

DIFFERENTIAL RESPONSE: PHASE I

**A report on the Monterey County Differential Response
Planning Process
Fall 2006**

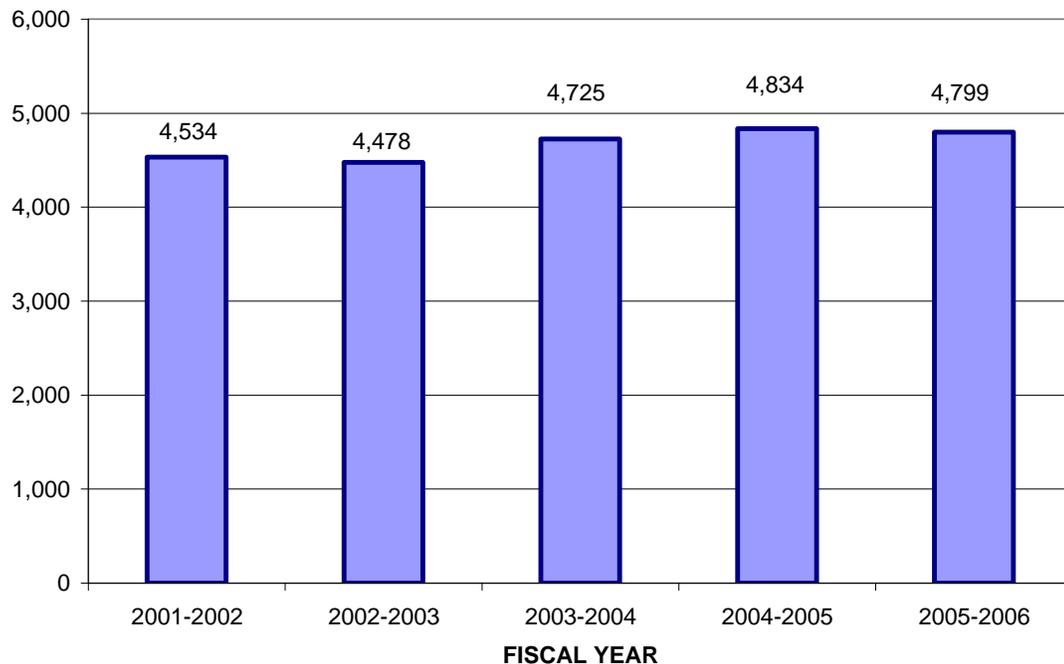
I. Introduction

1. What is Differential Response?

Differential Response (DR) is an early intervention program based on the concept that child safety is the mutual responsibility of communities and child welfare agencies. Communities can respond to children who are in danger of abuse and neglect at the first sign of a problem. Because of chronic under-funding and outdated funding structures that focus on child removal rather than strengthening families, county governments have few resources to invest in providing prevention services.

However, in a number of California counties Differential Response, part of the State's child welfare re-design, is creating valuable connections among community agencies, county programs and families. The result is a more responsive child welfare system, enhanced community services and improved family and child well being. (Foundation Consortium for California's Children & Youth, Summer 2005)

REPORTS OF ABUSE AND NEGLECT



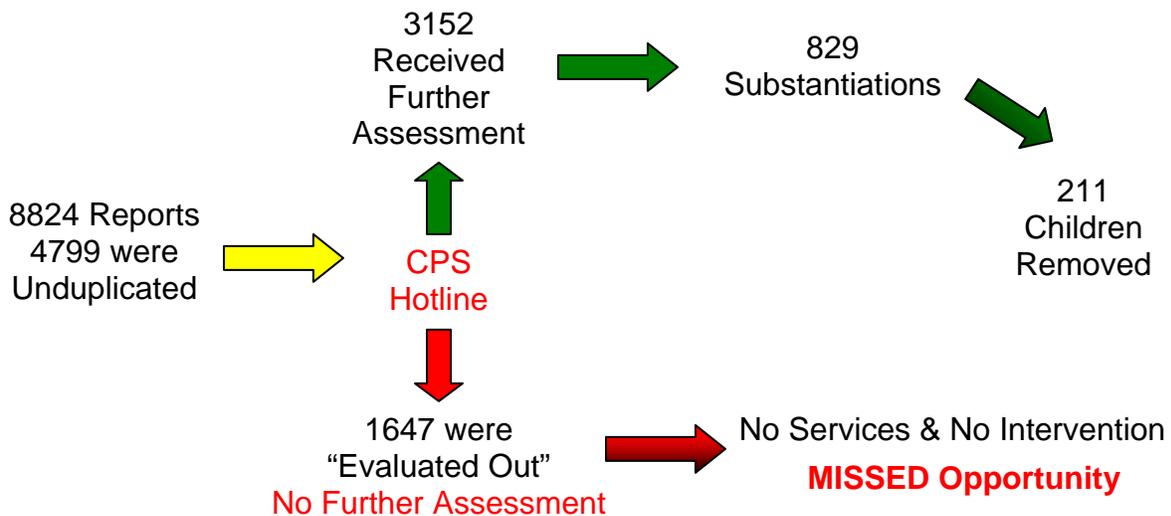
Through DR, families referred through the Child Protective Services Hotline are offered access to the services they need to keep their kids safe and at home. In this community-based program, families who do not reach the legal definitions for abuse and are not

assessed, instead meet with a community engagement specialist/case manager and are assessed and referred to community agencies for services. In DR, this is called Path 1 and is focused on children who are at low risk of harm. In 2005, there were 1,647 Monterey County children on whose behalf calls were made that would have qualified as Path 1 referrals.

A second category of calls into the hotline leads to further assessment by a social worker (3152 children in 2005). In that year, only 26% of the cases were instances of substantiated abuse (829), with 25% of those leading to removal of the child (211). The cases were closed for the remaining 75% and no further action was taken. With DR, those 2,323 children’s families would be engaged, assessed and referred to community-based services to ameliorate the issues impacting those families. Families work with both child welfare and other county agencies in collaboration with community partners to identify their strengths and challenges. This is called Path 2 and is focused on children who are at low to moderate risk of harm.

Monterey County Family and Children’s Services has no legal authority to hold cases open on these families or mandate that they access services. However, the community can engage and support families in prevention services that stabilize and strengthen their relationships and reduce their chances of entering the child welfare system. By working with families to identify solutions, DR promotes voluntary engagement in community services and a collaborative approach to keeping children safe.

