "egregious harm; sexual abuse; [and] abandonment," among others (Hudson, 2016; Jones, 2013, p. 53). By 2004, the year of Minnesota's first DR evaluation, the state was routing half of reports to AR, and in 2006, the state renamed the approach "Family Assessment Response" to avoid the connotation of a secondary "alternative" (Jones, 2013; Loman & Siegel, 2004). Minnesota is considered one of the DR leaders among states – its administrators and agency leadership frequently travel to other states to offer consulting and technical assistance regarding DR implementation (Loman, Filonow, & Siegel, 2010a).

By 2008, seven years after initial implementation, Minnesota was routing 64% of screened-in cases to the AR track (Jones, 2013; Piper, 2017). Notably, each of the 20 counties involved in the 2004 Minnesota evaluation was afforded great discretion regarding screening decisions, and percentages on a county level ranged from 21.3% of all cases to 61.4% that year (Loman & Siegel, 2004). The county with the lowest proportion had decided to delay track assignment until after a family's first caseworker visit, which represents a departure from standard DR practice and offers an example of conservative modifications to the approach (Loman & Siegel, 2004). In a seven-year examination of administrative data from the state by Jones (2013), the author found that for six out of the seven years (2004-2009), AR ("FA") families had higher re-report rates than their TR ("TI") counterparts (Figure 7):

Figure 7: Frequency and Percentage of Cases Re-reported for Child Maltreatment within 12 Months of Case Closing. Reprinted with permission from "From Investigating to Engaging Families: Examining the Impact and Implementation of Family Assessment Response on Racial Equity in Child Welfare," by Annette Semanchin Jones, 2013, Dissertation submitted to the University of Minnesota, p. 125.

Year	FA Re-reported	All FA	% of FA Re-reported	TI Re-reported	All TI	% of TI Re-reported	Total Cases Re-reported	Screened in Cases Not Re-reported	Total % of Cases Re-reported
2003	851	4829	17.6	2239	12543	17.9	3090	14282	17.8
2004	1315	5451	24.1	1141	8801	13.0	2401	12655	16.8
2005	1400	7006	20.0	923	8105	11.4	2456	13096	16.3
2006	1374	8744	15.7	648	6675	9.7	2323	13772	15.1
2007	1277	10166	12.6	535	5628	9.5	2022	12649	12.8
2008	1277	9796	13.0	535	4665	11.5	1812	12649	12.5
2009	1297	10614	12.2	486	4443	10.9	1783	13274	11.8

Jones' findings diverge from those of Loman and Siegel's Minnesota evaluation (2004), which had found a positive, significant difference for AR families – they were three percent less likely to be re-reported during the observation period than their randomized TR counterparts. Jones notes that her "study reflects on outcome data and implementation factors *after* the initial phase of implementation…at the final three stages, including full operation, innovation, and sustainability" as opposed to the prior evaluation, which had examined Minnesota's *pilot* period (p. 233). There are several reasons why a DR system might yield its most positive results during a pilot period, including large start-up grant funds that are not sustained over time. In particular, Minnesota received significant grant funding earmarked specifically for AR families during its pilot period.

In addition, New York's Office of Child and Family Services (OCFS) required local agencies newly implementing DR to divert at least 30-40% of their cases to the AR track. This was done to ensure that the program was serving enough families to be cost-effective and because OCFS felt that the "agency culture and practice shift" intended with the DR approach could only occur if a critical mass of staff gained experience with AR cases (Ruppel et al., 2011, p. 16).

In contrast, other states have taken a more risk-averse approach and have designated AR for use with a minority of cases that meet specific inclusion criteria. Illinois, one of the three QIC-DR sites, routed just eight percent of cases to AR during its brief experiment with the approach from 2010-2012 (Fuller et al., 2013). This low proportion resulted from the most stringent inclusion criteria of any of the states in the Safety Sample: families in Illinois could not receive AR if they had any previous substantiated maltreatment reports, and only specific allegations were eligible, including "inadequate food, inadequate shelter, inadequate clothing, medical neglect, [and] environmental neglect…" Cases involving youth under nine years and any youth with disabilities required an investigation if the allegation was for "inadequate supervision" (Fuller et al., 2013, p. 28).

Child age is an important consideration in the development of DR policy, as research has established that infants and young children are most at risk for serious injuries and fatalities among all victims of child abuse and neglect, comprising up to 80% of such fatalities in some studies (Texas DFPS Office of Child Safety FY 2018 Report, 2019; World Health Organization, 2002). Nevada and Texas exclude children younger than six years from the AR track by statute, and Virginia does by policy (Godsoe, 2012; Loman, Filonow, & Siegel, 2010b; Texas Administrative Code §700.553; Texas CPS Handbook, 2019). However, certain counties in California, such as Alameda, deliberately

route children zero to five years and those with a pregnant mother to their AR tracks with a goal of prevention and early family intervention (Conley & Berrick, 2010).[11]

With respect to maltreatment type, the majority of states covered in the Safety Sample prioritized neglect cases for AR with some allowance for cases involving risk of non-severe physical injury. Every state examined, with the exception of New Jersey, routed almost no cases involving sexual abuse to the AR track. New Jersey routed 15.8% of sexual abuse cases to the AR track in 2002 (Shusterman et al., 2005). It is unclear whether the state still allows such cases to receive an alternative response.

The implications of disparate AR diversion rates on child safety are explored most fully in recent cross-jurisdictional studies by Piper (2016, 2017) and Fluke et al. (2016, 2018). Piper's analysis of 13 states, using administrative data from 2000-2012, found that those that routed 33% or more of their screened-in reports to AR experienced higher re-reports for AR than the investigative track, and only states that kept their diversion rates below that threshold saw comparative reductions in recidivism among AR cases (2017). It is important to note that in studies like Piper's, which did not use random assignment but rather undertook a descriptive analysis of existing data, the AR group should be characterized by lower risk to begin with. The finding of higher re-reports on the AR track for the higher-utilization states (such as Tennessee and Missouri) therefore appears to corroborate Piper's hypothesis that AR is least likely to see high recidivism rates when targeted at a minority of lower-risk cases. Piper had previously found in an examination of three DR states (Louisiana, Tennessee, and Vermont) that the state with the lowest

[11] Despite its large population and national policy importance, California is not one of the states covered by the Safety Sample. Studies examining California were intentionally excluded from the final review of safety outcomes because the state's DR program diverges considerably from those of the other states included, and findings were therefore not sufficiently comparable. California serves cases that are screened *out* on one of its DR paths, which is not the case for the other states examined, where only screened-in cases are served.

percentage of cases consistently routed to AR and with the lowest percentage involving children ages zero to three, Louisiana, was the state with the lowest re-report rates for the AR track (Piper, 2016). In fact, a survival analysis found that AR cases were 25% less likely to be re-reported than TR cases in that state (Piper, 2016).

Fluke et al. (2018) analyzed county-level data from six states between 2004 and 2013 and found a "1% increase in rereports among AR [families] for every 1% increase in overall AR utilization" by a given county, again suggesting that as more families are routed to AR, recidivism for that group may increase and it is possible that this is because of increased risk in the AR group[12] (p. 133). Loman and Siegel found evidence of this in their Minnesota study, concluding that "more liberal interpretations of screening criteria result in higher proportions of families with child safety problems entering the AR caseload" (Loman & Siegel, 2004, p. viii). The authors do not, however, conclude that *entering* the AR track with safety problems means that the intervention cannot still produce better safety outcomes for those cases than the investigative approach and reduce recidivism upon exit. In fact, they argue the opposite: "workers in AR cases reported more improvements in child safety problems" by the end of their intervention than did investigative workers on the TR track (Loman & Siegel, 2004, p. viii).

[12] Notably, the study found that a one percent increase in AR use was associated with a three percent decrease in re-reports among *TR* families, which brought counties' overall re-report rates down. In electronic communication with Dr. John Fluke to clarify this result, he offered a number of plausible explanations for why higher AR utilization rates may result in safer outcomes for investigated families and for families overall. For example, it is possible that the investigated cases were "less likely to be re-reported because the remaining cases were clearly more in need of services and received effective interventions" or that "increased AR utilization reduce[d] the workload of [investigators] to a more manageable level allowing them to achieve better outcomes" (J. Fluke, Electronic Communication, June 17, 2019). The idea is that separating cases into AR and TR may allow for more targeted, intensive work to take place among the TR cases than may have been possible before, leading to more effective interventions and lower recidivism for investigated cases.

Prior CPS Involvement

A fairly consistent trend was found in the connection between CPS history and safety outcomes on the AR track. Specifically, a number of studies disaggregated analyses by the prior CPS involvement of their sample cases and found that the AR intervention made a positive, significant difference for the safety of children with *no prior reports* – an impact larger than for cases with one or more prior reports. For example, Loman and Siegel's study of Minnesota (2004) found that 48.5% of all families with CPS history (*regardless of track*) experienced a re-report during the two-year observation period, compared to 26.2% of families with no priors. When they analyzed these outcomes *by track*, they found that AR assignment made a significant difference in the survival rate for cases with no priors but made no difference in recidivism for those with previous reports.

Their follow-up study in 2012 corroborated this finding; the IAR researchers found that 36.2% of first-time AR families experienced a re-report in Minnesota from 1999-2010 compared to 39.5% of first-time TR families. Loman and Siegel also found in their second study of Ohio's DR system (2015) that the variable of "prior reports" was a stronger predictor of recidivism than track assignment to AR or TR, but both variables made a statistically significant difference. Jones' (2013) qualitative study of Minnesota caseworkers found that "most staff felt that [AR] was 'absolutely more effective' in keeping kids safe with 'first-time' families" (p. 192).

Nevertheless, some jurisdictions are committed to the view that it is worthwhile to "assign even tough, chronic[13] families to alternative response for the opportunity to try a new approach" if the investigative approach has not worked in the past (Loman, Filonow, & Siegel, 2010a, p. 30). In their examination of Ohio's DR system, which was modeled

[13] In social work, it is a best practice to describe families or individuals who recidivate as "frequently-encountered" rather than "chronic," which connotes pathology or disease.

after Minnesota's, Loman and Siegel found that the state did not often use prior history as a factor for path decision because of practical constraints, such as insufficient staff capacity to review such records and because of families' anonymity during the initial call (Loman, Filonow & Siegel, 2010a). Their results suggest that perhaps the state should have taken prior history into account, given the interaction they found between previous reports and the success of the AR intervention. The Ohio study by Murphy et al. (2013), however, found "no significant differences between AR and TR when examining re-reports in relation to prior history," suggesting that it is not always the case that first-time AR families have better safety outcomes than first-time TR families, even though a number of other studies found this to be true (p. 115). Murphy et al. (2013) examined fewer counties in Ohio than did Loman, Filonow, & Siegel (2010a), which may partly explain this discrepancy.

In 2014, the Minnesota legislature enshrined in statute an agency recommendation that prior CPS reports not count against a family, *or even be reviewed*, when making screening and track decisions, and it codified that "no information could be gathered from collateral contacts" when assigning a case to AR (Hudson, 2016, p. 15). At the other extreme, Illinois used the strictest eligibility criteria of any state on this measure, allowing no families with prior substantiated reports to receive the AR approach. Yet, Illinois reported some of the worst safety outcomes of any state in the Safety Sample. Although some may take this as evidence that AR is *not* most successful when reserved for first-time families, the Illinois study is characterized by some methodological idiosyncrasies that may account for this unexpected finding. A later section in this chapter examines the impact of methodology on disparate outcomes among the 20 studies in the Safety Sample, with a specific focus on the Illinois findings.

Allowance for Track-Switching

All DR systems examined in the Safety Sample allow for re-assignment of an AR case to the TR path if, upon a caseworker's first visit with the family, new safety information comes to light suggesting that the family is at higher risk than is appropriate for the AR track and should receive a full investigation. Almost no states examined allow for switching in the other direction – from an investigation to the AR path. Minnesota did allow it during the pilot period, but less than one percent of TR reports were ever switched to AR (Loman & Siegel, 2004). Missouri also allowed for switches in both directions – families who began with an investigation could be re-assigned to an AR "if the situation was found not to involve possible criminal violations and the worker believed the family could be better served through the assessment approach" (Loman & Siegel, 1997, p. 29).

In addition, all states examined provided services to AR families on a *voluntary* basis unless the case was switched from AR to TR.[14] That is, if no serious safety concern was identified at the initial caseworker visit, families could decline further services with no consequences. States varied widely in the percentage of cases that experienced a switch; fewer switches may either indicate a more accurate initial screening process, *or* a tendency to stay the course even when new safety risks are revealed during the initial caseworker visit. In Illinois, 22% of the cases screened for AR-eligibility and then randomized to the AR group were switched to a full investigation during the study period – this was the highest percentage of switches in the Safety Sample. In one Ohio study, just six percent of cases were switched from AR to TR; in Minnesota, an average of just five percent were; and in most states, the rates ranged from two to six percent (Loman & Siegel, 2004; Murphy et al., 2013; Piper, 2017). As states' DR systems become more well-established, criteria for path assignment become clearer and intake workers gain a greater understanding of the

[14] Or, in the case of North Carolina, if an AR case received a finding of "Services Needed."

kinds of cases that work well for AR, leading to better use of discretion and decreasing rates of track-switching over time. In Minnesota, track-switching diminished from 15.8% to 2.7% of cases over seven years (Jones, 2013). Therefore, Illinois' elimination of its DR system in 2012 after experiencing a high rate of inaccurate track decisions could be considered premature.

A minority of states use the validated Structured Decision-Making (SDM™) tool *prior* to track decision – most use a less comprehensive flow-chart or risk assessment tool to make the initial screening decision and the SDM™ is completed at the initial caseworker visit, which is why a case may be switched after the visit (Piper, 2016). Some researchers recommend that states consider using the SDM™ or other, similar tools to make the initial track assignment if time and staff capacity allow (Jones, 2013). Piper found in a study of three DR states that the one state that found significant, positive safety outcomes for AR in comparison to TR (Louisiana) used the SDM™ prior to track assignment (Piper, 2016).

Interestingly, Louisiana leadership nevertheless decided to discontinue the DR program in 2014 (after Piper's data collection period) because of general considerations of "safety, risk, and national research findings" (Louisiana DCFS Final Report on 2010-2014 CFSP, 2014, p. 81; K. Piper, Electronic Communication, April 15, 2019). A 2014 audit report covering Fiscal Years 2009-2013 specifically highlighted incorrect track assignment as an issue: "DCFS intake staff improperly referred 2,602 (2.8%) of 95,178 victims and perpetrators to AR, which is intended for low risk individuals, instead of to CPI" (Louisiana Legislative Audit Report, 2014, p. 3). As noted above, most states experienced a track-switching rate of between two to five percent, so Louisiana was not an outlier in this regard. However, many of the 2,602 cases involved track assignments that contradicted explicit state policy regarding initial eligibility for AR rather than track assignments that were revised after the discovery of further evidence at a home visit. As a result, agency leaders

decided to discontinue the program after considering this issue in light of a number of other findings noted in the audit report.

Report Source

No state reviewed in the Safety Sample used the report source (whether mandated professional, such as a social worker or teacher, or non-mandated community member) as a criterion for track assignment, but research suggests that some jurisdictions have used such criteria in the past (Shusterman et al., 2005). Almost all studies that examined report source found that reports from non-professional community members, such as a neighbor or friend, were more likely to be routed to an AR than reports from law enforcement and other professionals (Ortiz et al., 2008; Shusterman et al., 2005; Yuan, 2005). That is, reports from mandated professionals were considered to warrant a stronger response. Only one study, a 2015 examination of British Columbia's DR system that was excluded from the Safety Sample due to jurisdiction, found the opposite – reports from law enforcement, schools, and from children themselves were more often routed to AR (Ji & Sullivan, 2015). The authors hypothesized that intake staff felt the information provided by such sources was more credible and thorough, and therefore it was less risky to assign these cases to AR if the reporter characterized the incident as less serious. A child's neighbor, for example, may not provide enough relevant information for a hotline worker to feel certain about the suitability of AR for a particular incident, thus making TR a safer bet. If states do consistently allow for more discretion with calls from non-mandated reporters than professionals, they should examine what assumptions underlie this practice and examine whether it affects outcomes in their DR system.

