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Practical Strategies

Evaluating where we're at with differential response

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ABSTRACT

Objective: Differential response (DR) models have been implemented internationally since the mid-1990s as an innovative way of responding to child maltreatment. The purpose of the present article is to review the literature on DR and the implications it has for current child welfare research, policy, and practice.
Methods: A review of DR studies published from 2000 to 2012 available through various social service databases was conducted. DR evaluation reports from various states were also reviewed. Salient factors are reported.
Results: DR does not compromise child safety; positive results have been found with regards to family engagement, worker satisfaction, quicker response times, and involvement with community organizations.
Conclusions: Rigorous methodological testing needs to be conducted to further strengthen DR findings.

Introduction

Child maltreatment continues to be a problem plaguing our society, and despite efforts, child protection services (CPS) rate of investigations continue to increase (Shusterman, Hollinshead, Fluke, & Yuan, 2005). This rise in rates of reporting not only refers to the number of cases being investigated, but also to the types of cases being referred. Risk of maltreatment, neglect and domestic violence cases seem to predominate those being referred to CPS (Sedlak et al., 2010). Differential response (DR) surfaced out of political concerns for the sustainability of current child protection systems in recognition that positive child welfare cannot be the responsibility of one sole agency (i.e., CPS). DR aims to support CPS in addressing issues of over inclusion and under inclusion by offering flexibility in their response (Waldfogel, 1998). Rather than decreasing the number of children coming into care, traditional investigative risk assessment models may have involuntarily increased the numbers of children in need by not responding to lower level risk cases before they escalated into (Conley, 2007). DR models appeal to community organizations in supporting families, while recognizing the importance of building an alliance with families to promote family engagement. In addition to sustainability, DR has been propelled by a shift in our theoretical conceptualization of child maltreatment from a pathological to a more relational/ecological model. Traditional CPS approaches with risk assessment tools and prescriptive recommendations for parents to "seek treatment" to end the abuse are no longer sufficient. A DR model encourages that consideration be given to socio-environmental factors and their ability to serve as protective buffers against maltreatment while building resilience.

This article will provide an overview of DR and the efficacy of this model, while providing implications for policy, practice and research. Consideration will be given to DR implementation and causes for caution.

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Defining DR

Attempting to define DR is complex because it can be simultaneously understood as an administrative policy or clinical model for intervention, with little guidance surrounding its operationalization. To be considered a DR system, the CPS must have the capacity to provide both protective responses (i.e., traditional child protection orientation) and services using differential approaches (CWIG, 2008; Marshall, Charles, Kendrick, & Pakalniskiene, 2010; Merkel-Holguin, Kaplan, & Kwak, 2006; QIC-DR, 2009; US Department of Health and Human Services and Office of the Assistant Secretary for Planning and Evaluation, 2005). In this system, the protective pathway is restricted to referrals where the child has been severely maltreated, or where there is imminent risk for further abuse. The protective pathway remains responsible for determining substantiation (i.e., CPS decision that a child situation merits ongoing CPS involvement) through an investigation of forensic evidence, whereas the "non-investigative" DR pathway is usually applied to cases of low to moderate risk. This response focuses on engaging the family in an assessment of family needs and strengths, in order to determine what is needed to ensure child safety and well-being. Rather than being merely child-focused, DR aims to identify what individual and environmental barriers facing the family may be contributing to the maltreatment risk. In order to respond to the varied needs of a family, DR models usually have links with community-based partners and informal helping networks (Waldfogel, 2009). A formal decision of substantiation is typically not required in DR. Families are often given the option to refuse DR services, without consequence, as long as there is not significant concern for the safety of the child. Both the investigative and differential tracks allow for fluidity between referrals, and the capacity to re-assign families to different pathways in response to findings following the initial evaluation (US Department of Health and Human Services and Office of the Assistant Secretary for Planning and Evaluation, 2005).

Kaplan and Merkel-Holguin (2008) summarized 6 core values derived from the American Humane Institute of Applied Research meant to guide the development, implementation and evaluation of DR. DR encompasses the following values: (a) *engagement versus adversarial approach*: Parents are seen as partners in maintaining child safety rather than being "investigated"; (b) *services versus surveillance:* Rather than "policing" families, adoption of a non adversarial, non accusatory way will result in better outcomes; (c) *Label of "in need of services/support" versus "perpetrator":* Positively reframing the way we view a problem will allow for destigmatization of being associated with CPS; (d) *encouraging versus threatening:* Most traditional CPS services use their authority, and client fear of child removal, to ensure that certain steps have been taken. Through encouragement and reduction of a family's level of fear, they may be more willing to seek assistance; (e) *identification of needs versus punishment:* utilizing family strengths, while attending to the risk concerns, will help switch the perception of families to one that recognizes CPS as being able to provide support, rather than punishment; (f) *continuum of response versus one size fits all:* recognition that not all families warrant the same response and taking into consideration varied levels of risk reports.

DR effectiveness

The majority of studies involving evaluation of DR consists of quasi-experimental designs given ethical inability to allow for randomization into investigative versus differential tracks (Conley, 2007; English, Wingard, Marshall, Orme, & Orme, 2000; Marshall et al., 2010; Ortiz, Shusterman, & Fluke, 2008). The Minnesota Alternative Response (Loman & Siegel, 2008), was the only study that managed to conduct an experimental design by allowing random assignment of families deemed appropriate for DR into differential or investigative tracks. However, the study makes mention of the use of a discretionary power with regards to assignment to control and experimental groups. Given methodological limitations, many authors attempt to demonstrate equivalency of the two comparison groups by matching families based on social demographic characteristics. These studies are primarily concerned with the safety of the child being maintained in either investigative or non-investigative pathways. The outcome measure used as an indicator of child-safety is recurrence (i.e., re-report, re-entry, recidivism). Recurrence is measured by whether an additional report was reported to CPS following track designation or case closure. The index period for this report has been shown to differ from study to study with some researchers calculating recurrence as occurring during the intervention period, others calculating recurrence one month following a case closure. Recurrence was also interpreted as meaning different things depending on the study. Recurrence was defined as either a report to CPS Hotline or as a full-fledged assessment either at the investigative or differential track. A major limitation to using recurrence as an outcome measure is its validity as an accurate measure of child-safety and well-being. Table 1 summarizes findings from experimental studies conducted within the US and Canada. Conley and Berrick (2010) compared the differential treatment group children with children eligible for service, but denied due to program capacity. They found that no significant differences existed regarding likelihood of a re-report and timing of subsequent maltreatment group. Three of the six studies demonstrated a significant difference in out of home placements with the differential response group having lower rates of placement than the traditional investigative approaches. Positive outcomes were found on measures of improved family engagement and satisfaction (Marshall et al., 2010; Pennell & Burford, 2000). These measures were primarily demonstrated through qualitative analysis, but additionally through some quantitative measures through the structured-decision-making (SDM) instrument.

Additional findings revealed that assessment workers knew and could report more about the families they met than did investigators. When services were provided, they were generally provided more quickly (Siegel, 2012). Families responded much more positively to a DR assessment compared to investigations, and they played a larger role in determining a plan of