2005-2006 Referral Status



Path 3 is often referred to as the “traditional response”, where a child is deemed unsafe and actions must be taken on the child’s behalf with or without the family’s consent. Often this involves court intervention. With DR, efforts can be made to voluntarily engage the family through comprehensive assessments; in-depth case plans and focused services and supports. Such efforts, especially with non-offending family members, can

help preserve connections between the child and those family members, while protecting the child from harm. Through the Family to Family Program and Team Decision Making, Monterey County is already implementing many of the tenets of DR.

Goals of DR:

- Families will be linked to community-based services and resources based on their needs
- Services are accessible and culturally appropriate, and support is available
- Families are involved in setting goals based on their strengths
- Eligible families will be enrolled in insurance programs that will support healthy children
- Families stay out of the child welfare system and are connected to support systems within their communities
- The capacity of the community is developed to provide culturally competent, strength-based, accessible services relevant to the needs of families for keeping children safe and at home
- All families are more successfully engaged
- Decrease in reported abuse with children growing up in a more safe and stable environment in their homes
- Strong, well-coordinated public/private partnerships are developed to ensure services and supports are available for families
- DR is part of the larger system of care, a component of the continuum that includes Family to Family and Wrap-Around Services

2. Planning Process

The Department of Social and Employment Services, Family and Children's Services (DSES/FCS) contracted with the ACTION Council of Monterey County (ACMC) to lead a planning process to determine the best strategies for implementing Differential Response and to make recommendations for moving forward with incorporating the initiative into existing child welfare practices. The timeline for completing the process was 11 months, with funding of \$67,000 for planning and evaluation and an additional \$40,000 directly managed by DSES/FCS for incorporating a 3-month pilot into the local research on family engagement strategies. Funding was a blend of Monterey County Behavioral Health (MCBH) System of Care and state child welfare monies.

FCS participated in the statewide Breakthrough Series Collaborative (BSC) on DR, sponsored by the California Department of Social Services, the Foundation Consortium for California's Children and Youth and Casey Family Programs. Monterey County sent teams of 10 people, composed of staff, community partners and a birth parent to four BSC convenings in 2004 and 2005. The convenings were attended by over 40 other California Counties also learning about and planning for DR.

The BSC methodology utilizes small-scale rapid tests of change to implement improvements throughout an organization. These small tests of change, known as PDSAs (Plan, Do, Study, Act cycles) enabled FCS staff and community partners to begin testing

DR strategies in Monterey well before implementation of our local pilot. The convenings provided a wonderful opportunity share and learn from the experiences of other counties. The BSC also hosted an extranet, providing an additional venue for counties to post data, PDSAs and other DR documents.

As the final part of the BSC, Monterey County had the opportunity for Peer Technical Assistance from a mentor county, Contra Costa, which provided assistance and guidance in developing our model for implementation, offered frank assessments of challenges encountered in their process and provided numerous examples of sample forms and training formats. A two-day site visit (see Section V) helped clarify the important roles of engagement specialists, case managers and community partners. Their staff was available for consultation and a sharing of expertise to FCS staff.

In November 2005, a planning team was assembled under the guidance of Ricki Mazzullo, Executive Director of ACMC and Margaret Huffman, Program Manager from FCS. The team consisted of representatives from community agencies, FCS intake and emergency response staff, MCBH, Child Abuse Prevention Council (CAPC), foster youth, parents and SEIU 535. The planning team was actively involved in implementing several aspects of the process, making recommendations on the planning strategy and reviewing the recommendations for moving forward into Phase 2 of DR implementation. In addition, initial meetings were held with a local marketing consultant to strategize how to promote differential response to key populations: funding sources, FCS staff, community agencies and groups and the public.

On overview of the planning process is presented below:

a. Focus Groups & Community Surveys

Members of the planning team conducted 11 focus groups over a 2-month period with members of the FCS staff, community residents, parents who were previous recipients of child welfare services, foster youth and community agencies. A power-point presentation was developed with input from the team explaining the current system for handling referrals to the CPS hotline and the changes that would occur as a result of DR implementation. Anticipated outcomes for DR were explained (see goals above) to each focus group. Participants were asked a series of questions designed to help determine those services families would need to keep children safe in their homes, existing barriers to accessing services and the best strategies for engaging families in a non-threatening manner.

A community survey was developed in English and Spanish and distributed to participants in the community resident focus groups and to targeted community members who did not participate in a focus group. The survey was aimed at determining the services families need, existing gaps in services, barriers to accessing services and positive engagement strategies. (A summary of the focus groups and surveys is presented in Section II.)

b. Research: State and National

Researchers contacted several states and California counties for information on DR planning and implementation to determine which practices were applicable to Monterey County's families and existing community resources. The research included questions on the planning process, implementation strategies, funding streams, challenges encountered, successes, outcomes and types of community partners; i.e. discrete agencies, family resource centers. (See Section III a and b)

Based on the results of the research and a determination that all site visits would be within California, members of the team visited several counties: Contra Costa, Stanislaus, Sacramento and San Mateo. A visit to Alameda County, which has been implementing DR longer than any California County, is scheduled for October 2006. The summary of that site visit is not contained in his report. (See Section V)

c. *Research: Local Pilot*

A key to successful implementation of DR is determining the best method for engaging families and ensuring they access services. Utilizing available state funds, FCS worked with two community agencies, which had existing contracts with the department, to pilot both Path 1 and Path 2 over a 3.5-month period. Prior to beginning the pilot, community partners and child welfare staff were trained on the goals and philosophy of DR, the procedures to be used in implementing and evaluating the program and the value to families of this public-private partnership.

The key evaluation questions were:

- How successful and effective was the family engagement process?
- What community services are needed to support families?
- How many families can be accommodated through DR?
- What about the DR process worked well, what aspects proved to be challenges, and what barriers and obstacles exist to implementing an effective DR system?

It was decided that because of the relatively short term of the implementation, it would not be possible to adequately determine outcomes for families.

Community Human Services, in collaboration with Alisal Community Healthy Start, had primary responsibility for implementing Path 1 in the East Salinas, Seaside and Marina communities. Three methods of engaging families were tested once referrals had been made from the intake social workers.

Door to Hope tested Path 2, which focused on families, countywide, with reported substance abuse issues. Joint visits were made with Emergency Response (ER) social workers and a community case manager from the agency.