Differences in Caseworker Approach and Staffing Structure

In addition to variation in risk assessment and diversion criteria, another major area of difference between DR systems that can affect safety outcomes is the staffing structure and role of caseworkers throughout the life of a case.

Intake Staffing and Screening Processes

Most jurisdictions examined allow hotline intake workers to make the track assignment on their own, often using the tools discussed above and sometimes getting the input of supervisors (Loman, Filonow, & Siegel, 2010a). Some, however, including Colorado, Oregon, more rural counties in Ohio, and certain counties in Minnesota (most notably Olmsted), use robust team decision-making processes including formal group staffing meetings called "RED" teams: Review, Evaluate, Decide (Fuller et al., 2017; Loman & Siegel, 2004; Murphy et al., 2013; Winokur et al., 2015). Though this can be time-consuming and "logistically difficult," most workers report that it increases buy-in and decreases worker anxiety about making the wrong decision when assigning cases to a track (Fuller et al., 2017, p. 80; Murphy et al., 2013; Winokur et al., 2015).

Some researchers argue that RED teams offer consistency, structure, and reliability to DR systems (Sawyer & Lohrbach, 2005). Outcome data also corroborate that these teams help ensure more accurate track assignment and therefore reduce the need for switches. Researchers in Colorado attributed the state's low three-percent switch rate during its pilot to the use of both RED teams and a structured manual, the "Agency Response Guide," which guides intake workers through the track decision (Winokur et al., 2015). Colorado did not see a significant difference between tracks on the likelihood of re-reports, but a survival analysis did reveal that AR families were 18% less likely, over time, to have an *investigated* re-report (as opposed to a re-report that received an AR). This suggests that

risk among AR families significantly decreased compared to the equivalent group of AR-eligible families whose index report was randomized to receive a TR intervention instead.

Some agencies do not have specialized intake staff to exclusively answer hotline calls and make track assignments, but rather have investigative caseworkers rotate into the intake role periodically. This may be an advantage if the caseworkers have had experience with both AR and investigations and are better able to apply their experiences in the field to make the initial path assignment decision (Yuan, 2005).

Caseload Structure

DR systems also differ in how caseworkers are assigned to the tracks and whether workers serve both AR and TR cases or carry separate caseloads. Evidence suggests that specialized caseloads can produce better safety outcomes by allowing AR caseworkers to develop an expertise in the approach, but qualitative research also indicates that separating the units can have detrimental effects on caseworker morale, can result in an inequitable workload distribution, and can hinder information-sharing across units (Jones, 2013; Loman & Siegel, 1997).

Many states examined in the Safety Sample allowed county agencies to determine whether to use specialized or mixed AR/TR caseloads (Maryland, Ohio, Minnesota, New York, Missouri, and Oregon), whereas others used only specialized AR workers (Illinois, Colorado, Nevada). In Illinois, AR-dedicated workers and supervisors were selected from existing CPS employees based on seniority. According to the study's authors, the AR positions were "considered temporary 'details' that were filled for 12-28 month periods" after which an AR worker would return to doing investigations (Fuller et al., 2013, p. 21). This is the only state examined that used such a model, and Illinois produced the worst safety outcomes, suggesting that this model may not have been most conducive to success.

In Oregon, some counties began with the specialized model but switched to mixed units after staff conflict and grievances arose. Caseworkers felt that track assignments were not made transparently and observed an increased workload on the AR track (Fuller et al., 2017). Workers felt that AR cases involved a much greater workload due to group staffing sessions, RED teams, and more in-depth family engagement (Fuller at al., 2017). In fact, some AR caseworkers failed to complete the holistic family assessment because of workload constraints, affecting fidelity to the DR model. However, other states found that with specialized units, *investigative* workers (TR) experienced the more heightened workload after DR implementation, because lower-risk cases were routed to AR, leaving TR workers with the most complex, intense cases with the strictest timeliness mandates (Murphy et al., 2013). In fact, some TR workers in Ohio developed contempt towards their AR colleagues for what they perceived to be the inequitable workload: "We get the [difficult] cases, they get the low to moderate 'fluff' cases" (Murphy et al., 2013, p. 57).

Jones (2013) found in her study of Minnesota's system that the most positive safety outcomes for children were found in the counties that used separate AR caseloads and used a single worker per family from assessment through case closure. She found that mixed caseloads often led caseworkers to prioritize investigations and put AR families on the backburner, given the heightened level of risk on the TR track. According to one worker with a mixed caseload, "With our cases if you have investigations [and] you have family assessments [AR], the investigations always take priority…" (Jones, 2013, p. 152). Minnesota state guidelines recommend specialized units to avoid this problem, but the Oregon findings suggest that specialized units must be implemented in a way that maintains staff equity, fair workload distributions, and morale.

Many child welfare systems are increasingly trying to shift their entire agencies toward a more family-centered, strengths-based approach that engages rather than punishes

families in order to achieve the most sustainable safety outcomes (Winokur et al., 2014, 2015). Some researchers and caseworkers have argued that formally separating families into those who receive a more strengths-based approach (AR) and those who do not (TR) defeats this goal. They assert that it reinforces the idea that families with higher risk "deserve" a more punitive approach (Jones, 2013; Loman, Filonow, & Siegel, 2010a). Mixed caseloads may serve to ameliorate this distinction if workers' approaches on *all* cases gradually shift toward the family engagement principles encouraged on the AR track (Loman, Filonow & Siegel, 2010a). In Jones' study of Minnesota, "Several staff suggested that the integration of [AR] and [TR] teams helped move the agency in a positive direction that fully integrated the two approaches to incorporate a consistent, strengths-based, family engaged and safety-focused practice" (2013, p. 154).

Fidelity can suffer with mixed caseloads, however. Some workers carrying both AR and TR cases did not understand how their approach was supposed to differ across cases beyond the terminology used, and some found it "hard to break the habit" of entering a home with the fact-finding mindset of a traditional investigation (Loman, Filonow, & Siegel, 2010a, p. 62; Shipe, 2017). In addition, workers with mixed caseloads must remember and adhere to two different sets of "policies, rules, and timeframes; introduce themselves differently; and remember different…due dates" (Murphy et al., 2013, p. 57) and this can affect fidelity and increase worker stress, negatively affecting engagement with families.

Texas, which was not analyzed as a DR state in any of the studies in the Safety Sample because performance data are not yet available, takes a unique approach to caseloads in some regions that may prove promising (J. Martin, Personal Communication, April 8, 2019). In urban regions, there are entire units dedicated to AR because of the high volume of cases, whereas in rural areas with fewer cases, mixed caseloads are more

common and more efficient. Meanwhile, in suburban areas, Texas has mixed *units* – teams in which supervisors oversee both AR and TR caseworkers, but caseworkers maintain their own specialized caseloads. This approach could temper some of the detrimental effects of siloed teams, such as those seen in Oregon, while also preserving fidelity and encouraging staff expertise through specialized individual caseloads (Martin, 2019).

Timeliness Mandates and Fidelity to the DR Approach

Fidelity was also compromised in some cases by conflicting mandates and caseload pressures, which suggests a need to better clarify policies in DR systems and ensure that caseworkers have sufficient time to do the robust family engagement and assessment work intended on the AR track. Some caseworkers in Maryland and Minnesota noted that timeliness mandates, such as the requirement to make contact with all children (AR and TR) within 24 hours, conflicted with fidelity to AR policies, such as scheduling joint family meetings rather than individually making contact with children wherever they are, often at school (Jones, 2013; Shipe, 2017). Caseworkers noted that because of these mixed messages, they used a lot of discretion on AR cases and did not always implement in line with official agency guidelines or policies. In addition, a tendency towards blended and high caseloads in most counties meant that AR cases in Maryland were often closed with a simple referral well before the 60-day deadline in order to free up time for investigations (Shipe, 2017). This practice defeats one of the intended purposes of AR – to more thoroughly assess and robustly serve lower-risk families to prevent recidivism – and suggests that the state's DR implementation was at times more nominal than real. Agencies seeking to implement a DR system should carefully consider how their existing timeliness mandates align or conflict with their goals for the AR track.

In Minnesota, Jones (2013) found evidence that counties whose caseworkers were able to implement with more fidelity saw better child safety outcomes. She divided nine focal counties into three groups: those with the most positive safety outcomes for AR cases, those with mixed outcomes, and those with negative safety outcomes for AR cases compared to TR cases. Her analysis revealed that all three counties in the "positive outcomes" group adhered to the ideal of holding joint family meetings for the first visit. These counties also noted providing concrete support or basic needs assistance to families early on as a way to engage them and build trust, in contrast to the counties with negative outcomes, whose workers did not do this as frequently. The provision of services to address basic needs is central to many states' DR systems and is explored in the following section.

Emphasis on Basic Needs Assistance

Another critical difference in implementation between states with DR systems relates to services: in particular, the extent to which the agency places a strong emphasis on funding basic needs services such as rent, clothing, food, utilities, and furniture; the extent to which funds and an adequate service array are actually available; and whether these funds are equally offered to families on both tracks or are reserved for AR families. The rationale for a greater emphasis on basic needs in most DR systems (and on the AR track specifically) is that lower-risk families, specifically those with allegations of neglect, are often reported (and re-reported) because of persistent deficits in resources (Loman & Siegel, 2012; Loman & Siegel, 2015). A deficit might constitute maltreatment on its own, such as environmental neglect (often called "dirty house" cases) or nutritional neglect, or the resource deficits may exacerbate parental stress and lead indirectly to other forms of maltreatment such as physical abuse or severe discipline. Many jurisdictions with a DR system therefore combine the strengths-based, no-disposition casework approach with a

more robust and varied service array in order to reduce recidivism for AR families. Loman and Siegel argue that the DR approach is unique in its emphasis on basic needs: "before the introduction of DR, dealing with food, clothing, housing, transportation and the like was not generally seen as a *central* responsibility of CPS workers" (2012, p. 1664). In New Jersey's DR system, for example, one of the proposed objectives for DR is "Families experiencing a housing, rent, or utility crisis will be successfully stabilized" (NJ DCF, 2010, p. 21).

As mentioned previously, the early success of Minnesota's pilot program has been attributed in part to a large grant that supported DR's inception in that state. Pilot counties in Minnesota were given $4 in private matching funds for every $1 they spent on AR families – but the matching funds were *only* for AR families. Counties were directed to use at least 25% of the grant funds from the McKnight Foundation to address families' basic needs, and the remaining funds could be used for more traditional therapeutic/case management services (Johnson et al., 2005; Loman & Siegel, 2004). When researchers examined safety outcomes by the number of basic needs caseworkers met, they found that families with two or more basic needs met showed the greatest improvements in safety as measured by SDM™ scores; those with one basic need met had the next greatest improvement, followed by those who received no concrete services (Loman & Siegel, 2004). When the authors examined safety in terms of re-reports over time, the resulting survival analysis "support[ed] the hypothesis that the relative reduction in recurrence among experimental families compared to control families was associated with services" (Loman & Siegel, 2004, p. 128).

About 15.6% of workers in Minnesota reported the opinion that the DR approach would *not* be effective without supplemental service funds for families, and in metro counties, where poverty rates were higher, twice as many agreed (31.3%). This suggests

that although the more family-centered approach and lack of disposition can make a difference, funds for basic needs are also critical, especially for the lower-income families who comprise most of the CPS caseload (Loman & Siegel, 2004). As discussed, Jones' (2013) finding that Minnesota's AR families saw more re-reports after the initial pilot period suggests that these funds were integral to the state's early success. Indeed, Loman and Siegel themselves acknowledge that "It is unlikely the project could have been undertaken without [the] significant support" from the McKnight Foundation (2004, p. iv).

A follow-up analysis of Minnesota's system in 2012 confirmed that "among experimental [AR] families, material assistance was shown to significantly influence later reports" and that services were well-targeted towards the "poorest and most financially distressed families" (Loman & Siegel, 2012, p. 1665). The evaluators' analysis of Ohio in 2015 similarly revealed a "clear shift under DR toward material services" that led to reduced recidivism, particularly among the lower-risk families on the AR track (those with no prior reports) (p. 92). AR families in Ohio benefited from a $1,000-per family allotment for services and a $50,000-per county allocation of flexible funds from Casey Family Programs (Loman, Filonow, & Siegel, 2010a).

The evaluators noted that staff had concerns about the shifting role of child welfare agencies under the DR approach. For example, some caseworkers were reluctant to close cases because families were still requesting help, but caseworkers were unsure whether their requests reflected true needs, necessary for child safety, or rather "wants," such as a new appliance or furniture. In fact, Shipe (2017) found in her focus groups with caseworkers that many "felt the community perceived…that CPS was a 'catch-all' for addressing poverty" (p. 114). The intersecting goals of child welfare agencies and anti-poverty programs must be addressed and clarified, especially within DR systems, to ensure

that caseworkers and families have congruent expectations and understandings of the services available in an AR case (Loman & Siegel, 2012).

Overall, results suggest that in DR systems, especially those with private funding sources, families on the AR track do receive significantly more services and this often translates into better safety outcomes. However, as with every general trend observed in this review, there are exceptions. In Onondaga County, New York, AR families received basic needs assistance at a rate almost three times that of TR families (17.9% compared to 6.5%) and AR families received help securing public assistance benefits at a much higher rate than TR families as well (Ruppel et al., 2011). This was supported by grants for AR flexible funds from the Marguerite Casey Foundation, and the state also received money from the Casey Family Foundation for technical assistance. Despite these investments, Ruppel, Huang, and Haulenbeek did not find a significant difference on safety outcomes between families randomized to the AR and TR tracks. The researchers were only able to observe families for six months after case closure due to legislative constraints, which is a shorter period than other studies examined in the Safety Sample, so it is possible that longer-term outcomes may have shown more differences.[15]

In a DR pilot program in six Ohio counties (the "SOAR" Consortium, a different set of counties than those examined by Loman, Filonow, & Siegel in 2010 and 2015), AR families benefited from a large influx of resources earmarked for concrete needs as well; counties received between "$16,000 to $46,000 from QIC grant funds and $10,000 to $25,000 from Casey Family Programs" to support purchases of such items as "cleaning supplies, baby gates, safety alarms, gas cards, car repair, bus passes…" and more (Murphy et al., 2013, p. 83). Twice as many AR families received material services compared to

[15] Differences in outcome measurement, including length of follow-up, are discussed more fully later in this chapter (pp. 63-66).

their randomly-assigned TR counterparts (44% vs. 23%), and TR caseworkers expressed concern over the imbalance in availability of funds. After almost a year of follow-up, however, evaluators found *no* significant differences in re-reports – 37% of AR families and 36% of TR families experienced at least one re-report. This held true even when a survival analysis controlled for prior CPS history and type of past re-report.

Furthermore, in Illinois, cash assistance up to $400 was available for each AR family, and "assistance over $400 was available in certain circumstances with DR Project Director approval" (Fuller et al., 2013, p. 23). In addition, each AR family was entitled to twice-weekly in-home visits by a specialized caseworker. Despite these supports, Illinois saw the least positive safety outcomes in the sample, suggesting that services, whether financial or interpersonal, may not be a panacea for preventing maltreatment.[16]

Along with the Ohio SOAR counties and Illinois, the third site that benefited from the QIC-DR grant was Colorado. Funds were intended to be available to both AR and TR families equally, but in practice, AR caseworkers had an easier time accessing these funds for their clients because of supervisory and management decisions that favored AR cases. In addition, there was a designated staff member responsible for connecting AR families to public programs such as Medicaid, cash assistance, food stamps, and housing resources. As mentioned previously, Colorado saw more positive results in the long run for AR families compared to the AR-eligible families who were randomly assigned to TR instead (Winokur et al., 2015).

Meanwhile, some jurisdictions examined in the Safety Sample achieved positive outcomes with cost-neutral approaches to service provision, in which no additional funds were allocated specifically for AR families. Combined with the negative Illinois results,

[16] See pp. 66-70 for a fuller explanation of the Illinois results.

this suggests that the availability of extra funds for the AR track may be neither a necessary *nor* sufficient condition for securing superior outcomes for those families – preventing recurrence is more complicated and involves an interaction of the caseworker approach, services, and unique family circumstances and CPS history. As mentioned, North Carolina saw a significant reduction over time in overall re-reports in counties that implemented DR, and those counties did not benefit from any supplementary service funds. Caseworkers instead frontloaded direct service time with families on the AR track, with an average of 50 more minutes per case, compared to investigations, prior to a case decision being made (Lawrence et al., 2011). Missouri and Maryland also took cost-neutral approaches to service provision and found some positive, but more modest, results (Loman & Siegel, 1997; Shipe, 2017).

In Missouri, overall recidivism *increased* in both pilot DR counties and non-DR counties, but the increase in DR counties was smaller, so the authors judge the effect of DR to be a "relative decline" in recidivism (Loman & Siegel, 1997, p. 96). This decline was not found to be statistically significant, however. There were three categories in which the evaluators found that re-reports declined or stayed level in DR counties, while increasing in non-DR counties, leading to statistically significant differences in recidivism: 1) reports in which children lacked basic necessities, 2) reports in which children lacked supervision and proper care, and 3) reports for educational neglect. These findings were even more pronounced for families with three or more children.

Maryland also took a budget-neutral approach, and although the evaluation determined that track assignment did not significantly predict re-reports, Shipe (2017) found that "the odds of having a substantiated recurrence were found to be 2.15 times higher for a family with a previously unsubstantiated report for a TR compared to families who received an AR" (p. 91). This suggests that the AR approach can significantly improve

safety in a way that the traditional investigative procedure may not, especially for families who are at lower risk and may have an investigation closed with a simple finding of "no maltreatment" despite ongoing needs. However, Shipe found that because CPS was not providing services directly with funds dedicated to this purpose, "resource availability was a constant struggle" that was exacerbated by families' lack of health insurance, lack of follow-through on resource referrals, and communication issues between various providers (2017, p. 101). Jurisdictions like Maryland that implemented DR with no additional funds dedicated to AR families' basic service needs relied on relationships and linkages with community-based organizations to provide voluntary services to families. However, as discussed in the following section, the formality and success of these relationships varied widely within the Safety Sample, influencing safety outcomes.

Role of Community-Based Agencies and Stakeholders

States in the Safety Sample diverged considerably with respect to the level of formal involvement CPS agencies had with community-based organizations and stakeholders. Although most of the states frequently referred AR families to local nonprofits for voluntary services, some intentionally incorporated these organizations into their DR infrastructure from the start and formally contracted with them to increase capacity and their ability to meaningfully serve AR families. Research suggests that DR systems engender closer ties between public child welfare agencies and community-based organizations, which can benefit all system-involved families in the long run regardless of track (Loman, Filonow, & Siegel, 2010b).

Formal Partnerships

A few of the jurisdictions examined had formal partnerships with community organizations to benefit AR families specifically. In one county in Minnesota, an AR specialist from a contracted community-based organization accompanied the public caseworker to the first visit for the safety and risk assessment, after which the case was immediately handed off to the community worker barring any identified safety risks (Loman & Siegel, 2004). In Oregon's now-defunct DR system, AR families were also able to request that a community-based nonprofit worker accompany the public agency caseworker to the first visit (Fuller et al., 2017).

In Illinois, community workers were integral to the assessment process; *all* AR families were first visited by a pair of workers that consisted of a public agency worker and a private agency contractor (Fuller et al., 2013). In North Carolina, meanwhile, the DR system included a close collaboration with Work First, the TANF program in the state. This involved joint home visits and case plan development when possible, with the goal of reducing duplicated services and ensuring efficient and complementary service provision by the two agencies (Lawrence et al., 2011).

Nevada had the most formal partnership with community-based agencies of any state in the Safety Sample. The state's ten Family Resource Centers ("FRCs") are immediately contacted when a case is assigned for an AR, and staff at the FRCs conduct the safety and risk assessments instead of public agency workers (Loman, Filonow, & Siegel, 2010b). These staff are dedicated solely to AR families and have a caseload cap of 15 families. (The Illinois private workers similarly had a caseload cap of 12 families.) Because of this low ratio, capacity is limited on the AR track in Nevada; a maximum of 20% of screened-in families can actually receive the AR, and during the evaluation period, this proportion was just 11%. This capacity constraint led to a "natural experiment" or

quasi-experimental set-up for outcome measurement, and evaluators found that 31.9% of control cases experienced a re-report (whether screened in or out) compared to 25.6% of AR cases. When examining only subsequent reports that were screened in for an investigation or AR, the evaluators found a significant reduction in recidivism among AR families compared to a group of TR families with similar CPS history.

When the evaluators used a survival analysis approach to examine this relationship over time and to control for a number of covariates, they found an even stronger result: "DR families can be expected to show a reduction in maltreatment report recurrence over a 40-month period of 27 percent compared to a similar group of families that are investigated" (Loman, Filonow, & Siegel, 2010b, p. 124). AR families in Nevada likely benefited from the broader focus and longer casework periods allowed under DR; for example, the authors explain that educational neglect cases "are often closed rapidly out of necessity in the CPS system but are often serviced for weeks in DR" under Nevada's system (p. 20).

Despite these promising results, the formal partnership arrangement with the FRCs had some weaknesses. Loman, Filonow, and Siegel (2010b) found that family assessments in Nevada were viewed by some as "CPS-Lite" and not true CPS cases because they were separated from the public agency through the FRC network. In addition, the evaluators found that a very small proportion of eligible families actually received the family assessment approach because of the limited capacity of the FRC arrangement and the caseload caps. Therefore, the quality of the AR intervention may be higher with such a specialized contract arrangement, but the quantity of families it can reach will be lower. States considering such a system must consider how to balance capacity and caseload ratios in order to produce the best overall safety outcomes for as many families as possible.

Informal Referral Relationships and Community Perceptions

In most jurisdictions with DR systems, especially those without formal contractors, AR workers must identify and develop relationships with local service providers to whom to refer their clients. Often, this can have a productive ripple effect for families on both the AR and investigative tracks. In some counties in Ohio, evaluators found that "AR workers have come to be viewed as experts on available community resources, acting as positive information resources for TR workers…" (Murphy et al., 2013, p. 56). Ohio AR workers reported a greater knowledge of community resources and a greater number of contacts with external agencies than did traditional investigative workers (Loman, Filonow, & Siegel, 2010a).

In New York State, the introduction of the DR system fostered new relationships with "non-traditional service providers such as neighborhood organizations, community action groups, and self-help groups" (Ruppel et al., 2011, p. vi). A common sentiment among caseworkers and supervisors across most jurisdictions was that the DR approach encouraged and required caseworkers to think more creatively about how to meet families' needs (Loman & Siegel, 2004; Loman, Filonow, & Siegel, 2010a). In Missouri, evaluators surveyed 556 community leaders and found that they were significantly less likely to describe the CPS-family relationship as "adversarial" and more likely to describe it as supportive in DR pilot areas than in non-DR jurisdictions (Loman & Siegel, 1997, p. v).

Regardless of caseworker creativity or initiative, community resources must be available to produce positive outcomes. Jones (2013) found in her analysis of nine Minnesota counties that the group of three counties with the worst safety outcomes was also the only group whose caseworkers noted a lack of community services in their area, including "culturally responsive services and limited concrete supports" (p. 206). Meanwhile, staff in the three counties with the best safety outcomes on the AR track "were

near a metro area that had an abundance of culturally-specific services" (p. 200). In the original Ohio study, caseworkers similarly noted that the three main problems hindering their success on the AR track were "Lack of community resources….Limited worker knowledge of community resources….and [high or mixed] caseloads" (Loman, Filonow, & Siegel, 2010a, p. 114).

In the majority of jurisdictions examined, staff and leadership at community organizations understood the AR approach and did not have serious concerns about it. In Colorado, community stakeholders were even invited to sit in on RED team meetings to better understand how path assignments were made (Winokur et al., 2015). However, in some qualitative studies, community leaders expressed reservations about the DR system's relative ability to ensure child safety when compared to the traditional approach with which they were more familiar. In North Carolina, for example, some community providers worried that the state was not sufficiently "holding families accountable" and that reports made by community members were not being followed up on (Lawrence et al., 2011, p. 2364). Some stakeholders also worried about the sustainability of positive outcomes after flexible funds were reduced or no longer available beyond pilot periods (Loman & Siegel, 2004). This is a reasonable concern given the findings by Jones (2013) in Minnesota years after the pilot. Some community members also expressed confusion regarding the acceptability of sharing case information between community partners and the state agency (Lawrence et al., 2011). Clarifying policies and boundaries with respect to information-sharing is a critical part of establishing a successful DR system that relies on community referrals.

Some jurisdictions found that community members, especially public school staff, did not fully understand what constituted a safety issue rather than a poverty issue that did not require CPS intervention (Shipe, 2017). Given the increased emphasis on basic needs

under many DR systems, this is an understandable point of confusion, and it suggests that perhaps more regular training of community partners and institutions should occur with the introduction of DR in a community. Shipe's qualitative study revealed that "Schools…only learned about the investigative process when their report was not accepted" (2017, p. 106). Some studies found that members of law enforcement tended to be skeptical of the AR approach, with some fearing its effect on child safety, while others found greater levels of cooperation between law enforcement and CPS following DR implementation (Murphy et al., 2013; Winokur et al., 2015). For example, the Ohio SOAR study found that "Law enforcement officers expressed concern about preserving the chain of evidence if criminal charges needed to be filed at some point" after an AR, given that there is no formal fact-finding pursuit in an AR (Murphy et al., 2013, p. 62). Greater training of community partners such as law enforcement and school staff on the purpose of, and safeguards within, the AR approach may help facilitate better cooperation with CPS and ultimately better outcomes for children and families involved. CPS agencies should solicit, consider, and address the input and concerns of community stakeholders before, and during, DR implementation.

Developing strong informal relationships with community partners is critical for fostering positive child safety outcomes within DR systems, especially because formal purchased services may only be available for one-time procurements, but families' needs for services may extend beyond case closure (Martin, 2019). In many states, including Texas, AR caseworkers are encouraged to set families up for longer-term success by identifying and strengthening their informal support networks with extended relatives and community organizations. The goal is not to start and complete a discrete set of purchased services while the family is system-involved, but rather to cultivate a more sustainable

support network so that families do not re-enter the system after case closure (Martin, 2019).

A study excluded from the Safety Sample because of its qualitative nature nevertheless offers important insights into how informal relationships with community providers may be strengthened in order to produce better safety outcomes (Zielewski et al., 2006). A group of researchers at the Urban Institute interviewed community service providers in Kentucky and Oklahoma, both of which implement DR statewide, to understand how community partnerships can contribute to or hinder the success of DR systems. For example, the authors noted that rural areas typically do not have formal service contracts with local nonprofits, whereas this is more common in urban areas. Contracts can foster stronger accountability and consistent funding for service providers to ensure they remain part of the service array for AR families (Zielewski et al., 2006). In rural areas, providers and agency staff often formed closer relationships because there were fewer community organizations, and this led to fewer duplicated services and more cohesive collaboration. However, service availability in these areas sometimes suffered from a limited number of providers. Meanwhile, in more urban areas, challenges included long waitlists for services, often filled by families who were not formally involved with CPS but were seeking voluntary services.

The authors also found that communities varied widely with respect to formal follow-up on community referrals; some workers would simply hand families a list of resources, whereas others would accompany families to their initial appointment at a local nonprofit. Overall, the authors found that follow-up by workers was rare in AR cases in both states. Interestingly, the authors found that community providers, even those with CPS contracts, often did not know whether they were serving AR or TR families and whether the services were mandatory or voluntary. In fact, the *families* often did not know either:

"When asked about themselves, none of the several families that had undergone an alternative response actually knew that they had received this alternate approach…While child welfare workers apparently view [it] as less invasive and more helpful, families may not share this view" (Zielewski et al., 2006, p. 12).

In some ways, it may be a positive sign if practice on both tracks converges such that all families receive an equally family-centered approach and do not notice a distinction, but this does not appear to be the reason for families' unawareness of which approach they received. Instead, some research has found that families do not perceive the AR track and associated services as any less mandatory than the TR track (Navarro, 2014). Services are supposed to be voluntary for AR families, but as Stacey Shipe notes in her Maryland evaluation, "there is a tacit understanding that family compliance is necessary as a lack of doing so may lead to a TR in the future" (2017, p. 12). In that state, discretionary considerations such as past family engagement with AR service referrals can influence whether a family receives an AR or TR upon a re-report, so families may indeed perceive an AR as a more compulsory process than it is often framed.

Jurisdictions considering implementing a DR system that relies heavily on community-based organizations to provide voluntary services should consider the issues noted by Zielewski, et al. (2006) in terms of contracts, referrals, and follow-up procedures in order to ensure that AR families actually receive recommended services. Agencies should ensure that community providers work with families in a manner that honors the intention of providing services on a voluntary basis and allows them to withdraw barring any further safety concerns. Otherwise, the AR track may lose its distinction in practice from the investigative track and low-risk families may not benefit from the approach as intended.

Differences in Study Methodology

Study Design

In addition to jurisdictional differences in DR system design, including track assignment policy, staffing structures, basic needs funding, and the formality of community partnerships, another reason for disparate findings on safety and limited generalizability is the wide range of study methodologies employed in DR evaluations. Below, the studies in the Safety Sample are categorized by overall methodology, followed by a discussion of the strengths and weakness of various research approaches and the implications for drawing conclusions about DR.

Figure 8: Studies in the Safety Sample by Methodology

Single-State Experimental Design, Randomized Controlled Trials	**Single-State Quasi-Experimental Design**	**Single-State Comparisons of Administrative Data with Statistical Controls**	**Multi-State Comparisons of Administrative Data with Statistical Controls**
Winokur et al., 2015 (Colorado) Fuller et al., 2013 (Illinois) Murphy et al., 2013 (Ohio SOAR) Ruppel et al., 2011 (New York State – Onondaga County) Loman, Filonow, & Siegel, 2010 and 2015 (Ohio) Loman & Siegel, 2004 and 2012 (Minnesota)	Fuller et al., 2017 (Oregon) Lawrence et al., 2011 (North Carolina) Loman, Filonow, & Siegel, 2010 (Nevada) Loman & Siegel, 1997 (Missouri)	Shipe, 2017 (Maryland) Jones, 2013 (Minnesota)	Fluke et al., 2018 Piper, 2017 Piper, 2016 Fluke et al., 2016 Ortiz et al., 2008 Shusterman et al., 2005

Randomized controlled trials ("RCTs") are considered the gold standard in research design for isolating and measuring the effects of a specific intervention and ruling out competing explanations for observed outcomes (Hoefer & Jordan, 2008; Okeh & Ugwu, 2009). In social science research, however, it can be difficult for ethical and practical reasons to adhere to the conditions required for such experiments, including random assignment of individuals or families to one intervention over another and assurance of equivalent groups after the assignment process. In fact, one county in the New York State study declined to do an RCT and instead used statistical controls because it sought to provide the AR approach to every eligible family as a matter of ethical principle (Ruppel et al., 2011).

Eight of the 20 studies in the Safety Sample executed an RCT despite the noted challenges. In the experiments in Colorado, Illinois, Ohio (3), Minnesota (2), and Onondaga County (New York State), all screened-in CPS reports were first analyzed for AR-eligibility based on individual state criteria and policies. Then, from among the group of families eligible for AR, families were randomly assigned to receive the AR intervention *or* a traditional investigation (TR). This meant that in those states, all families participating in the experiment were lower-risk families to begin with, even those receiving the TR. That is, no families received an intervention that was "lighter" than what they were screened for, but some families (those assigned to TR) received a more heavy-handed approach than they would have in the absence of experimental conditions.

Strengths and Limitations of the RCT Approach, Including Inconsistent Use of Intention-to-Treat

Strengths of the RCT approach included the fact that the AR intervention was tested for its impact on the precise population that would receive it under natural conditions in a

given jurisdiction and that the control families were similar in risk level to the experimental group.[17] Studies that simply compare administrative outcome data for AR and TR families, without random assignment, cannot tell us whether low-risk families are better off with an AR or the traditional approach, which is the true research question that would establish AR's effectiveness as an evidenced-based practice. Instead, such studies are comparing outcomes for two groups of families who are systematically different in risk from the beginning, which does not allow for the necessary counterfactual comparison of equivalent groups.