A total of 145 families were served: 81 through Path 1 and 64 through Path 2. Both quantitative and qualitative data were collected through forms that tracked

participant characteristics and services accessed, as well as focus groups and interviews with staff that participated in the pilot. (See Section IV)

d. Recommendations: Plan for Phase 2 implementation

The ACTION Council submitted a plan for the next phase of implementation that has been reviewed and accepted by DSES and the planning team. The plan provides a detailed overview and timeline that includes:

- Developing a steering oversight committee charged with maintaining accountability for the initiative;
- Building the capacity of the community to provide services and supports to families and children;
- Improving and streamlining the referral process, providing on-going review of the implementation process to allow for corrections when needed;
- Implementing Path 1 and Path 2 over a period of two to three years in all areas of the county for children 0 – 18 years.

ACMC would “incubate” DR and at the end of Phase 2 would, in conjunction with DSES, determine whether DR should become part of FCS or remain a community-based initiative.

Funding for the initial period (December 2006 – June 2007) will be \$505,800 with the majority of funds going out to the community to build service capacity. (See Section VI)

II. Focus Groups and Community Surveys

Focus Groups

One of the first steps in the planning for Differential Response implementation was to conduct a series of focus groups to determine the services families need to keep their children safe, barriers to accessing those services and the best ways to engage families to encourage them to seek services.

A total of 11 focus groups were conducted:

- ◆ 5 with Family and Children’s Services staff: Clerical and Social Service Aides, Adoption and Placement Support units, Salinas Emergency Response and Intake units, Seaside staff, Court and Family Reunification units
- ◆ 6 with community groups: community-based organizations, East Salinas community members, Seaside community members, foster youth, parents who have been previous recipients of child welfare services, relative caregivers

At each focus group the following questions were asked; some were modified to be more meaningful to the particular group (i.e., youth, mentor moms):

1. What kinds of services do you think families need to help them keep their kids safe?
2. What do you think may be barriers to families using services they may need?
3. What are the best (least threatening) ways to approach families and engage them in seeking help? (asked of community residents) *or*
Do you have any ideas on how these barriers may be overcome? (asked of staff)

DSES staff members were all asked an additional question:

1. Would you be interested in participating in DR implementation? If so, what would you need to help you test or implement DR?

Community agency staffs were asked:

1. If families were referred to you for services, would you now have the capacity (staff, facility, funding) to serve them?

The following responses were provided:

- a. **Services** (All groups identified a “laundry list” of services families need)
 - Affordable childcare, respite care
 - Domestic violence services, anger management
 - Alcohol and drug treatment
 - Parent education
 - Mental health counseling
 - Life skills counseling
 - Job skills training

- Family activities
- Affordable recreational activities for kids and teens
- Health and dental services

Also listed were issues that families face:

- Lack of affordable housing
- Low wages
- Unsafe neighborhoods
- Undocumented

In general, families need:

- Information on what services exist and how to access them
- Services that are in their own language and culturally appropriate
- Services that are located in their neighborhoods — schools, churches, community centers, and/or home-based services
- Services available during “non-business” hours
- Services without having to wait
- Early intervention
- More shelters for both men and women, and for men with children
- Therapists, not interns – and they need to see the same person each time

Some specific recommendations:

- Assisted living services/independent living skills for low-functioning families – not substance-addicted, or living with physical or developmental disabilities
- Voice mailboxes, telephones, answering machines so they can be contacted
- Use of more non-traditional community partners

b. Barriers

There was agreement across groups on barriers:

- Language
- Transportation
- Fear: children taken away, deportation, increased violence (in DV cases)
- Access; waiting lists
- Shame; cultural pride in self-sufficiency
- Legal status; don’t know their rights
- Denial that a problem exists
- Hours services provided
- Money
- Lack of knowledge/education about services
- Feeling overwhelmed
- Distrust
- Lack of support from family and friends

c. Family Engagement/Overcoming Barriers

Family Engagement

- Engagement specialists that “look like” the family members or have experienced similar problems; i.e. mentor moms
- Send a member of the community, someone trusted
- Asking families how to help; engage them in developing own goals, focus on strengths
- Someone connected with the local church
- Someone with cultural sensitivity
- Develop a means of addressing issue of shame
- Provide information through public service announcements, in clinics, grocery stores, laundries, community events, etc. so families are aware of program before someone comes to their door
- Be very clear that the person engaging the family wants to help and is not there to check up or intimidate
- Be sure schools have information and are involved in program; send information about programs home with children (parents read them)
- Someone who will address families’ fears

Overcoming Barriers

- Transportation, bus tickets
- Services provided at hours people can access
- Eliminate waiting lists
- Find ways to address needs of undocumented families
- Services must be culturally sensitive and in families’ language
- Citizenship projects and services
- More funds for services
- Involve churches, schools: these are places in neighborhoods familiar to families (generally trusted)
- Involve community members, seniors – engage as mentors for families
- Develop a “warm line” and resource book
- Provide in-home services, like counseling, parent education
- Support groups, if people have to wait for services
- Develop more resources in south and north county
- Money to pay for services if families not eligible for Medi-Cal or Healthy Families
- Legal advice

d. DSES Staff Participation

- Marketing, spreading the word, participate in community events
- Participate in piloting ideas: reduction in caseload when involved in committee or pilot; overtime or flexible schedules
- Help CBOs to build capacity

e. CBO Capacity

All agencies present were concerned with a potential increase in clients with no money to pay to increase capacity. Only one agency said they could see more clients, but still would not have funds to provide some specific forms of assistance. Many agencies had waiting lists or were at capacity. To see more clients, they would have to increase staff.

Keeping Children Safe Surveys

Surveys were distributed at the community meetings in East Salinas and Seaside, as well as to people involved in receiving substance abuse services (for whom no focus group was convened). The survey was available in English and Spanish and was designed to determine what families felt they needed to keep children safe and in their homes.

Questions were distributed across three general categories:

1. What types of services do families currently access and what is their relative importance?
2. What are the reasons that services may be difficult to use?
3. What are the community issues that are of concern to families?

The majority of respondents (68 of 95 total) were from East Salinas (93905 zip code), while 11 lived in Seaside (93955). Eighty-three percent (83%) were female, 85% identified themselves as Hispanic and 75% listed Spanish as their primary language.