However, as Kathryn Piper points out, the necessity of track-switching in some cases compromised the integrity of the experimental groups because higher-risk families were systematically removed from the treatment groups in these instances once they were identified as inappropriate for the AR intervention (Piper, 2017). The fact that studies handled track-switching differently in their outcomes analyses jeopardizes comparisons of outcomes across the experimental studies and the Safety Sample as a whole.

One of the key analytic differences was whether a study used the intention-to-treat approach or simply dropped track-switchers from its data set. The intention-to-treat approach is a way of analyzing outcomes in randomized controlled trials that "ignores noncompliance, protocol deviations, withdrawal, and anything that happens after randomization" (Gupta, 2011, p. 1). The benefit is that participants' outcomes are analyzed based on their original assignment rather than actual treatment receipt, which may have been affected by confounding variables – exogenous to the intervention itself – that influenced how or why they complied, withdrew, or switched treatments (Sainani, 2010). The approach is thought to better approximate realistic conditions, in which such deviations

[17] When significant differences were found between AR and TR families' characteristics after randomization, such as family size or prior risk, statistical controls were used in the outcomes analyses to preserve group equivalence (e.g., Ruppel et al., 2011).

may indeed affect outcomes, while preserving the original random assignment to the treatment or control condition.

Of the RCTs, the three QIC-DR sites (Illinois, Colorado, and Ohio SOAR) and the follow-up Ohio study by Loman and Siegel (2015) used the intention-to-treat (ITT) approach to handle track-switches and explicitly stated doing so. Meanwhile, Loman and Siegel did not use ITT in their Minnesota studies (2004, 2012) nor their original Ohio study (2010a), and neither did Ruppel, Huang, and Haulenbeek (2011) – they simply dropped track-switchers from the analysis altogether. In addition, Oregon's quasi-experimental study dropped track-switchers from its outcomes analysis as well. This approach may have introduced bias into the outcomes for AR families in these studies, as it meant that a group of higher-risk families (track-switchers) were selectively removed from the AR group to which they were originally assigned.

The authors of the Colorado study argue that ITT is a more conservative approach to research because although it "diminishes analytic power, it avoids spuriously basing conclusions on characteristics related to attrition and crossover" (Winokur et al., 2014, p. 19). Despite these strengths, the ITT approach means that interpretation of studies with high numbers of track-switchers is a bit more complicated, and may underestimate the true ability of AR to keep children safe (Fuller et al., 2013).

Illinois Evaluation – Interpreting the Results

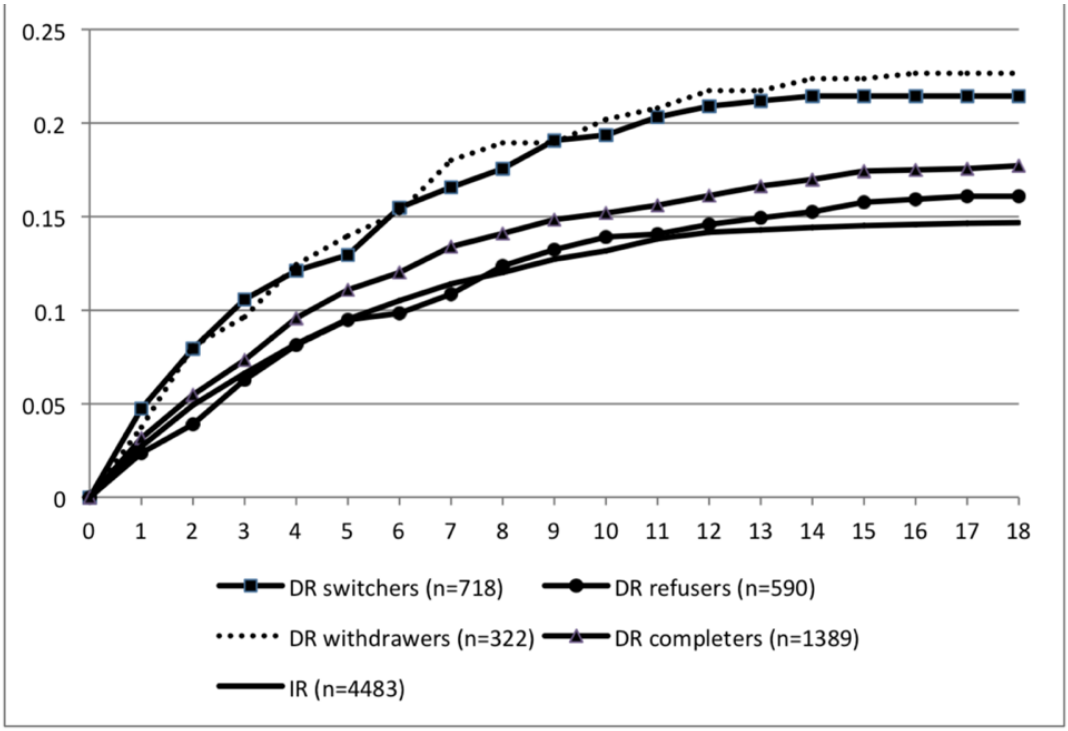
The Illinois evaluation, one of the studies that used ITT, warrants further discussion because its quantitative findings diverged greatly from those of most of the other studies in the Safety Sample (Fuller et al., 2013). Illinois had the highest percentage of track-switchers of any of the states in the Safety Sample – around 22% of the 3,101 families assigned to the AR group. These families did not receive an AR assessment or the

subsequent AR services (stipend and caseworker visits) but were treated as if they had in the overall quantitative outcomes analysis. The fact that the state with the highest proportion of track-switchers and an ITT approach produced the worst safety findings suggests that using this method may understate the ability of AR to ensure child safety. Illinois chose to discontinue its DR system after these evaluation findings, but they should be interpreted with caution due to this aspect of the methodology. Future evaluations should carefully consider whether the intention-to-treat approach is analytically sound in studies of vulnerable populations that require the switching of groups, post-assignment, for ethical or policy reasons.

To its credit, however, the Illinois study offers more detailed information than most of the sample studies regarding the precise completion and attrition rates of the AR-assigned families, which bolsters the credibility and usefulness of its findings. The AR intervention is intended by design to be a voluntary process, with families given the option to withdraw from agency involvement or services at any time if a track-switch is not determined to be required. Therefore, rather than just analyzing the two original groups of AR-assigned and TR-assigned families, Fuller et al. (2013) identified four distinct groups *within* the AR-assigned group to examine the effects of receiving differing levels of "AR treatment" (pp. 4-5). The four groups were the following: 1) "Switchers," those families discussed above who were AR-assigned but who were required to receive the investigative treatment instead; 2) "Refusers," those families assigned to AR who immediately opted out of the AR assessment or services; 3) "Withdrawers," those families assigned to AR who accepted the initial assessment but did not complete all offered services; and finally 4) "Completers," those families assigned to AR who accepted and completed all offered services (just 45% or 1,389 of the 3,101 AR-assigned families). The authors ran survival analyses on all four groups in addition to the TR-assigned group, and the findings offer

some deeper insights into this study's unique results in contrast to the rest of the sample (see Figure 9 below).

Figure 9: Cumulative Probability of Maltreatment Re-Report Among DR Subgroups. Reprinted with permission from "Differential Response in Illinois: Final Evaluation Report" by Tamara Fuller, Martin Nieto, and Saijun Zhang, 2013. Children and Family Research Center, School of Social Work, University of Illinois at Urbana Champaign, p. 67.



The x-axis represents months after case closure, with the y-axis displaying the cumulative likelihood of re-report. The families at highest risk of re-report were the "Withdrawers," representing families who were assigned to AR but voluntarily withdrew in the middle of services. The authors suggest that families may have withdrawn because of additional stressors that made it difficult to participate in services (which may have also

resulted in the additional reports), or that caseworkers may have re-reported these families themselves if they were concerned about the family's choice to prematurely withdraw. The families at next highest risk were the "Switchers," who were required to switch from AR to TR precisely because they were found to be at higher risk than appropriate for AR upon the first visit. The AR "Completers" had the median risk level – less risk than the withdrawers, which seems to suggest that *completing* AR services does contribute to increased safety. However, the AR "Refusers," who declined to even begin AR services, were at lower risk than the Completers, which is not easily explained, except perhaps by the possibility that families who refused involvement had self-assessed and accurately determined that they were not in need of any further services to keep their children safe. It is possible that their initial CPS report was close to baseless or was of the least risky nature to start. Finally, the families at least risk were those who received the traditional investigation, which seems to support the notion that the traditional, more heavy-handed method of serving families through CPS keeps children safer than the AR approach. However, when these stratified findings were examined for statistical significance, Fuller et al. (2013) found that the cumulative risk probabilities were *not* significantly different between AR Completers and Refusers, on the one hand, and investigated families on the other. In the evaluators' words, this means that "children within families who actually received DR or who made the decision to decline DR services after the initial visit by the DR caseworkers were as safe as those children who received an investigation" (Fuller et al., 2013, p. 90). This interpretation, after careful disaggregation of the AR group into four subgroups, indicates that the results of the Illinois evaluation do not represent the death knell for DR systems that many critics of the approach have tried to claim (Bartholet, 2015; Heimpel, 2014). Rather than eliminating DR where it exists and reverting to the traditional one-size-fits-all CPS approach, the more prudent course of action might be to make a

stronger effort to retain families in AR services while still allowing for family self-determination. The Illinois results suggest that more research is needed into the *reasons* that families withdraw or stay involved in AR services, as the Completers had better safety outcomes than the Withdrawers.

The authors emphasize that their methodology, including the ITT approach, preserved a high level of internal validity, and therefore the study's findings represent an accurate measure of the impact of Illinois' DR system on child safety. However, they acknowledge that it lacks external validity (generalizability) because of the many ways in which Illinois' DR system differed from those of other states. External validity is ultimately a concern for all of the studies in the Safety Sample given the many differences in DR systems described in this chapter.

Quasi-Experimental Designs

The quasi-experimental studies differed slightly from one another in design, but generally compared outcomes in jurisdictions implementing DR with those in jurisdictions not yet implementing DR in the same state rather than comparing outcomes by track *within* a DR system. The studies of Oregon and Nevada used formal statistical matching procedures to construct equivalent groups at the individual family level (Fuller et al., 2017; Loman, Filonow, & Siegel, 2010b). The Oregon evaluation ultimately examined outcomes for *four* groups: AR and TR families in DR districts, and AR-matched and TR-matched families in non-DR districts. The Nevada evaluation compared a group of AR families to a group of comparison families excluded from AR only for capacity reasons. North Carolina's and Missouri's evaluations matched counties or jurisdictions on several demographic factors but did not match or compare outcomes for individual families (Lawrence et al., 2011; Loman & Siegel, 1997). North Carolina and Missouri compared

data between time periods in addition to comparing the jurisdictions, which added another layer of complexity and rigor to their quasi-experimental designs.

Differences in Outcome Measurement

At a minimum, all studies in the Safety Sample, per inclusion criteria, examined the percentage of families in a DR system who experienced re-reports as the main measure of child safety. Some analyzed this percentage by track assignment and others by the diversion rate. However, 12 of the 20 studies went further than simple percentages and completed survival analyses, a more rigorous statistical test. According to Loman, Filonow, and Siegel (2010a), survival analyses are the proper analytic method for examining recidivism in studies of DR where the observation period is limited and families within a study have *different* follow-up periods available for observation. Survival analyses account for the varied follow-up periods (families followed for a shorter period may show fewer re-reports as a result) and the right-censoring of the data (the possibility that families may experience an uncaptured re-report *after* the observation period). Families within a single study often had different follow-up periods because they entered the studies at various times, depending on when their report was received within the experimental assignment window.

It is critical to do a survival analysis when possible to ensure the accuracy of time-sensitive results and control for additional variables. For example, in Loman and Siegel's original Minnesota evaluation (2004), the authors initially found a statistically significant difference in percentage of re-reports between the two tracks (27.2% for AR compared to 30.3% for TR). However, when they subsequently ran a survival analysis, they found that significant differences only emerged between the AR and TR tracks when the families with prior CPS histories were removed.

The length of the observation period affected the results of studies in the Safety Sample as well. Loman and Siegel's 2015 follow-up study of Minnesota examined 8-9 years of data for each family, whereas most studies examined a follow-up period of 6-18 months. Overall, more positive significant differences between outcomes on the AR and TR tracks were found in studies with longer follow-up periods (Loman & Siegel, 2004, 2012, 2015; Loman, Filonow, & Siegel, 2010a; 2010b; Winokur et al., 2015). This suggests that administrators and evaluators should not be quick to deem DR a failure if significant differences do not emerge after a few months of follow-up. It may take longer for the approach to make a measurable impact.

In Onondaga and Tompkins Counties in New York, for example, families were only followed for six months after their intake date because of a legislative mandate to complete the study by a certain date in 2010 (Ruppel et al., 2011). Although the authors emphasize the rigorous nature of their study (an RCT in Onondaga County and closely matched groups using the propensity score matching method in Tompkins County), they acknowledge that most studies of DR have found significant differences between groups after a full 18-24 months of follow-up, so their study was limited from the start (Loman & Siegel, 2004; Loman, Filonow, & Siegel, 2010a; Ruppel et al., 2011). Indeed, they did not find any significant differences in the six-month period.

In addition to length of follow-up period, another important decision that evaluators have to make is when to begin counting re-reports. Many studies purposely did not begin measuring re-reports until after assessment completion or case closure. This was done in order to give the intervention time to make an impact for the family, to reduce the possibility of surveillance bias, and to reduce the possibility of counting multiple reports regarding the same incident (Fuller et al., 2013, 2017; Jones, 2013; Loman, Filonow, & Siegel, 2010b; Piper, 2016; Shipe, 2017). The IAR researchers

acknowledge in their 2010 Ohio study that this is a best practice in research of this kind, but they relaxed that rule for themselves in the analysis: "Ideally, follow-up data should be measured starting with *the closing of the target case.* However, in the present evaluation this procedure would have further shortened the time for follow-up. For this reason, we decided to begin counting new reports from the date of the initial target report that led to experimental or control assignment of a family" (Loman, Filonow, & Siegel, 2010a, p. 136). Another group of studies started counting re-reports immediately upon assignment of the index report or waited just a very short period, such as 1-7 days, to avoid only duplicate reports (Fluke et al., 2016, 2018; Ortiz et al., 2008; Piper, 2017; Shusterman et al., 2005; Winokur et al., 2015). For future DR research to be more generalizable, evaluations should follow a more consistent protocol with respect to the measurement period and should ideally begin counting re-reports after the intervention of interest has ended, whether that is defined as the assessment period or the service period for cases formally opened for services.

RACIAL AND EQUITY ANALYSES

Racial disproportionality is a serious concern within child welfare just as it is in the criminal justice system and other public institutions (Roberts, 2002). Although some scholars continue to debate whether this is primarily attributable to different underlying maltreatment rates or racial bias on the part of reporters and caseworkers, there is significant evidence that racial bias plays a role (Bartholet, 2015; Gourdine, 2019; Roberts, 2002). Rivaux et al. (2008), for example, found that even when risk and poverty were held constant, caseworkers in Texas were more likely to remove African-American children from their homes and to provide in-home family-based safety services to White families. Among other benefits, DR has been touted as a way to address racial

disproportionality by limiting the number of families who receive an unneeded investigation for poverty-related neglect referrals. Indeed, some states including Texas and Oregon have made explicit in policy or research documents that their DR systems were intended to combat disproportionality (Texas DFPS Initiatives to Reduce Disproportionality, 2019; Fuller et al., 2017). Given the associations between race and socioeconomic status in the U.S., it is reasonable to expect that a program that works to better support families in poverty would also impact the racial composition of system-involved families.

Eleven of the 20 studies in the Safety Sample examined how race/ethnicity interacts with DR implementation, beyond simply reporting race as part of the demographic description of the sample (which almost all studies did). In particular, the impact on African-American families was examined in many studies. Three of the 11 studies found evidence that African-American families were less likely to be assigned to the Alternative Response track than similar White families for at least some years of DR implementation, if not all years (Jones, 2013; Loman & Siegel, 1997; Shipe, 2017). This suggests that African-American families may have been perceived by screeners as "higher-risk" than similar White families simply due to racial bias and therefore were not able to benefit from the AR approach. Four studies found that race did not significantly predict track assignment (Ortiz et al., 2008; Piper, 2016; Ruppel et al., 2011; Shusterman et al., 2005). The remaining four studies of the 11 examined whether DR systems impacted *recidivism* differently by race, rather than impacting initial track assignment. The only study that found a significant difference on this measure was the original Ohio evaluation (Loman, Filonow, & Siegel, 2010a), which found that AR "produced the best results among African-American families" (p. 140). Specifically, AR produced the greatest reduction in recidivism, relative to the TR group, for African-American families

in the study sample. The authors caution that this result may be primarily attributed to poverty rather than race, but this still bolsters the argument that AR can benefit families with unmet basic needs.

As mentioned, Oregon included in its DR logic model the anticipated outcome that "Disproportionality will be reduced among children of color" (Fuller et al., 2017). The evaluation *did* reveal modest declines in disproportionality of minority children (including both African-American and Native American children) following DR implementation, but this occurred in *both* DR districts and non-DR districts, precluding a conclusion that it was indeed DR that made the difference (Fuller et al., 2017).

The study that examined race most closely was conducted in Minnesota (Jones, 2013). African-American families were less likely to be assigned to AR during the first few years of Jones' seven-year observation period, but by the end of the period, they were more likely than White families to be assigned to the AR track. Some caseworkers saw the AR approach as particularly well-suited to families of color: "Several staff in the counties stressed the importance for families of color to feel empowered, given mistreatment and mistrust of families and communities of color in the past by social services and child welfare" (p. 188).

Jones also found that "the flexibility of [AR] can de-escalate situations that might have been largely a misunderstanding," and that this is especially important for working with diverse clients who may have different views of child-rearing, may face language barriers, or may not realize that certain behaviors legally constitute maltreatment in their jurisdiction (p. 189). Berrick's (2018) review of several cases in California provides further evidence that power differentials between caseworkers and families can be exacerbated by racial or cultural differences. As immigration continues to diversify the United States, approaching families with a collaborative, culturally responsive stance will be increasingly

critical for fostering family engagement instead of provoking fear or defensive reactions from caregivers. This does not mean that child maltreatment should be tolerated as a matter of cultural child-rearing differences, but rather that caseworkers should be aware of culturally-specific practices, like "coining" (a form of dermabrasion therapy practiced in some Asian communities), which may present as child abuse but are viewed by families as traditional healing practices (Tan & Mallika, 2011).

COST TRENDS

Given that most child welfare agencies in the U.S. are public entities accountable to taxpaying citizens, any new reform must be assessed not just on its effectiveness, but on cost and efficiency as well. Some critics argue that in serving a broader range of families and providing more basic needs assistance, "DR requires a siphoning of limited resources from higher to lower risk cases," putting higher-risk children in peril (Heimpel, 2014, p. 1; Hughes & Rycus, 2013). However, others argue that investing in services upfront can prevent longer-term costs associated with maltreatment recurrence (Loman, Filonow & Siegel, 2010a).

Just six of the 20 studies in the Safety Sample included a formal analysis of cost-effectiveness in addition to safety outcomes (Fuller et al., 2013, 2017; Loman, Filonow, & Siegel, 2010a; Loman & Siegel, 2004; Murphy et al., 2013; Winokur et al., 2015). The remaining studies simply noted whether the jurisdiction took a cost-neutral approach or received flexible funds, or they did not incorporate a discussion of cost at all. Many acknowledged that this is an under-developed area of DR research and cited important limitations in their own cost analyses. In addition, the methodologies varied widely between cost studies just as they did in the safety analyses. However, a few key trends emerged.

Studies of Colorado, Illinois, Minnesota, and Ohio all found that DR systems produced modest cost savings. Researchers in Colorado compared cost data for over 3,000 AR cases to 2,000 TR cases and determined that follow-up costs (those incurred after 365 days of involvement with a family) were significantly lower for AR cases (Winokur et al., 2015). Evaluators in Illinois randomly selected 200 AR and 200 TR cases from the sample and found that although initial costs were significantly higher for AR cases because of stipends and caseworker time, subsequent costs were significantly lower, leading to overall savings (Fuller et al., 2013). The authors note that follow-up costs were lower because of fewer out-of-home placements among the AR families and fewer intensive family preservation services. This suggests that in some ways, AR families *did* see better long-term safety outcomes than their TR peers, even though the recidivism data using overall re-reports suggested that this was not the case in Illinois.

In Minnesota, the evaluators similarly divided the cost analysis into an initial period and a follow-up period, with the latter pertaining only to families who became re-involved for a subsequent report after the index report (Loman & Siegel, 2004). They compared 299 AR cases to 299 TR cases and found again that initial costs were higher for AR families because of greater upfront service provision and caseworker contacts. The follow-up period was more costly for TR families, leading to an overall net savings among the AR families even when balanced with their higher initial costs. When the evaluators analyzed the costs by the number of families who did not recidivate, they concluded that for 1,000 families, "the cost of achieving [recurrence avoidance] would be $398,000 less using AR than it would have been with the traditional approach" (Loman & Siegel, 2004, p. 165).

The Ohio SOAR study by Murphy et al. (2013) also found that AR cases cost the state less than TR cases on average. However, the authors acknowledge that the very small

sample for which they were able to acquire cost data (66 AR cases and 60 TR cases) severely limits the value of this finding.

The final two studies of the six that analyzed cost found that AR cases cost more, on average, than traditional investigations. Loman, Filonow, & Siegel (2010a) examined 190 AR families and 236 TR families in Ohio and calculated that AR cases were more expensive overall. However, much of this could be attributed to the additional funding that was intended to be used specifically to meet AR families' basic needs in the early stages of a case. The authors did find reduced spending on follow-up costs, though this did not outweigh the more costly upfront expenditures to produce a net savings for AR overall. Finally, the evaluators in Oregon found that in districts implementing DR, both AR and TR cases cost more than their matched comparison cases in non-DR counties because of increased caseworker contacts and service provision. Although more time spent with a caseworker and increased services could be worthwhile investments, this study did not reveal better safety outcomes in the DR districts, and Oregon soon decided to eliminate its DR program because of a host of organizational and workforce challenges plaguing the entire agency – not just the DR districts.

Quantitative analyses examining re-reports and cost-effectiveness are critical for evaluating the DR model and demonstrating its value to policymakers, funders, and other stakeholders. However, qualitative studies probing how families and caseworkers receive the AR approach and how it changes their attitudes and behaviors provide another rich source of data to inform a fuller picture of DR's impact.

Chapter 6: Caregiver and Caseworker Perceptions of Differential Response

CAREGIVER PERCEPTIONS

Despite mixed findings on safety and cost, qualitative studies of the AR approach within DR systems overwhelmingly show that families react more positively to their CPS intervention and caseworker than do TR families. Of the 20 studies in the Safety Sample, 12 included an examination of family perceptions of the AR approach through methods including surveys, focus groups, and/or individual interviews. Of the 12, 10 received surveys from *both* AR and TR families, allowing for comparisons to be made, and nine of those 10 revealed significantly more positive responses from AR families on many of the key indicators (Fuller et al., 2013; Loman & Siegel, 1997, 2004, 2012, 2015; Loman Filonow, & Siegel, 2010a; Murphy et al., 2013; Ruppel et al., 2011; Winokur et al., 2015). Common measures of family reception included satisfaction with treatment by the caseworker, satisfaction with services received, ease of contacting the caseworker, and a sense of inclusion in decisions made about their family and the service plan. All of the studies acknowledged that family surveys were subject to self-selection bias, since families were not required to respond. Nevertheless, most studies were able to collect between 100-500 surveys from each group, allowing for tests of statistical significance between AR and TR family responses.

For example, in Colorado, AR families were 1.6 times more likely than TR families to rate satisfaction with their caseworker highly and 1.7 times more willing to call them for help in the future (Winokur et al., 2014, 2015). AR families were also significantly less likely to report feeling stressed or disrespected during their first visit with the caseworker. These findings were echoed throughout many of the studies (Fuller et al., 2013; Loman & Siegel, 2004; Ruppel et al., 2011).

Fuller et al. (2015) conducted in-depth interviews with 20 parents in Illinois who had been served on the experimental AR track in order to explore their experiences and identify what they found helpful or unhelpful. Parents primarily noted that they found the caseworker to be a source of emotional support, in that they served as good listeners who normalized the difficulties of parenting and the experience of CPS involvement. Parents also appreciated when caseworkers provided information and referrals to services in the community, and some expressed gratitude for the direct provision of concrete services, such as a bed or crutches for an injured child. Some parents, however, expressed frustration over being denied concrete services that they requested. As mentioned, future DR implementation should ensure that both families and workers are aware of the level of basic needs provision that is available in their state's DR system in order to maintain congruent and realistic expectations about services.

Although these results bode well for DR and for the experiences of AR families specifically, it is certainly not the intention of the approach for families in traditional investigations to have negative experiences with their caseworkers, be unsatisfied with the services they receive, or feel they are not provided sufficient agency or autonomy in ensuring their children's safety. In a DR system, *all* families are still the agency's clients and must be treated fairly. Of course, there is a level of coercion that must occur in some cases to keep children safe, especially for those in which the maltreatment rises to the level of child removal or criminal charges. However, it is worth considering how the DR track system may negatively affect families who receive investigations.

In illustrating this concern, Dumbrill (2006a) argues that "rather than balance the pendulum, [DR] may institutionalize both pendulum extremes in a single model. Intrusion, for instance, may increase for families streamed into a forensic response…if workers feel more comfortable with a model that reserves intrusion for 'worse' cases" (p.

14). That is, DR systems may lead to investigative caseworkers taking an intentionally more punitive or deficit-based approach with their families due to the distinction made between cases. At least one study's results appear to confirm this worry (Fuller et al., 2017). In Oregon, families on the TR track *within DR districts* reported significantly higher levels of fear, confusion, and anger compared to matched investigated families in *non-DR districts*. This suggests that in some DR systems, families routed to investigations may indeed be approached in an intentionally more punitive or adversarial manner because they have been formally designated as requiring a more heavy-handed intervention compared to their AR counterparts.

Implications of Family Buy-in for Child Safety

Some researchers argue that process measures, such as family satisfaction, may have limited value for strengthening child safety outcomes, which is the primary goal of CPS systems: "It is not clear if parents' emotional responses have a discernible relationship to services and outcomes" (Merkel-Holguin et al., 2015). However, given the Illinois findings that "Withdrawers" had worse safety outcomes than "Completers" of AR services, it is plausible that families who have a better initial experience with their caseworker may be more willing to cooperate with AR service plans, leading to better outcomes. It could be informative for future studies to link families' surveys, provided they gave consent, to their case outcomes and administrative data to examine this relationship. In addition, designing strategies to reduce selection bias in the collection of family survey responses may help to produce data on family and parent engagement that is more representative of the DR caseloads overall, rather than just those families who had a more positive or more negative experience. It may also be worth exploring the degree to which families know about DR prior to being approached for an assessment

rather than an investigation, and whether this changes their reception of the initial caseworker visit.

Texas, for example, has a policy requiring caseworkers to explain the intervention before meeting with families (Texas DFPS, AR Resource Guide, 2018). Perhaps public awareness campaigns regarding the approach may help ease parents' apprehension about CPS involvement in DR states and could foster more cooperation upon the first visit. It may also be worth spreading awareness about DR to mandated reporters in their training so that they understand the range of interventions they may be initiating with their report and can communicate that to families when necessary (Yuan, 2005).

Although positive family reception is not included in most DR logic models as an outcome, it is reasonable, based on what is known about family engagement in voluntary services, that more positive reception may, as an intermediate outcome, lead families to more fully engage with their caseworker and with community-based services, leading indirectly to better child safety outcomes (McCurdy & Daro, 2001). In fact, Loman & Siegel (2015) argue that "Family engagement is a positive outcome in itself and a necessary condition for ongoing work with families" (p. 87). Many of the studies in the Safety Sample offered examples of success stories on the AR track in which the caseworker's strengths-based, future-oriented approach led to substantial, lasting change for the family. For example, one client in Ohio recounted that "It was all about putting plans in place and figuring out things that I needed to get stable on my feet…I went from being a drug dealer to a full-time college student. I've got my own home, car, and my children have clothes and toys. I worked very hard but she [my AR worker] is absolutely the one who helped get things completely in place…" (Murphy et al., 2013, p. 120).

The negative safety findings from Illinois, which were the worst among the Safety Sample and contributed to the discontinuation of the DR pilot in that state, contrast with the very positive *qualitative* findings among families in the pilot (Fuller et al., 2013). The Illinois evaluators found a statistically significant difference (in the positive direction) for AR families compared to TR families on all of the following survey questions, among others (Fuller et al., 2013, pp. 73-75):

- *Are your children safer because of your experience with the child welfare agency?*
- *Are you better able to provide necessities like food, clothing, shelter, or medical services because of your experience with the child welfare agency?*
- *Overall, are you and your family better off or worse off because of your experience with the child welfare agency?*
- *Are you a better parent because of your experience with the child welfare agency?*

Overall, the evaluators found that "[o]ne of the most consistent findings to emerge from the Illinois DR evaluation is that parents who received [an AR] felt more strongly positive about all aspects of their child protective services experience when compared to parents who received an investigation" (p. 91). It is important to note that both investigated families and AR families received the Family Survey at the conclusions of their cases, so the pool of AR surveys represents the families who remained committed to services the longest and did not drop out (i.e. the "Completers" group rather than the "Refusers" or "Withdrawers" discussed on pp. 68-69 of this report). Therefore, it is not surprising that the quantitative and qualitative findings would differ, given that the quantitative analysis included families with four levels of AR dosage but the survey was given to the Completers. The qualitative findings bode well for the Alternative Response approach – the work of Fuller et al. (2013) in Illinois suggests that when families *actually receive and*

participate in recommended AR services, they find them helpful and perceive an increase in their children's safety and wellbeing.

CASEWORKER PERCEPTIONS

Even more than basic needs provision, caseworkers' ability to approach families with a more intentionally strengths-based, collaborative demeanor is arguably at the core of the DR theory of change (Loman & Siegel, 2004; Loman, Filonow, & Siegel, 2010a; Martin, 2019). In addition to family reception of caseworkers' approach, qualitative studies have also examined caseworkers' own perceptions of the DR model and their work on AR and TR cases. Chapter 5 covered how differences in staffing structures and timeliness mandates may affect child safety and caseworkers' ability to implement the AR approach with fidelity. Among the Safety Sample, 15 studies analyzed how caseworkers *felt* about the approach as a whole, including their workload, family cooperation, differences in how they approached families, and other key aspects of serving AR families.

Caseworker job satisfaction is critical for child safety. Turnover is historically very high among frontline CPS workers, estimated by some sources as between 20-40% annually (Casey Family Programs, 2017). If an agency loses close to half of its caseworkers per year, case continuity suffers, often leading to weaker relationships with clients, eroded trust in the agency by stakeholders, and worse family outcomes (Strolin, 2005).

Findings among caseworkers were less consistently positive than they were among studies of family reception. In Oregon, increased workload among AR workers was a significant concern, and the state paused its implementation of DR because of a backlog of incomplete assessments (Fuller et al., 2017). Increased time and contacts with AR families were themes echoed in many of the studies, which may account for the higher workload. For example, in Ohio, AR workers had significantly more face-to-face, phone, and

collateral contacts on behalf of their families than workers in the control group, and in Illinois, AR families received an average of 7.8 face-to-face contacts compared to 2.3 on the TR track (Fuller et al., 2013; Loman, Filonow, & Siegel, 2010a). In North Carolina, Lawrence et al. (2011) found a significant association between the amount of time a caseworker reported spending with the family during the assessment phase of a case and the resulting reduction in recidivism.