Types of services were divided into four categories: services for children, services for youth, services for adults and families, and services for parents. The highest number of responses for each category is:

1. *Services for children:* 28% accessed drop-in childcare or respite care, 23% perinatal and infant parenting services and 20% after-school childcare. Drop-in childcare (20%) and after school programs (19%) were deemed of highest importance for families. By contrast, only 10.5% of respondents believe that mentoring services for children are important.
2. *Services for youth:* 29.5% participated in domestic violence classes for teens, 19% accessed youth family planning services, 16% youth gang intervention. The highest needs expressed were for youth family planning services (21%) and domestic violence prevention classes (19%).
3. *Services for adults and families:* 56% participated in ESL classes, 27% accessed alcohol and drug prevention services, and 24% domestic violence prevention classes or counseling. Services deemed most important were ESL classes (35%), drug and alcohol treatment (21%), mental health services (19%) and domestic violence counseling (18%).
4. *Services for parents:* top services accessed were parenting classes (26%), places for parents to meet and talk to other parents (24%) and family counseling (20%). Services most important to families were parenting classes and family counseling (both 19%) and anger management classes (17%).

The predominant barriers families experienced in accessing services were language or cultural barriers, transportation, lack of childcare and cost. Only 14% said they had little or no difficulty using services.

The survey offered a list of community issues of concern to families: immigration, food, housing, transportation, employment and health services. Employment (69.5%), housing (62%) and health care (60%) caused the most worry for families in the respondents' community. However, all the issues listed were of concern for more than one-third of respondents.

Both the focus groups and the surveys identified specific services that families need and barriers to accessing those services. Needs expressed were remarkably similar: childcare, substance abuse services, parenting classes, anger management (domestic violence counseling) and mental health counseling. However, families also expressed concern about a number of issues that speak to larger societal problems and disparities that include employment, affordable housing and healthcare, concerns that must be addressed in the implementation of this initiative.

III. Research: State and National

Early in the planning process, two researchers gathered information and data on the approaches and experiences in designing Differential Response systems from other communities across the state and nation. They reviewed and analyzed available reports and documents on DR in other communities and interviewed child welfare services staff in California and other states. Their report provided a summary of what was learned through this research process and a series of recommendations related to the next steps in the design and direction for the development of DR in Monterey County. The research findings are presented in two principal sections.

The first section presents the findings from research on Differential Response (or Alternative Response) in places outside of California that have had systems in place for longer periods, and as a result offer a more comprehensive view and include information on both process and outcomes. The second section presents the results from research on DR implementation in California. Although California's experience does not offer the same long-term perspective available from researching other states, the experiences of other counties in California are likely to be informative for DR design in Monterey County.

a. National

Since the mid 1980s, there has been a resurgence of interest and investment in "Alternative Response," "Title IV-E Waivers," and "Differential Response" by 21 states: Alaska, Arizona, Georgia, Idaho, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Missouri, Nevada, Oklahoma, Pennsylvania, South Dakota, Utah, Virginia, Vermont, Washington, West Virginia, and Wyoming. Of these 21 states, the ones that were examined regarding the California intent to move to Differential Response are Missouri, Virginia, Mississippi, Florida, Minnesota, and Arizona. Of the six state systems, the one with the greatest documented longevity in the area of differential response is Minnesota, which formally started efforts in 1984. Although newer (1997), the Arizona system of Differential Response provides the second (behind Minnesota) best data, including hard data points, policy/operational development, and anecdotal information. The six states selected for this report are representative of the best, worst, and most common, and most comprehensive trends in the 21 states with DR programming.

Research across multiple states has shown that moving into DR requires comprehensive planning, including making “room” for setbacks, failure, and adjustment. There are many methods to approach the planning process and the research clearly reveals that there are 3 key areas to be considered in the plan development:

1. Change management. This is a change management process involving sophisticated cultural changes on an identified timeline with a defined communications plan, both internal and external (community) to CPS.
2. Program development. This is the “who, what, why, how and when” of DR. This is an assessment and planning process that has both internal (public agency) and external (community) participation.
3. Fiscal resources. This is the financial process for getting the money for doing everything from planning through implementation of DR. In most states this involves both internal (public agency) and external (community) resources.

The researcher concluded that success of DR relies on the recognition that the 3 essential planning areas include many “sub plans” that must be addressed in detail. The motivation for change is based in beliefs, which are communicated as values about social needs. This is the base level of change process that must be addressed before any program or fiscal planning can succeed. The issue is not just communicating what the changes or the process will be, but getting commitment from both agency and community members to embrace the beliefs/values that will fuel change and make program and financial change possible. Specifically, cross-state research has shown:

1. Take the time to do a comprehensive plan.
2. Start small, no larger than county level, usually in one specific area of the county (i.e. one city or town).
3. Communicate continuously internally and externally.
4. Be prepared to face setbacks, failures, and adjustments.
5. Enlist the community regarding planning, values/beliefs, program development, program implementation, service provision, and financial resources.
6. Assign specific CPS social workers and supervisors to oversee and implement the project.
7. There must be an initial screening phase, followed by an initial assessment (internal to CPS), followed by a comprehensive assessment (by the service provider/community case manager). At this point, there must be two functions occurring: case management, and service provision. Finally, it is the responsibility of the community case manager to close the case.
8. In the most successful states there are very structured protocols and timelines for communication and service provision.

Monterey County has dedicated itself to embracing the Family to Family tenants in a manner that has created much of the foundation for DR programming that

many other states lacked in initiating DR work. However, given the cross-state problems in implementing DR in all but one state (Arizona), the researcher recommended that Monterey County implement DR programming in a manner that allows the best use of funding, but allows full development of DR planning as the key component of social services redesign. The issue is that DR is a keystone piece of operations in the larger context of welfare redesign: it is not a separate piece of that design; it is an integrated component that requires many other structural components be in place before it can be implemented successfully.

The states researched employ a model where dedicated DR social workers rather than community partners provide all initial screening and assessment. Because this is not the model utilized by California counties, this aspect of the national research was not applicable to Monterey County. However, other lessons learned have value for the local process.

Emphasis was placed on the importance of both departmental and community “buy-in.” The researcher concluded that it was essential to determine whether or not existing community providers have the capacity to deal with an increase in clientele that are poverty-bound, with the majority of needs centered on basic living (food, clothing, shelter), and mental health (counseling, substance abuse). If there is lack of capacity, then the entire program development should be put on a time line that focuses on developing community-based funding resources. The need is simply too great for it to become government responsibility in its entirety, but assistance can be provided to build the capacity of the community to respond.

In Monterey County development of a DR fiscal model may well be different than any other in the cross-state comparison. Most out of state DR fiscal models rely on a combination of waiver, plus blended funding from different federal sources, to fund DR programming at the local level. Given the paucity of state level blended funding in California for DR, this makes the county a good demonstration project for private and/or government funding. It also provides an opportunity to directly test whether local communities, such as Salinas, that have both great wealth and great poverty, will provide a level of voluntary funding that will enable increasing government matching funds, and/or community programming that relies on private funding.

b. State

Like Monterey County, most counties in California are relatively new to DR, and as a result there is limited outcomes data available. However, there is a great deal of information on the experiences and lessons learned in other counties in the course of their initial design and implementation of DR. In conducting this research, counties were selected based upon recommendations from Breakthrough Series Collaborative staff, and/or similarities to Monterey County with respect to various demographic characteristics.

While each county is unique in many ways, there appears to be a number of common elements and success factors. During the initial implementation phase counties, for the most part, are relying upon limited funding streams, and significantly, in most cases this includes state provided “Redesign” funds to implement Differential Response. In the counties the researcher spoke to directly, the long-term financing of DR remains a critical question. Another design element that counties had in common is that they built upon the existing infrastructure—Family Resource Centers and/or Family to Family Network—and existing contractors to implement Differential Response. Moreover, the other California counties rolled out DR in selected and targeted ways – they did not implement countywide initially. Typically, they focused on a specific geographic region of the county with a high need (often identified through a needs assessment process), and a community partner in place to serve these families.

Echoing the findings from research on DR in other states, information obtained on other California counties stressed:

1. The importance of an extensive planning and pilot process for Differential Response
2. The importance of both internal (CWS) and external (community partners) communication for DR success
3. Developing champions at all levels of staffing, cross-training, to facilitate not only system change – but culture change as well. A number of counties indicated that at first it was difficult for CWS staff to “let go” of the families and entrust them with the community organizations
4. The importance of educating the community about the new DR system was also cited as an important step by many counties

Although there are considerable similarities in the DR implementation process, there does not seem to be any clear consensus on some of the key operational features that should drive local DR model selection. The research suggests that no one model is the right choice. In each county the development of DR was based upon the particular characteristics and resources (including community infrastructure) in that county. The important lesson for Monterey County is that these factors need to be integrated into the pilot testing in order to inform the final DR model design.

The researcher made several recommendations based on lessons learned in other counties. Many of these recommendations mirror those deduced from the national research.

1. Dedicate the time and resources necessary for a comprehensive planning and implementation process that creates buy-in and promotes effective partnerships with all key stakeholders – both internal and external. A system change like Differential Response also requires culture change.

2. In the initial or pilot stage, implement Differential Response in selected and targeted geographic areas based upon the identified needs of children and/or infrastructure and resources to implement the DR system.
3. In the pilot implementation, test multiple approaches to providing services and engaging families.
4. Build upon existing infrastructure and resources, such as Family to Family and/or the Family Resource Centers to implement Differential Response in Monterey County. Linking with and building upon Family to Family – this has been an approach adopted in other counties (e.g. Contra Costa).
5. Utilizing existing Family Resource Centers can serve as a method to link families and services. In Monterey County, Family Resource Centers were built around School Readiness and serving families with children ages 0 to 5 in three areas of the county. The Cabrillo FRC located in Seaside/Marina, and the Alisal FRC in Salinas might be community partners and areas to target for initial launch since we see the most number of children in these areas.
6. Differential Response should serve children of all age groups in the initial phase. Recent analysis of Monterey County Assessed Out (A/O) referrals does not suggest a compelling reason to focus on a particular age group. Where such an approach has been adopted elsewhere it seems to be related to financial issues.
7. Build partnerships; keep staff informed at all agencies and all levels; bring issues back to the table as they arise and include all members at the table; cultivate “champions” at all levels; conduct community education at the foundational stage.
8. Differential Response needs to be financially feasible for community partners. Community agencies are currently providing services at capacity given current staffing and resources.
9. Address sustainability in financing sooner rather than later.
10. Arrange additional site visits in other California counties to obtain a more in-depth understanding of different approaches to Differential Response. Based upon this research, good candidates for site visits include—Sacramento, Stanislaus, and Placer counties.

Financial Information Obtained on DR in California

In conducting interviews with program staff in California Counties, the following questions about funding and finance were asked:

1. How have Path 1 and Path 2 of DR been funded in your county? What funding sources have you utilized?
2. Has your county been able to leverage funding from other sources for the DR system?
3. How has your county been using DR funds? (Are you paying for services, staffing, etc.)

The information obtained on funding and financing is not as comprehensive as desired, and is likely the result of interviews with DR program staff who have a high degree of knowledge of the system, but who are less knowledgeable about

the financial details. Based upon the information obtained from other sites in California, most counties have relied and continue to rely principally on state funding sources for DR implementation. The issue of long-term financial sustainability of DR still remains a critical question for counties across the state.

Many counties have developed partnerships with First 5, which contributes a substantial amount of money to serve children 0-5 through DR. For example, Stanislaus County First 5 has committed to funding \$1 million per year for three years in contracts with family resources centers for services to DR families. Several counties use their PSSF funds for DR; two of those researched receive funding from CAPC. In addition, a few counties like Los Angeles and Stanislaus, utilize AmeriCorps volunteers to staff community partner organizations.

IV. Research: Local Pilot

Differential Response (DR) Pilot implementation was conducted between March 17, 2006 and June 30, 2006 and was part of the overall DR planning process. The pilot was a collaborative effort between the Department of Social and Employment Services and community partners—Community Human Services, Alisal Community Healthy Start, Door to Hope, and the ACTION Council of Monterey County. The goals and objectives of the evaluation were limited in design, given the short period of time the pilot was functioning, and number of referrals that were assigned to DR. The key evaluation questions were:

- How successful and effective was the family engagement process?
- What community services are needed to support families?
- How many families can be accommodated through DR?
- What about the DR process worked well, what aspects proved to be challenges, and what barriers and obstacles exist to implementing an effective DR system?