Despite this positive finding for safety, the impact of increased workload on caseworkers must be addressed if agencies seek to retain caseworkers and preserve case continuity for their clients. As discussed, some states saw an increased workload for *TR* cases if they routed the majority of lower-risk cases to AR workers. Indeed, it was the AR workers in Nevada at the Family Resource Centers who rated "satisfaction with workload and duties" higher and burnout lower than their CPS counterparts (Loman, Filonow, & Siegel, 2010b, p. 106). This again speaks to the success of the FRC model in that state, but its unique structure, including very low caseloads, may not be easily replicated in all jurisdictions. In traditional systems with AR and TR workers both housed within CPS, agency managers must ensure that caseloads on both tracks are reasonable given the additional casework and family assessments that may be required by their DR model *and* given the possibility of higher-risk cases being concentrated in the TR track. When this is not managed well, DR systems may be eliminated due to capacity and workload issues, such as in the case of Oregon (Blackburn, 2019; Geiser, 2017).

Some AR workers felt that the approach was significantly different from established CPS practice, whereas others felt that it was just a way of formalizing or "institutionalizing practice they always tried to do" with families prior to DR (Loman & Siegel, 2004, p. 48). In Minnesota, over three-quarters of workers felt that AR was "very" or "mostly" able to keep children safe – only 4.1% felt it was not successful (Loman &

Siegel, 2004). One particular worker noted that "If anything, we close AR cases knowing more about the [families] and doing more for them, and the family is not angry" (p. 71).

Overall, AR workers in the reviewed studies tended to express satisfaction with the more flexible approach under the DR system and the additional resources they were able to offer families, especially in states with flexible funds available. However, one limitation of the research is that caseworkers were not randomly assigned to cases in *any* of the studies in the Safety Sample. It is possible that AR caseworkers may have self-selected into those positions because of characteristics not captured in the studies. However, randomization of caseworkers may not be a necessary research strategy if caseworkers in the field are always able to self-select. In other words, measuring the efficacy of the "AR approach" as an intervention in isolation from specific caseworker characteristics may not be a meaningful goal *if* the intervention is always implemented by caseworkers with common characteristics, such as an orientation towards strengths-based social work rather than a background in criminal justice or forensic investigation work, for example. It is not clear that all states and jurisdictions do allow caseworkers to self-select, so randomization of workers in future DR evaluations may be fruitful if possible.

Chapter 7: Recommendations

Recommendations for Policy and Practice

The balance of evidence supports continued implementation of Differential Response in states that currently have such systems in place. Only two of 20 studies found evidence that children are less safe when served by the alternative tracks in DR systems, and one of the two (Illinois, in Fuller et al., 2013) could be considered an outlier given its high rate of track-switching combined with the evaluation's use of the intention-to-treat approach. This methodology meant that hundreds of families who received an investigation were analyzed as AR families, weakening the validity of a conclusion that families *actually served with an AR* are less safe. In addition, a disaggregated analysis by AR "dosage" or compliance found that families who completed AR services were no less safe than their investigated counterparts. The second study, Jones' 2013 examination of Minnesota, showed that although re-reports on the AR track were higher than on the TR track for six of seven years in the study, the rates of recidivism converged by the end of the observation period and racial equality in track assignment improved over time as well.

The experiences of states such as Illinois, Oregon, and Massachusetts, which ended their DR systems based on safety or capacity concerns, should not deter other states from building and piloting their own DR systems. Positive child safety outcomes in DR systems require a strong commitment from state agency leadership and a willingness to make adjustments over time rather than expect immediate success. It is not a simple task to build a new stage of service in a child welfare system – building a Differential Response program requires garnering sufficient political and financial support to allow for the hiring of additional staff, the development and implementation of new training curricula and resources, and additions to a state's child welfare information technology infrastructure. In

Massachusetts, stakeholders suggested that state leadership did not take the necessary steps to support and strengthen DR before doing away with the approach prematurely (Scharfenberg, 2015).

This review identified some key factors, highlighted below, that states should consider when designing a DR system in order to ensure that children are kept safe on the AR track and that staff are able to implement the approach with fidelity to its key components.

- ***Theory of Change:*** Before implementing a DR system with one or more AR tracks, agency leaders must think through and articulate their purpose in doing so. This process should involve consultation with frontline caseworkers, administrators, past clients, researchers, and community partners who serve system-involved families. As discussed throughout this review, the DR reform has been framed as a solution to several of the persistent challenges facing child welfare systems – family fear, disengagement, adversarial caseworker relationships, resource deficits, maltreatment recurrence, service scarcity, racial disproportionality, and others. In order to achieve and sustain desired outcomes for families, and to demonstrate in credible research that the DR approach significantly contributes to these outcomes, agencies should define and operationalize them in a more focused and consistent way. Researchers have developed a number of DR logic models in their evaluations of DR systems across the country, but it is imperative that state leaders go through this process prior to implementation, and outside of the evaluation context, to ensure they proactively design policies and allocate sufficient resources in ways that adhere to the fundamental goals of their DR initiative and that do not conflict with pre-existing CPS policies, timelines, and mandates to which caseworkers are held.

- ***Diversion Rate and Eligibility Criteria:*** As a state's diversion rate increases, the risk level of the families on the AR track generally increases. Administrators should determine specific eligibility criteria to guide intake screeners' path assignments and ensure that they are trained and receive ongoing supervision regarding proper track assignment. If possible, given staff capacity, path assignment should be made in group staffing meetings with cases later transferred to individual workers to establish the reliability and consistency of decisions. States should consider taking precautionary measures during the roll-out of their DR systems, such as barring children ages zero to five years from AR, as Texas does, given that the AR track is still fairly new in Texas and the state is still monitoring early outcomes (Martin, 2019). States should also decide whether there are particular allegations (such as physical and sexual abuse) that should be barred entirely from AR eligibility. Kathryn Piper's research (2017) suggests that a diversion threshold of 33% of reports or lower is generally safe, but a state's composition of report severity can differ from those of other states, so the highest diversion rate that still produces positive outcomes on the AR track will differ by jurisdiction.
- ***CPS History:*** As part of determining eligibility policy, states must decide whether families with extensive CPS history should still be eligible for the AR track, and whether past AR interventions constitute "CPS history" with the same weight that past investigations (and/or substantiated investigations) do. Most studies found that AR works better for first-time families. States are advised to reserve AR for families with no or few prior CPS encounters to achieve the best outcomes and ensure children are kept safe.

- ***Caseloads and Timeliness Mandates:*** The decision to assign mixed or separate caseloads to staff affected both child safety outcomes and staff morale in the studies reviewed. Although not unanimous, most evidence supports separate staff for AR cases to support model fidelity and the development of expertise in the AR approach. Separate caseloads sometimes engender tensions between AR and investigative staff due to inequitable workload or perceived workload, so it is imperative for states to ensure that all staff understand the challenges and benefits inherent in both kinds of cases. It is also critical for agency leadership to monitor caseloads and ensure that their size does not preclude caseworkers' full engagement with each family regardless of track. Caseworkers should be allowed more time to make initial contact with AR families given the intended practice of scheduling a full family meeting for which all parties are available and present.
- ***Partnerships with Community Providers:*** DR systems, and child welfare systems overall, benefit from the development of strong partnerships with community-based agencies with a varied service array because agency funding is often limited. States in the current review that lacked large grants for basic needs purchases were still able to produce positive outcomes for AR families *if* they developed strong referral relationships with experienced community providers. States in which community stakeholders understood the AR approach and its safeguards to a greater degree saw better outcomes and stronger community buy-in, suggesting that training and outreach to partners such as schools, law enforcement, and medical personnel are worthwhile efforts. Community partners should be reassured that the goal of an AR intervention is the same as the goal of an investigation: keep children safe. Although their practice may differ slightly, the priority of both investigative and AR workers remains the same.

- ***Gradual Implementation:*** States considering first-time implementation are advised to follow a county-by-county or regional roll-out approach to determine what works and what does not before taking the reform to scale statewide. Texas has had success with this approach and left its largest region, Houston, for last – the goal was to acquire ample experience with AR over five years before thousands of children in Harris County became eligible for it (Martin, 2019). This may work better than the rapid implementation seen in states like Illinois, which discontinued its program after just two years of experience with it.

RECOMMENDATIONS FOR RESEARCH AND EVALUATION

The Differential Response approach is not considered an evidence-based policy by the California Evidence-Based Clearinghouse for Child Welfare. This may be attributed in part to the flexibility and variation with which the approach is implemented in each state, making it difficult to identify a single comprehensive model to which fidelity can be measured, beyond the core components delineated in Chapter 2. However, another factor is the limited research available on DR systems and the fact that much of the research has been conducted by the same few groups, calling into question the objectivity of the findings (according to some scholars). A more varied array of evaluators beyond the Institute of Applied Research and the QIC-DR partners would help lend additional credibility to DR research given criticisms of limited evaluator diversity.

Evaluations should also follow a more consistent protocol with respect to observation length, the handling of track-switching and the use of intention-to-treat, and the decision of when to begin counting re-reports. The studies in the Safety Sample varied widely in such methodological decisions, which undoubtedly contributed to their different findings. Based on the research reviewed, evaluators are encouraged to examine families'

outcomes for at least one year post-case closure to give the AR intervention time to make a difference, to control for the surveillance effect, and to allow for measurable differences to emerge between investigated families and AR families.

It may also be fruitful for more studies to follow the unique methodology employed by Fuller et al. (2017) in their study of Oregon's DR system: instead of examining just two groups, AR and TR families, the authors examined outcomes for *four* groups: AR and TR families in DR districts, and *matched* families for the AR group and TR group (all of whom received an investigation) in non-DR districts. Although this was a quasi-experimental rather than experimental design, the propensity score matching method and four-group design allowed for the examination of both the effect of the *AR approach* compared to investigations within DR systems, as well as the effect of *DR systems overall* on families of all risk levels compared to the traditional one-track system. This is an important distinction, because many CPS systems implemented their DR programs with the goal of improving outcomes for *all* of their client families, not just the families diverted to AR, by promoting a more family-centered, strengths-based approach throughout the agency.

The Illinois study, also led by Tamara Fuller and her colleagues (2013), is instructive in that survival analyses were run by "dosage" of AR treatment rather than just by initial group assignment. When results were disaggregated this way, useful insights emerged regarding the effects of completing AR services compared to declining immediately, compared to beginning services and subsequently withdrawing. More research into family retention in AR systems, and how this affects safety outcomes, could be valuable for states that see high attrition and/or poor safety outcomes on the AR track upon early implementation.

Based on the research reviewed, additional questions for further exploration include the following:

- Should the scope of reporting to CPS be widened to include requests for basic needs services, and not just for protection from maltreatment, given the direction that DR has been steering many CPS systems? Should child welfare agencies collaborate more closely with antipoverty organizations, given the significant intersections in needs and families served?
- Should the public be provided more information about DR in states where it exists, such as offering mandated reporters a description when they are trained for their jobs?
- Should the type of reporter influence the type of response received, and why?

Chapter 8: Limitations and Conclusion

This review was limited in a number of ways that must be acknowledged. It included an in-depth examination of just 20 studies out of a larger sample of 43 relevant studies on DR that were initially identified. The 23 excluded studies offered important insights into DR systems and their outcomes, but they collected or analyzed their data in ways that were not directly comparable to the 20 studies in the Safety Sample, making it difficult to identify patterns and sort their results in the same way to draw conclusions about features of DR systems and their correlations with positive outcomes.

In addition, many of the studies in the Safety Sample were conducted in the early 2000s, and it is likely that DR practice in those states has evolved and improved since then, but newer studies have not yet been published or disseminated. The studies in the current review only covered 19 of the 39 states (and D.C.) that currently have or have ever had DR systems, so a number of jurisdictions were not incorporated. The current review also did not include formal interviews or original primary source research with evaluators, staff or families in the states of interest beyond short conversations and electronic communication (Blackburn, 2019; Fluke, 2019; Martin, 2019, Piper, 2019).

The current review represents an effort to analyze and compare the findings of the most rigorous available studies examining the impact of the Differential Response approach in the United States. DR is one of the most rapidly-proliferating reforms in child protection, and it is important for those in the field to have an understanding of what we know and do not know about its ability to keep children safe through engaging families to a greater degree than the traditional investigative process. DR is ultimately about working *with* families, not against them, in child protection efforts whenever possible. Whether it remains a force in child welfare or gradually diminishes in use, its underlying principles of

strengths-based family engagement and collaboration with caregivers – a partnership in pursuit of the ultimate goal of child safety – should form the foundation of any child protection response.

Appendices

APPENDIX A: STATE DIFFERENTIAL RESPONSE POLICIES

Legend: 1=Statewide 2=County/Regional Level 3=Discontinued 4=No Policy Found

Alabama 2	The alternative response system was implemented at the county level in 2002. The alternative track is called a "CPS Prevention Assessment." Source: http://dhr.alabama.gov/services/Child_Protective_Services/Documents/2017APSRPosting.pdf, p. 29
Alaska 3	DR started as a pilot program in 1999 and expanded to additional sites in 2001. In 2009, legislation to continue to fund DR was not passed, and the program ended. Source: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/QIC-DR_Lit_Review%20version%20%202.pdf, p. 5
Arizona 3	Legislation in 1997 authorized a "dual-track" program, with the alternative track called the "Family Builders" program and administered by the Arizona Department of Economic Security. Family Builders was in effect from 1998-2004. It ended due to high-profile child fatalities associated with the alternative track. However, in 2014, the Arizona legislature directed the Department of Children's Services to re-examine policy on AR and consider possibilities for re-implementation. Statutory changes will be needed if it is to be re-implemented, because current statute requires that all accepted child abuse and neglect reports be investigated. Source: https://www.azauditor.gov/sites/default/files/16-102_Highlights.pdf
Arkansas 1	DR was implemented statewide in 2012-13. Source: https://www.sos.arkansas.gov/uploads/rulesRegs/Arkansas%20Register/2012/Nov12Reg/016.15.12-009.pdf

California 2	DR was originally implemented as a 2-year pilot program in 2003 at the county level. It continues to be implemented at the county level. California's system has 3 tracks, including one for screened-out reports that still receive a response. Source: http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2010/I-49_10.pdf
Colorado 2	A series of high-profile child deaths in 2007 led to urgency in reform efforts. The Governor's Child Welfare Action Committee met and proposed a number of recommendations, including the development of an alternative response system. In 2009, the Quality Improvement Center for DR (QIC-DR) selected Colorado, Illinois, and Ohio as sites for evaluation, and in 2010 it began in Colorado with a 5-county consortium. DR continues to be implemented at the county level. Sources: https://www.ncbi.nlm.nih.gov/pubmed/24997071, 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.pdf
Connecticut 1	DR was originally piloted in 2006 and implemented statewide beginning in 2012. The AR track is called "Family Assessment Response" or FAR. Source: https://portal.ct.gov/-/media/dcf/DRS/pdf/DRSinConnecticutpdf.pdf?la=en
Delaware 4	DR is not currently being implemented. However, a commission recommended in a 2016-17 action plan that the state consider it, especially for cases involving domestic violence, substance-exposed infants, and chronic neglect cases accepted by the child welfare agency. Source: https://courts.delaware.gov/childadvocate/docs/2017CJA%20Application%20_Appendices.pdf, p. 5