Models Tested

Referrals were appropriate for Path 1 if the referral indicated low-risk, and would have been “assessed-out” in the traditional child welfare system. In these cases, community workers acted as engagement specialists and community case managers; there was no child welfare system response. Path 2 assignment was appropriate for cases with low-to-medium risk indicated in the referral. In Path 2 cases, a joint-response, with the Emergency Response Social Worker and DR community worker was arranged. After the Social Worker conducted a safety assessment, if no significant risk was indicated, the case was handed off to the DR community worker. If high risk was indicated, the case was handled through the traditional child welfare system.

The planning team completed a preliminary review of one month’s (July 2005) “assessed out” referrals to help define the scope of the pilot: county-wide or targeted zip codes; specific ages of children or all ages; specific service focus or all types of service needs. The data revealed the highest numbers of referrals in the 93905 zip code (21%), 15% of referrals from South County and 10% from Seaside. There was a fairly even distribution across age groups for children over two years. Parenting skills, substance abuse treatment, counseling and anger management topped

the list of parental service needs. Based on these results and adopting the model used by our mentor county, Contra Costa, the following pilot was developed:

For Path 1, three different models were tested, with each model representing a different family engagement method.

1. The first model was conducted in the 93905 zip code area of Salinas and utilized a community engagement specialist (CES) for initial contact and assessment before a “warm handoff” was made to the community case manager for developing a case plan and arranging for services without fee payment.
2. The second model was conducted in the cities of Seaside and Marina (zip code areas 93933, 93955). In this model, the CES also served as the community case manager, and arranged for services in the community without payment for services.
3. The third model was conducted in Salinas (93905). In model 3, the CES had limited engagement with the family, conducting an assessment, and acted as a broker for services to be paid for within established limits.

Path 2 was conducted using a single model, and was restricted to those cases where substance abuse, including alcohol, was indicated. This restriction was based upon the particular expertise of the community partner participating in the pilot implementation. In addition, assignment to Path 2 was also initially limited to the Salinas, Monterey Peninsula, and North County areas; however, during the pilot the decision was made to expand coverage to the entire county.

Training

Differential Response Training was provided separately to department staff and community members who were participating in the initial pilot. The purpose and focus of the trainings were as follows:

- a. To gain an understanding of DR, its value and structure and how that impacts Intake and Initial Assessment in ER Services.
- b. To demonstrate an understanding of strategies for engaging families utilizing a strength-based approach.
- c. To have an understanding of the benefits of working with community/department partners.
- d. To enhance skills at evaluating practice and providing feedback.
- e. To expand knowledge of resources, specifically Medi Cal and Healthy Families.

Those in attendance were provided foundational skills aimed at equipping them with the tools to implement and evaluate the work they would be conducting.

Evaluation

The DR Pilot evaluation was designed in two distinct components, referred to here as the quantitative evaluation and the qualitative evaluation. The quantitative evaluation refers to the data collected on forms by DSES and DR community workers and entered into an MS-Access

database. The qualitative evaluation refers to the information collected through interviews, focus groups and program reports after the pilot testing was completed.

a. *Quantitative Methodology*

The quantitative evaluation data was collected through a series of forms developed by DSES staff and the ACTION Council. These forms were used to collect and track data relevant to the key questions of interest for the evaluation—participant characteristics, an assessment of services needed by families (as well as identified strengths), whether the family was successfully engaged, and the types and frequency of services provided. These common forms were utilized for each of the models and paths tested and completed for each family referred. These data collection and tracking forms included:

- DR Referral Form
- DR Intake and Assessment Form
- Community Based Program Feedback Form (Initial and Follow-up)
- Community Services Case Plan

One of the key limitations was the accuracy and completeness of the data submitted on the forms. The nature of the referral process introduces data that is both incomplete and of questionable accuracy. Some reports were quite detailed and highly accurate (such as those from mandated reporters) while other referrals contain little information.

b. *Quantitative Results*

A total of 145 referrals were received for entry into the database. There were 84 referrals assigned to Path 1: Pilot 1 recorded 26 referrals, Pilot 2 recorded 34, and Pilot 3 recorded 24. For Path 2, address data was provided for 47 (77%) of the 61 referrals received. Of those referrals with address data, 31 (66.0%) were in the Salinas area, 11 (23.4%) were in the Monterey Peninsula area, and 5 (10.6%) were in South County.

DR Pilot-Service Needs Identified from DR Feedback Form			
Service Needs	Path 1 Number	Path2 Number	Total Number
Employment	6	3	9
Financial/Other Public Assistance	2	3	5
Medi-cal	2	1	3
Housing/Shelter	5	1	6
Food/Nutrition	3	0	3
Transportation	4	3	7
Child Care	3	2	5
Legal Assistance	3	2	5
Teen Resources	8	2	10
Health: Medical	5	1	6
Health: Dental	3	0	3
Education: Adult	2	0	2
Education: Child	4	0	4
Language: ESL	2	0	2
Language: Translation/Interpreter	2	0	2
Parenting Education	12	8	20
Develop Support Systems	8	1	9
AOD Service	2	2	4
DV Services	7	1	8
Healthy Families	1	0	1
Counseling/ Mental Health	15	8	23
Anger Management	4	2	6
Develop Safety Plans	1	0	1
Case Management	5	4	9
Home Visits	4	5	9
Restructure Household Rules	6	0	6
Family Meetings/Communication	5	2	7
Help Family set up family outings	6	1	7
Advocacy	5	1	6
Total Needs Identified	135	53	188
Total Initial Assessments	80	60	140

- Families' strengths and needs identified:* Among the 84 Path 1 referrals, the most frequently identified family strengths were stable housing (27.4%), adequate food resources (20.2%), positive family relations (17.9%), and interest in child's education (17.9%). For the 61 Path 2 referrals, the most frequently reported family strengths were stable housing (16.4%), positive family relations (9.8%) and access to health services (9.8%). For Path 1 referrals, the most often identified needs were counseling/ mental health (42.9%), parenting education (33.3%), teen resources (28.6%), and advocacy (26.1%). The Path 2 referrals most often reported substance abuse (41.0%), counseling/mental health (23.0%), and developmental support systems (19.7%).
- How successful and effective was the family engagement process?*
The results indicate that families were successfully engaged in 46.9% of all cases that were received by DR community workers. The success rate differed

somewhat between pilot models. For Path 2 (Door to Hope), families were engaged successfully in 43.3% of cases. For the models tested at Alisal Community Healthy Start, families were successfully engaged in 34.6% of cases in pilot 1, and 34.8% of cases in pilot 3. The success rate was highest in pilot 2 (Seaside and Marina), where 70.6% of families engaged. For Path 2 referrals, the findings indicate that 59.4% of the referrals involved an initial joint visit, and 9.4% of the referrals reported a transition visit.