Florida 3	Florida, along with Missouri, was one of the first two states to implement DR. The program was known as the Family Services Response System or FSRS. However, it was halted in 1998 due to safety concerns. Pilots began again in 2008 in 3 counties, but the evaluations revealed mixed results. In 2009, the DCF Family Safety Office recommended that a DR system be implemented statewide after the convening of a statewide workgroup to guide implementation, but this workgroup was never established. Florida's child welfare system is almost entirely run by private agencies. Source: https://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-105cf.pdf
Georgia 1	DR was first implemented in 2012 and is now statewide. Source: http://dhs.georgia.gov/sites/dhs.georgia.gov/files/related_files/document/DHS%20Board%20Presentation%20DFCS%20June%2020.2012.pdf
Hawaii 1	DR was implemented statewide in 2005. Now there are 3 tracks if a report is accepted – two are voluntary, and the third is an investigation. Sources: https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=92&sectionid=2&articleid=1500, https://humanservices.hawaii.gov/ssd/files/2013/01/CFSP-2014-FINAL.9-30-14.pdf
Idaho 4	The state is considering and assessing the feasibility of DR but has not yet implemented it. Source: https://healthandwelfare.idaho.gov/Portals/0/Children/AbuseNeglect/2014APSR5yrSumAtt.pdf
Illinois 3	The DR program began in 2010 and was known as PSSF – Pathways to Strengthening and Supporting Families. It was unique because it was not housed as part of CPS but instead in a separate unit. It required an in-home assessment within 3 days, and offered cash assistance up to $400, including twice-weekly home visits. However, it was

	discontinued in 2012 due to safety concerns and high investigative caseloads that required more workers on the investigative side. Source: http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/Documents/Year%201%20Site%20Reports/illinois.pdf
Indiana 4	No policies or implementation guidance found.
Iowa 1	In 2013, the legislature directed Iowa's Dept. of Human Services to implement DR, and in 2014 it was rolled out statewide. Source: https://dhs.iowa.gov/sites/default/files/Differential_Response_Conversation_Presentation.pdf?021820191905
Kansas 4	No policies or implementation guidance found.
Kentucky 1	DR began in 2001 statewide. The alternative track is called "FINSA" or a "Family in Need of Service Assessment." Reports of abuse or neglect in certain settings, including daycares, schools, and residential facilities, are always investigated. Source: https://chfs.ky.gov/agencies/dcbs/dpp/Documents/EvaluationoftheMultipleResponseSysteminKentucky_09.pdf
Louisiana 3	AR was first implemented in 1998 and was rolled out statewide in 2008. The program was eliminated in 2014 due to safety concerns. Source: http://www.dcfs.louisiana.gov/assets/docs/searchable/Child%20Welfare/PlansReports/2014%20APSR%20final%20report%20on%202010%202014%20CFSP.pdf

Maine 1	AR was implemented statewide in 2003. Source: https://www.oregon.gov/gov/policy/Documents/LRCD/Meeting4_012216/Differential_response/National_research/Final_Cross_Site_Evaluation_Report.pdf, p. 19
Maryland 1	The authorizing law took effect in 2012, implementation began in 2013, and it was fully implemented statewide as of July 2014. Source: https://dhr.maryland.gov/child-protective-services/alternative-response/
Massachusetts 3	DR was originally implemented statewide in 2009, but then discontinued in 2016 after a 2015 Governor's Press Release acknowledged child deaths in families that had originally been routed to the assessment track. Source: https://www.necir.org/2015/11/17/gov-baker-eliminates-controversial-dcf-two-tier-system-risk-children/
Michigan 4	DR is not currently implemented. State leaders considered DR, but after studying it, decided not to implement it. Source: https://www.michigan.gov/documents/dhs/Workgroup_Results_CPS_413428_7.pdf
Minnesota 1	Minnesota piloted DR in 14 counties in 2001. By 2005, it had been rolled out statewide and was re-named "Family Assessment Response." It is one of the states with the most rigorous evaluations of its DR program, and this came with a lot of institutional support and funding. Evaluators acknowledge that the results are not easily replicable. Source: http://www.sciencedirect.com/science/article/pii/S0145213414001446
Mississippi 4	No policies or implementation guidance found.

Missouri 1	Along with Florida, Missouri was one of the first states to implement a DR pilot program. It began in limited counties in 1994 and was statewide by 1998. Source: https://www.oregon.gov/gov/policy/Documents/LRCD/Meeting4_012216/Differential_response/National_research/Final_Cross_Site_Evaluation_Report.pdf
Montana 4	No policies or implementation guidance found.
Nebraska 2	The legislature first authorized DR in 5 counties in 2014, but it was eventually rolled out to almost 30 counties. Source: https://voicesforchildren.com/wp-content/uploads/2016/06/Alternative-Response-2017.pdf
Nevada 1	A pilot project began in 2007, and by 2009 it was operating statewide. Source: http://dhhs.nv.gov/Programs/Grants/Programs/DR/DR_Program/
New Hampshire 4	No policies or implementation guidance found.
New Jersey 2	DR was implemented at the county level beginning in 2007. Source: https://www.nj.gov/dcf/about/budget/090505_assemblybudget.html
New Mexico 4	DR was first considered in the 2017 legislature but no statute was passed and it was never implemented. Source: https://www.nmlegis.gov/Entity/LFC/Documents/Early_Childhood_And_Education/Hearing%20Brief%20-%20Child%20Protective%20Services%20-%20September%202017.pdf

New York 2	The state first enacted legislation to allow for a "Family Assessment Response" in 2007, and made it permanent in 2011. Over 20 counties now participate (optional, not a statewide mandate). Source: https://www.nysenate.gov/legislation/laws/SOS/427-A
North Carolina 1	The state began a pilot DR project in 2002 in 10 counties. The legislature expanded it in 2004 due to positive early results, and in 2006, it was implemented statewide. Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3864820/
North Dakota 4	No policies or implementation guidance found.
Ohio 1	Ohio's DR pilot project began in 10 counties in 2007. It was evaluated in 2010 with positive results, and statewide rollout was written into statute in 2011. Sources: http://jfs.ohio.gov/ocf/DifferentialResponse.stm; https://ohiochildlaw.org/differential-response/
Oklahoma 1	DR was implemented statewide in 1998, and Oklahoma was one of six states evaluated in 2016 by the federal government. Source: https://www.ok.gov/health2/documents/2014%20-%202018%20State%20Prevention%20Plan%20FINAL.pdf
Oregon 3	DR was originally implemented on a county level in May 2014. Statewide implementation was planned, but progress was halted in 2016 due to a backlog of assessments. It was evaluated in 2017 by the University of Illinois and subsequently discontinued by Senate Bill 942. Sources: https://gov.oregonlive.com/bill/2017/SB942/; https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/112008; https://cfrc.illinois.edu/pubs/rp_20170630_OregonDifferentialResponseFinalEvaluationReport.pdf

Pennsylvania 1	An alternative system called "General Protective Services" or GPS was first developed in 1994 and is now statewide. Source: https://www.media.pa.gov/Pages/DHS_details.aspx?newsid=253
Rhode Island 4	Rhode Island has no formal DR system. All screened-in reports get investigated. However, RI has a program called "Family Care Community Partnerships" or FCCP which is a referral for services after an investigation has been completed. Source: http://www.dcyf.ri.gov/FCCPTogetherRI/
South Carolina 1	South Carolina established a diversion program known as "Appropriate Response" and began statewide rollout in 2012. Source: https://dss.sc.gov/resource-library/statistics/cw/capta_state_plan.pdf
South Dakota 3	South Dakota experimented with DR from 1994-2002, but it was never incorporated into legislation, and it was eliminated in 2002. Now, there is a single track called the Initial Family Assessment or IFA, which tries to incorporate the strengths-based practices of AR into the investigative process. Source: 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
Tennessee 1	DR was implemented statewide in 2009. There are 3 tracks: Investigation, Assessment, and Resource Linkage. Source: http://www.casey.org/media/DifferentialResponseReport.pdf, p. 15
Texas 2	DR implementation began in 2014 and is projected to be completed statewide by the end of 2019. Source: https://www.dfps.state.tx.us/Investigations/alternative_response.asp

Utah 3	As of 2014, Utah was re-considering introducing DR. It had previously been discontinued after a pilot period. Source: http://www.ncsl.org/research/human-services/state-legislation-differential-response.aspx
Vermont 1	Vermont enacted DR legislation in 2008, began implementing in 2009, and rolled it out statewide by 2010. Source: https://dcf.vermont.gov/sites/dcf/files/Protection/docs/2012-CP-Report.pdf, p. 12
Virginia 1	DR was first included in statute in 1996, was piloted in 1998, and was rolled out statewide in 2003. Source: https://law.lis.virginia.gov/vacode/title63.2/chapter15/section63.2-1504/
Washington 1	Washington implemented DR statewide in 2014. Source: https://www.dshs.wa.gov/sites/default/files/CA/acw/documents/IVEFAR022113.pdf
West Virginia 3	DR was implemented on a pilot basis in 1998 but discontinued in 2007. Source: https://dhhr.wv.gov/bcf/Reports/Documents/Annual%20Service%20Plan%20Review%20%28APSR%29.pdf, http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.498.5189&rep=rep1&type=pdf
Wisconsin 2	A pilot program began in 2010 and it was subsequently rolled out at the county level. Source: https://dcf.wisconsin.gov/cwportal/access-ia/ar

Wyoming 1	DR was implemented statewide in 2009 with three tracks. Source: https://www.oregon.gov/gov/policy/Documents/LRCD/Meeting4_012216/Differential_response/National_research/Final_Cross_Site_Evaluation_Report.pdf, https://as.tufts.edu/uep/sites/all/themes/asbase/assets/documents/fieldProjectReports/2007/Team3_CFS_Report.pdf

APPENDIX B: STUDIES INCLUDED IN THE SYSTEMATIC REVIEW – "SAFETY SAMPLE"

	Author(s), Publication, Year	Title	Sample Size/Data Source for Quantitative Analyses	Main Research Questions
1	John D. Fluke, Nicole Harlaar, Brett Brown, Kurt Heisler, Lisa Merkel-Holguin, and Adam Darnell *Child Maltreatment*, 2018	**Differential Response and Children Re-Reported to Child Protective Services: County Data From the National Child Abuse and Neglect Data System (NCANDS)**	5,547 county re-report rates in 6 states (KY, MN, MO, NC, OK, TN) from 2004-2013. Data Source: NCANDS	1. Does increasing the rate of DR utilization affect child safety outcomes?
2	Kathryn Piper *Children & Youth Services Review*, 2017	**Differential Response in Child Protection: How Much is too Much?**	Administrative data from 13 states (KY, MN, MO, OK, WA, WY, LA, NC, TN, VA, VT, IL, MA) for cases screened in from 2000-12 (including both AR and TR cases). Data Source: NCANDS	1. What rate of DR utilization is most effective for reducing subsequent reports of abuse/neglect for cases assigned to the AR track?
3	Stacey Shipe *ProQuest Dissertations*, 2017	**Alternative Response in Child Welfare: A Mixed Methods Study of Caseworker Decision Making**	Administrative data for 2,871 families from 3 jurisdictions in Maryland. This included 1,858 TR cases and 1,013 AR cases screened in during 2013-14. Data Source: Maryland SACWIS (State Automated Child Welfare Information System) and Maryland Dept. of Human Resources Database	1. What are the differences in child and family characteristics for families receiving a TR vs. an AR? 2. What child and family factors predict a re-investigation among AR and TR families? 3. What factors predict a substantiated re-report? 4. What organizational and external factors influence caseworker decision-making?

4	John D. Fluke, Nicole Harlaar, Brett Brown, Kurt Heisler, Lisa Merkel-Holguin, and Adam Darnell *U.S. DHHS, Assistant Secretary for Planning and Evaluation*, 2016	**Differential Response and the Safety of Children Reported to Child Protective Services: A Tale of Six States**	Administrative data from 6 states (KY, MN, MO, NC, OK, TN). 4.3 million cases examined, 2 million of which were AR interventions. 5,587 observations of county utilization rates and re-report rates from 2004-13. Data Source: NCANDS	1. Are children in counties with higher DR utilization rates more or less likely to be re-reported (and/or have substantiated re-reports) than those in counties with lower rates? [A second analysis was later published in 2018 with different findings; see row 1 of this table].
5	Tamara Fuller, Michael T. Braun, Yu-Ling Chiu, Theodore P. Cross, Martin Nieto, Gail Tittle, Satomi Wakita *University of Illinois School of Social Work*, 2017	**Oregon Differential Response Final Evaluation Report**	Administrative data for 18,172 families total, screened in between 2014-15: 4,898 AR families in DR districts matched with 4,898 similar investigated families in non-DR districts, plus 4,188 investigated families in DR districts matched with 4,188 similar investigated families in non-DR districts. Data Source: OR-Kids (OR's SACWIS System)	1. Are there differences in maltreatment re-reports between families who receive an AR or TR assessment and similar families who receive a CPS assessment in a non-DR district? 2. Are there differences in the short-term and long-term costs associated with serving a family in an AR or TR assessment compared to serving similar families in a CPS assessment in a non-DR district?
6	Kathryn Piper *ProQuest Dissertations Publishing,* 2016	**Differential Response in Child Protective Services: A Comparison of Implementation and Child Safety Outcomes**	Administrative data from 6 states (3 DR, 3 non-DR) from 2000-12. DR states were LA, VT, and TN. Non-DR states (at the time) were TX, WI, and IN. In Louisiana, 4,893 AR cases were compared to 4,893	1. What factors related to DR implementation and policy are associated with lower recidivism rates for AR cases as compared to their TR counterparts in the same state and in states without a DR approach?

			matched TR cases. In Tennessee, 31,546 AR cases were compared to 31,546 matched TR cases. In Vermont, 1,131 AR cases were compared to 1,131 matched TR cases. Data Source: NCANDS	
7	L. Anthony Loman, Gary Siegel *Child Abuse & Neglect*, 2015	**Effects of approach and services under differential response on long term child safety and welfare**	Administrative data for 2,382 AR families and 2,247 TR families in 10 Ohio counties, collected from 2008-2013. Data Source: Ohio SACWIS	1. How will AR affect parents' engagement with the caseworker? 2. How will AR affect service reception and utilization? 3. How will families' safety outcomes differ with AR?
8	Marc Winokur, Raquel Ellis, Ida Druryc, John Rogers *Child Abuse & Neglect,* 2015	**Answering the big questions about differential response in Colorado: Safety and cost outcomes from a randomized controlled trial**	Administrative data for 3,194 AR cases and 1,802 IR cases enrolled and randomized between 2010-12. Data Source: Colorado SACWIS	1. Are children whose families are assigned to a family assessment response as safe or safer than children whose families are assigned to investigation response? 2. What are the cost implications for child welfare agencies that implement a DR system?
9	Tamara Fuller, Martin Nieto, Saijun Zhang *University of Illinois School of Social Work*, 2013	**Differential Response in Illinois: Final Evaluation Report**	Administrative data for 3,101 (3,019 analyzed, 82 missing) AR-assigned cases and 4,483 TR cases screened in from 2010-12. Data Source: Illinois SACWIS	1. How is the assessment response different from the investigation response in terms of family engagement, caseworker practice, and services provided? 2. Are children whose families receive an assessment response as safe as or safer than children whose families receive an investigation? 3. What are the cost and funding implications to the child protection agency of the

				implementation and maintenance of a differential response approach?
10	Annette Semanchin Jones *ProQuest Dissertations Publishing*, 2013	**From Investigating to Engaging Families: Examining the Impact and Implementation of Family Assessment Response on Racial Equity in Child Welfare**	Administrative data for 67,071 AR cases and 55,024 TR cases screened in between 2003 and 2009. Data Source: Minnesota SACWIS	1. What impact has FAR had on child safety and racial equity outcomes in MN? 2. Which aspects of FAR implementation can help account for differences in outcomes by counties?
11	Julie Murphy, Linda Newton-Curtis, Madeleine Kimmich *Human Services Research Institute (prepared for QIC-DR),* 2013	**Ohio SOAR Project: Final Report**	Administrative data for 1,202 AR cases and 2,013 investigated cases screened in between 2010-12. Data Source: Ohio SACWIS and SOARDS (Six Ohio Counties Alternative Response Data System) developed specifically for the study.	1. What key factors related to implementation and model fidelity affect safety? 2. To what extent does the new approach affect child safety/maltreatment recurrence? 3. What are the cost implications of the new approach?
12	L. Anthony Loman, Gary Siegel *Child Abuse & Neglect,* 2012	**Effects of anti-poverty services under the differential response approach to child welfare**	Administrative data for 2,605 AR families and 1,265 TR families screened in between 2001-02 but tracked through 2010. Data Source: Minnesota SACWIS	1. What are the long-term effects of providing material or anti-poverty services to families with reports of child maltreatment under a DR system? 2. How do these services affect subsequent reports and removals?