The reason most frequently noted for families not engaging with DR services in Path 1 referrals was the inability to locate the families based upon the information available from the referral. Notably, there were very few cases in either Path 1 or Path 2 where community workers indicated that the family did not engage as a result of families declining services, or from a lack of cooperation or follow-through.

Unfortunately, data collected was insufficient to make a determination on the most effective method of engagement: numbers were too small, the location where each model was tested differed; (i.e. each model in Path 1 should have ideally been tested in each zip code to accurately determine the effectiveness of a particular engagement strategy).

c. *Qualitative Methodology*

Qualitative data was collected through focus groups and interviews conducted with the staff and supervisors involved with Differential Response at the end of the pilot implementation. The community engagement specialists/community case managers and the executive directors of the community partner agencies submitted summary reports. Although these qualitative methodologies differ in format, the questions and topics covered with all participants were similar.

A total of 4 focus group discussions and 9 interviews were conducted with similar questions asked in both formats:

- *How would you describe your experience with the DR pilot implementation?*
- *What worked well or what did you consider successful?*
- *What difficulties and challenges did you encounter?*
- *Based upon the pilot experience, what support is needed to do DR work successfully?*

The potential limitations with these methods, in general, include the comfort level of the respondents in participating in the discussions and in answering the questions in a completely candid manner - particularly in the group format.

d. *Qualitative Results*

Most staff involved in the pilot reported the experience as positive, and were excited by the prospect of providing services to families in a prevention/early intervention based

model. However, they reported challenges in implementation particularly with respect to the workload, which was time intensive compared to the traditional child welfare model: the learning curve and “growing pains” associated with a new system, the increased scrutiny of each referral, the duplicative data entry required for the pilot testing, and the coordination required between child welfare and DR community workers. The process proved particularly time consuming at the point of intake and in the process of ‘referral exchange’ between intake workers and the community workers. It was noted that instructions for assigning cases to DR were not clear, and a majority of referrals were sent back in the initial phase of the pilot. There were issues, questions and concerns related to information sharing and appropriate disclosure of information between DSES and DR community workers.

There was particular satisfaction in knowing that there was some level of contact with families that otherwise would not have received any help or assistance. Overall, there was strong ‘buy-in’ to the concept of DR, and that this was a fundamentally sound approach to working with families. There was also affirmation from DSES staff that the selection of the community partners for the pilot process was good – they were “grass-roots” oriented, and knew the community well. While the relationship between DSES staff and DR community workers was not as trustful and open at the onset of implementation, several respondents mentioned that communication and the general relationship between DSES workers and DR community workers improved over time, particularly for Path 2.

However, issues of trust between DSES and community workers remained a challenge throughout the pilot implementation. One reason for this appeared to be a concern, or a “tension” around paraprofessionals making decisions about families that would be better made by social workers. Problems at the referral stage were also a recurring theme and many referrals with mention of substance abuse seemed to have been directed to Path 2 regardless of risk level. The community partners felt they often had insufficient information to attempt to engage families effectively, and quite often lacked sufficient information to locate families. Logistical difficulties were encountered during Path 2 in arranging joint-visits with social workers and community workers within the 10-day period required for investigation. Often, the social workers received the referrals late and needed to respond without taking the community partner along or they decided to make the first visit alone.

There were some issues identified related to the community resources available with concerns noted that the capacity of service providers is not sufficient for DR. It was a challenge to make referrals to resources when those services were not immediately available (e.g. waiting lists). This also illustrated the importance of the community case managers knowing the full scope of resources available in each community.

Conclusions and Recommendations

The Differential Response pilot implementation was too limited in duration, size, and scope to form any definitive conclusions regarding many of the central evaluation questions—especially

those best addressed through the quantitative data collection. This includes which model/method is most successful in engaging families, the capacity limits of the system, and the most pressing services needs of the families. However, a number of important lessons were learned in the pilot process, particularly related to the operational aspects of implementing Differential Response.

Evaluation findings identified the need for a more extensive and comprehensive training process in advance of the pilot testing. The procedures and protocols need to be clarified at the onset in order for them to be implemented in a standardized manner. Moreover, this could have alleviated some of the issues related to workload and time commitment.

The referral intake process and transfer of referrals to the DR community workers was a problematic area of the pilot implementation. Intake workers noted that it was time consuming and difficult to do Differential Response on top of the normal intake process. Early on, few referrals seemed to be making their way to the DR caseload. This seemed to be corrected mid-way through the pilot process, but it emphasizes the importance of training. There also appeared to be a backlog or delay in moving referrals into the DR caseload. The emergency response social workers reported that they frequently received Path 2 referrals near the end of the 10-day response period. As a result, coordinating joint visits with ER workers and DR community workers within the 10-day window was challenging, and social workers often made the initial visit on their own, which was contrary to the pilot design.

The findings point to problems with appropriate case assignment in the DR caseload. This appears to be a consequence of the structure of this pilot with Path 2 being focused only on substance abuse. It seems that in many instances that referrals indicating substance abuse were assigned to Path 2 irrespective of the safety assessment determination. In other words – referrals that should have been Path 1 were instead directed to Path 2 because substance abuse was indicated.

Although the data collected from the quantitative evaluation was insufficient to make a determination on the most effective method of engagement, the qualitative findings support a case management model as opposed to “limited” engagement and referral to services. The pilot experience indicated that making contact is the critical point—once families were contacted face-to-face, there was considerable success in getting them connected with resources. This underscores the importance of referral accuracy and proper information sharing between DSES and DR community partners. The qualitative findings further suggest that families were benefiting from the services provided through Differential Response. A wide array of service needs was identified among the families, indicating that a comprehensive network of community services is needed to implement DR effectively.