13	C. Nicole Lawrence, Katie D. Rosanbalm, and Kenneth A. Dodge *Children & Youth Services Review*, 2011	**Multiple Response System: Evaluation of Policy Change in North Carolina's Child Welfare System**	Administrative data from 9 DR counties and 9 matched control counties from 1996-2005. Data Source: North Carolina state data system	1. How does DR affect child safety, timeliness of response and case decision, frontloading of services, case distribution, and collaboration with community-based providers?
14	Joanne Ruppel, Yufan Huang, and Gail Haulenbeek *Report to the Governor and Legislature of the State of New York*, 2011	**Differential Response in Child Protective Services in New York State: Implementation, Initial Outcomes and Impacts of Pilot Project**	Administrative data from Onondaga County only for the impact study – 946 AR cases and 546 TR cases screened in from 2009-10. Data Source: NY State CONNECTIONS Data System	1. To what extent did FAR increase/decrease the satisfaction of families? 2. To what extent did FAR increase the percentage of families provided or referred to services that addressed their needs? 3. To what extent did FAR reduce subsequent abuse/neglect reports? 4. To what extent did it reduce the number of children for whom petitions were filed in family court?
15	L. Anthony Loman, Christine Filonow, Gary Siegel *Institute of Applied Research*, 2010	**Ohio Alternative Response Evaluation: Final Report**	Administrative data for 2,285 AR families and 2,244 TR families screened in during 2008-09. Data Source: Ohio SACWIS	1. How do re-reports and removals differ by track? 2. Are there different outcomes by race? 3. What are the cost implications of the new approach? 4. How do staff and families receive the new approach?
16	Gary Siegel, L. Anthony Loman, Christine Filonow *Institute of Applied Research*, 2010	**Differential Response in Nevada: Final Evaluation Report**	Administrative data for 1,861 AR cases and 1,105 investigated cases screened in from 2007-10. Data Source: UNITY System (Nevada SACWIS)	1. How does DR in Nevada affect child safety outcomes? 2. How do caseworkers and families receive the new approach? 3. To what extent does service receipt differ by track? 4. How do characteristics of families differ by track?

17	Mary Jo Ortiz, John D. Fluke, Gila R. Shusterman *U.S. DHHS*, 2008	**Outcomes for Children with Allegations of Neglect Who Receive Alternative Response and Traditional Investigations: Findings From NCANDS**	Administrative data for 93,576 families screened-in during 2004 and 2005 in 5 states (KY, MN, OK, WA, WY). Data Source: NCANDS	1. How do patterns of re-report differ between AR and TR for neglect cases specifically?
18	Gila R. Shusterman, Dana Hollinshead, John D. Fluke, and Ying-Ying T. Yuan of Walter R. McDonald & Associates, Inc. *U.S. DHHS*, 2005	**Alternative Responses to Child Maltreatment - Findings from NCANDS**	Administrative data for 313,838 children reported to NCANDS in 2002; 140,072 of them had received an AR. Data came from 6 states: KY, MN, MO, NJ, OK, WY. Data Source: NCANDS	1. What are the characteristics of children who received an AR? 2. How are the circumstances of the reported maltreatment related to the chances that a child receives an alternative response or an investigation response? 3. How do outcomes differ between children who receive an AR and children who receive an investigation response?
19	Gary Siegel, L. Anthony Loman *Institute of Applied Research,* 2004	**Minnesota Alternative Response Evaluation Final Report**	Administrative data for 2,860 AR families and 1,305 TR families in 14 counties screened in during 2001 and 2002. Data Source: Minnesota Social Services Information System (SSIS)	1. How does DR affect child safety outcomes? 2. How do caseworkers and families receive the new approach? 3. To what extent does service receipt differ by track? 4. How do characteristics of families differ by track? 5. What are the cost implications?

20	Gary Siegel, L. Anthony Loman *Institute of Applied Research,* 1997	**Missouri Family Assessment and Response Demonstration Final Evaluation Report**	Administrative data for 2,922 families in DR pilot counties and 2,558 families in control counties. Data Source: County and state data systems	1. How does DR affect child safety outcomes? 2. How do caseworkers and families receive the new approach? 3. To what extent does service receipt differ by track? 4. How do characteristics of families differ by track?

APPENDIX C: STUDIES REVIEWED IN INITIAL SAMPLE BUT EXCLUDED FROM THE FINAL SAFETY SAMPLE

	Author(s), Publication, Year	Title	Sample Size and/or Units of Analysis	Main Research Questions & Reason for Exclusion from Safety Sample
1	Colleen Janczewski, Joshua Mersky *Children & Youth Services Review*, 2016	**What's so different about differential response?: A multilevel and longitudinal analysis of child neglect investigations**	Administrative data from 997,512 cases, 284 counties, and 39 states between 2001 and 2010. Data Source: NCANDS	1. How does DR implementation affect the number and demographic composition of cases investigated and substantiated for neglect? **Does not examine safety in terms of re-reports.**
2	Tana Connell *ProQuest Dissertations Publishing*, 2016	**Accessing Alternative Response Services: A Multi-Level Examination of Family and Community Characteristics on Racial Equity**	Administrative data on 31,802 families reported to New York State's Administration for Children and Families from 2010-11. Data Sources: NCANDS and New York State Council on Children and Families - Kids' Well-Being Indicators Clearinghouse (KWIC)	1. What is the effect of community characteristics on a county having an AR pathway? 2. How do CPS policies for AR pathways influence which families receive an AR? 3. What is the effect of family and community characteristics on assignment to AR pathways? **Does not examine safety as re-reports; no comparison group.**
3	Institute of Applied Research Associates *Institute of Applied Research*, 2015	**Alternative Response in Maryland Program Evaluation**	Administrative data for 33,498 CPS reports from 2013-15, including 11,125	1. How does Alternative Response impact the safety of children and the well-being of children and families involved in the child

			families assigned to AR. Data Source: Maryland SACWIS (CHESSIE: Children's Electronic Social Services Information Exchange)	welfare system? 2. Are screening criteria applied appropriately and consistently in selecting cases for AR versus the investigative response (IR), and are cases switched, if warranted by child safety or better service to families, from one response pathway to the other? 3. Is there consistency across counties in the implementation of AR? 4. What is the level of family engagement in AR interventions? **Evaluators were unable to compare groups on long-term recurrence outcomes due to data expungement policy.**
4	Gary Cameron, Nancy Freymond *Child Abuse & Neglect*, 2015	**Accessible service delivery of child welfare services and differential response models**	Qualitative data for 179 parents at case opening and 137 at follow-up. No years of data collection specified. Data Sources: Parent surveys, interviews, and agency files.	1. How does the location of services for families on an AR track affect service uptake? 2. How do families perceive services? **Jurisdiction is Ontario, Canada. Only offers qualitative findings.**
5	Tamara Fuller, Megan Paceley, Jill Schreiber *Child Abuse & Neglect*, 2015	**Differential Response family assessments: Listening to what parents say about service helpfulness**	Telephone interviews with 20 AR parents screened in in Illinois during 2010-12. Data Sources: Phone interviews, written surveys.	1. What do parents served by AR find most helpful? **Offers qualitative findings only.**

6	Maria Harries, Rosemary Cant, Andy Bilson, David Thorpe *Child Abuse & Neglect*, 2015	**Responding to information about children in adversity: Ten years of a differential response model in Western Australia**	Administrative data concerning 55,785 children in the province of Western Australia from 1990-2005. Data Source: Western Australia Dept. for Community Development Client Information System	1. How did Australia's DR intervention "New Directions" affect re-report rates? **Jurisdiction, no control group.**
7	Colleen Janczewski *Child Abuse & Neglect*, 2015	**The influence of differential response on decision-making in child protective service agencies**	Administrative data for 297 counties with reports screened in between 2009-10. Data Source: NCANDS	1. After accounting for community characteristics such as poverty and race, to what extent does DR lead to different investigation, substantiation, and removal rates among cases with neglect allegations? 2. Second, if significant relationships exist between decision outcomes and county-level characteristics, does DR moderate these relationships? **Does not measure safety in terms of re-reports.**
8	Annette Semanchin Jones *Child Abuse & Neglect*, 2015	**Implementation of Differential Response: A Racial Equity Analysis**	Administrative data for all screened-in reports in Minnesota from 2003-2010: 122,095 cases total.	1. Is race a predictor in pathway assignment to FAR or TR in Minnesota? 2. Is race a predictor of path-switching? **Does not examine safety in terms of re-reports.**

			Data Source: Minnesota SACWIS (SSIS)	
9	Daniel Ji and Richard Sullivan *Research on Social Work Practice*, 2015	**The Manifest and Latent Functions of Differential Response in Child Welfare**	Administrative data for 8,678 AR cases and 25,195 investigated cases in Vancouver between 2007-12. Data Source: Ministry of Children and Family Development Management Information System (MCFD MIS)	1. What is the proportional assignment of cases in the British Columbia FDR pilot sites for FDR vs. INV? 2. What is the rate of pathway re-assignment, and when does it happen? **Jurisdiction is British Columbia, Canada; does not compare recidivism by group.**
10	Karen McCallum, An-Lin Cheng *Public Health Nursing*, 2015	**Community Factors in Differential Responses of Child Protective Services**	Administrative data for 31,277 AR cases and 31,222 investigated cases from five states (KY, LA, MO, NC, VA) screened in prior to 2010. Data Source: NCANDS	1. What are the differences in child, family, and case characteristics by track? 2. What are the relationships of county-level community factors for AR and non-AR paths in the model, when controlling for child, family, and case characteristics? **Does not examine safety in terms of re-reports.**
11	Annette Semanchin Jones *Journal of Public Child Welfare*, 2015	**Effective Implementation Strategies of Differential Response in Child Welfare: A Comparative Case Analysis**	Qualitative data from focus groups with 70 workers and interviews with 13 supervisors from nine Minnesota counties. Dates not specified.	1. What are the factors that enhance DR implementation and are associated with positive family outcomes? Specifically, how does implementation differ between the counties in MN that have seen more positive outcomes than others?

			Data Sources: Focus groups and interviews of Minnesota CPS staff.	**Offers qualitative findings only; findings are discussed more thoroughly in the 2013 paper that was included in the Safety Sample.**
12	Krista Thomas *ProQuest Dissertations Publishing*, 2015	**Understanding Predictors of Family Engagement: An Examination of Worker Characteristics**	Secondary analysis of data collected by Fuller et al. (2013) and Winokur et al. (2015) – both discussed in Appendix B. Data Sources: See original studies cited above.	1. To what extent do various factors, independently or together, contribute to positive or negative caregiver engagement at the first and last meeting, among families eligible for the AR pathway in Colorado and Illinois? **Does not examine safety in terms of re-reports.**
13	Lisa Merkel-Holguin, Dana M. Hollinshead, Amy E. Hahn, Katherine L. Casillas, John D. Fluke *Child Abuse & Neglect*, 2015	**The influence of differential response and other factors on parent perceptions of child protection involvement**	Secondary analysis of data collected by Fuller et al. (2013) and Winokur et al. (2015) – both discussed in Appendix B. Examined parent surveys for 463 families in Colorado and 1,132 families in Illinois, including both AR and TR cases. Data Sources: See original studies cited above.	1. How do parents perceive AR and TR tracks and caseworker involvement? **Does not examine safety in terms of re-reports.**

14	Colleen Janczewski *ProQuest Dissertations Publishing*, 2014	**Differential Response and Agency Decision Making: A National Study of Child Neglect Cases**	Administrative data for 994,045 CPS cases in 297 U.S. counties screened in prior to 2010. Data Source: NCANDS	1. How does DR affect those families who do not get diverted? In particular, how does DR change the proportion and characteristics of the population of children experiencing investigations, substantiations, and removals from their homes? **Does not examine safety in terms of re-reports.**
15	Ignacio Navarro *California State University - Institute for Community Collaborative Studies*, 2014	**Family Engagement in "Voluntary" Child Welfare Services: Theory and Empirical Evidence from Families under Differential Response Referrals in California**	Administrative data and worker surveys for 3,566 families with reports between 2009-13 in 14 California counties. Data Source: Data from Family Resource Centers	1. Do DR families perceive services to be voluntary? How does their behavior differ as compared to walk-in clients without a DR referral? **Offers findings on family engagement but not safety; examines California, which was excluded from this report for reasons described in Footnote 11 on p. 37.**
16	Ramona Alaggia, Tahany Gadalla, Aron Shlonsky, Angelique Jenney, Joanne Daciuk *Child and Family Social Work*, 2013	**Does Differential Response Make a Difference: Examining Domestic Violence Cases in Child Protection Services**	Administrative data for 785 CPS cases in Southern and Eastern Ontario beginning in 2007. Data Source: Ontario Child Abuse and Neglect Data System	1. How did DR implementation in Ontario affect the pathways of domestic violence cases within the child welfare system? **Jurisdiction is Canada; does not have treatment and control groups by DR treatment, but rather by DV involvement.**

17	Todd Franke, Sofya Bagdasaryan, Walter Furman *Journal of Public Child Welfare*, 2011	**Differential Response in Rural Counties: Path Differentiation, Service Receipt, and Case Disposition**	Case files for 90 cases from 11 rural counties in California from 2007-08. Data Source: California Dept. of Social Services	1. How are rural counties in California assigning families to the two tracks? 2. How has the composition of services changed since the implementation of DR? **Jurisdiction is California; does not examine safety by re-reports.**
18	Sheila Marshall, Grant Charles, Kristin Kendrick, Vilmante Pakalniskiene *Child Welfare*, 2010	**Comparing differential responses within child protective services: a longitudinal examination**	Administrative data for 259 FDR (AR) cases and 328 TR cases screened in during 2005-06 in one region of British Columbia. Data Source: Government Ministry Database for Intake and Investigations	1. To what extent does Family Development Response (FDR, similar to AR) lower rates of re-entry into CPS involvement and child removal? **Jurisdiction is Canada.**
19	Amy Conley and Jill Duerr Berrick *Child Maltreatment*, 2010	**Community-based child abuse prevention: Outcomes associated with a differential response program in California**	Administrative data for 134 Track 1 cases and 511 control cases in Alameda County from 2002-06. Data Source: Alameda County Case Management System	1. How does California's 3-track DR program affect recidivism rates for children screened out of a CPS response (Track 1)? **Jurisdiction is California.**
20	Amy Conley *ProQuest Dissertations Publishing*, 2008	**An Assessment of Differential Response: Implications for Social Work Practice in Diverse Communities**	Administrative data for 161 Track 1 clients and 447 control clients. Interviews with 27 staff and 50 clients.	1. How does California's 3-track DR program affect recidivism rates for children screened out of a CPS response (Track 1)?

			Data Source: Alameda County Social Services Child Welfare Services Case Management System	2. What are the implementation implications? **As noted in Footnote 11 on p. 37, studies of California were intentionally excluded because its DR system serves screened-out cases.**
21	Gary Dumbrill *Child Abuse & Neglect*, 2006	**Parental experience of child protection intervention: A qualitative study**	Interviews with 18 parents in British Columbia and Ontario, Canada. Data Source: Qualitative interviews	1. What shapes parents' perceptions of the CPS intervention? **Offers qualitative findings only. Jurisdiction is Canada.**
22	Erica Zielewski, Jennifer Macomber, Roseana Bess, Julie Murray *The Urban Institute Child Welfare Research Program*, 2006	**Families' Connections to Services in an Alternative Response System**	Interviews and focus groups with an unspecified number of child welfare workers, administrators, providers and clients in Kentucky and Oklahoma. Data Sources: Qualitative interviews	1. How do families connect to services in a DR system? What improvements can be made? **Offers qualitative findings only.**
23	D. J. English, T. Wingard, D. Marshall, M. Orme, A. Orme *Child Abuse & Neglect*, 2000	**Alternative responses to child protective services: Emerging issues and concerns**	Administrative data on 1,263 cases referred between 1992-95 in Washington State.	1. How do case characteristics and outcomes differ for cases referred to Washington's CBARS program vs. traditional response, and within CBARS, for different

			Data Source: CBAR (Community-Based Alternative Response) File System	levels of service engagement? **The DR-like system analyzed in this study began in 1988; it was not sufficiently comparable to the systems developed post-1993 because it served cases that are screened out of CPS services and were instead referred to a nonprofit provider.**

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