More important than the specific operational issues that need to be addressed for future implementation – is the broader issue of relationship building, trust, and communication between all partners in the Differential Response system (DSES and community agencies). Improvement and progress was demonstrated in this regard at the end of the pilot testing. However, there is still resistance evident that is likely to be changed only through further experience and interaction.

This pilot period might be more appropriately viewed as a “pre-pilot” test, which provided significant insight into the operational modifications needed for developing a more comprehensive pilot test for Differential Response in Monterey County. With the benefit of this pilot experience, modifications can be made to ensure models are implemented correctly, and processes and procedures are standardized across all parts of the system. This requires extensive training in advance of the next phase. This will also require a culture change – it is imperative that DSES and DR community partners develop a positive and trusting relationship between them. However, culture change is not just something that needs to be accomplished between DSES and DR community partners; it also needs to take place within DSES.

It is clear that there is a need for a staff person dedicated specifically to Differential Response to provide oversight and support of the system. This will assist in streamlining the referral process, and in ensuring consistent implementation of DR procedures.

The development of a centralized on-line data collection system for Differential Response, such as the CARES system in San Mateo, would also be of tremendous benefit. This will eliminate the time required for follow-up communication between DSES and community agencies regarding available information. Moreover, it will assist in standardizing the reporting and tracking of information in the DR system and should be a goal for Phase II implementation of DR in Monterey County.

The pilot process did demonstrate that there is widespread support for the concept of DR both within DSES and in the community. Although the information is very limited, there was near universal belief that even in this limited pilot, families were benefiting from differential response.

V. Site Visits

Site visits proved very helpful in our previous planning process for CHERISH, so the decision was made to visit as many California counties as possible with applicable models for Monterey County. A variety of planning team members, community partners and FCS staff participated in the visits giving us a broad range of perspectives with which to evaluate each model.

In general, every county benefited from an extensive planning process, which included child welfare staff, community partners, other public agency staff and community members. All found it essential to include staff in creating the new program and focused time and resources on changing the internal culture of their departments.

The models utilized by each site varied; however, Contra Costa County was the only county that employed community engagement specialists to make the initial contact with

families prior to referring them to community case managers for oversight of service provision. Most counties contracted with Family Resource Centers, a model that will be difficult for Monterey County to employ, since we only have two established resource centers in the county. However, the planning processes, community partner relationships, referral processes and evaluation strategies are applicable to our county.

Contra Costa County: October (in Salinas) and December 2005

As part of the Breakthrough Series Collaborative, Monterey County was matched with a mentor county, Contra Costa. In October, three members of their staff had an initial peer technical assistance visit, which focused on the operational components of DR including data, contracts and processes. In December, a 10-member team from Monterey County visited Contra Costa County for two days and had an opportunity to converse with child welfare staff, community partners, faith-based partners and former consumers. The visit also included observing a community partner meeting, the East County Redesign Committee meeting and a visit to their Independent Living Program center for youth aging out of foster care.

Contra Costa is a pilot county for DR. The county has three distinct regions; East with a diverse population of African-Americans, Hispanic and Asian Americans; West, which is predominantly African-American and Central, which is predominantly Hispanic. Although in their pilot, the county referred families with children of all ages, once implemented they are focusing on children ages 0 – 5 because their data indicated this was the population with greatest need.

The county has worked hard to build relationships and partnerships with the faith-based community because according to a needs assessment conducted by the county, families often go to their church or faith-based organization (FBO) when they need help. This process has been arduous for a variety of reasons: mistrust between child welfare staff and FBOs, difficulty for faith-based groups to partner among themselves, and fear from the FBOs of losing their identities or compromising their beliefs. There is a faith-based subcommittee in East County to advise child welfare from its perspective, which has recently applied for nonprofit status to help congregations come together as a collaborative for services. In Central County, the Inter-Faith Coalitions brings FBOs together on a regular basis. At the time of our visit, West County was working on engaging and partnering with FBOs.

a. Model

The county uses Community Engagement Specialists (CES) to engage Path 1 families; because of confidentiality requirements, the CES are contracted county employees. One CES is assigned to each region of the county. A referral is made by intake to the CES who make an unscheduled visit to the family within 10 days. All CES are mandated reporters and inform the families of that fact. Once the family has agreed to participate, a warm hand-off is made to a community case manager during a transitional visit that includes the CES, community case manager and family.

There are 14 community case managers who work with either Path 1 or Path 2 families and carry a caseload of 15 families each. They are connected to Path 1 families by the CES and Path 2 families by the ER social workers. Community case managers will work with families up to one year. Community case managers are employed by community service providers (12) and faith-based organizations (2) that either provide services to the families themselves or refer them to other providers.

Because of the limits on caseload and the length of time that families may be case-managed, the CES have found themselves unable to “hand-off” families at certain times and in certain regions, which has proved frustrating. However, some Path 1 families have been able to work with Path 2 community case managers when space allows.

Contra Costa has been very successful in engaging both Path 1 and Path 2 families. A CES will visit multiple times, if needed, to build trust and work with the family according to its timeline. The rate of warm hand-off transitional visits for Path 2 is very high: in east and west county about 80% and in central county, 99%.

b. Funding and Sustainability

Most of the funding from the state (\$500,000 - \$600,000) has been used to contract for community case managers, although part of it is used for administration, training and direct service. They blend funding from Preserving Safe and Stable Families, Family Preservation, foundations and other partnerships. Contra Costa is able to sustain its current program, but will need additional funding for any expansion.

At the time of our visit, community agencies and FBOs were not being paid for services to families – funds to those organizations were used to employ community case managers. When queried, we were told that agencies had sufficient capacity to serve the influx of new clients from DR referrals. Subsequent conversations with Contra Costa staff, however, indicate that agencies have reached capacity and have waiting lists for services.

c. Data Collection and Evaluation

All contracted partners are required to attend case coordination and review meetings to establish and maintain consistency in implementation. Twice monthly a leadership team meeting is held for child welfare to coordinate efforts of each region. Joint meetings are held for ER and community case managers to build trust and relationships. First 5 funds a consultation and review team that provides support from mental health, substance abuse, childcare, public health and child development specialists to all Contra Costa home visitors, including community case managers.

Community case managers report to child welfare every three months on the level of engagement with their families, and this information is inputted into a database that is separate from CWS/CMS. (By agreement, pilot counties do not track Path 1 outcomes in CWS/CMS because connection to community services is not punitive.) Recidivism rates are tracked. They are working on a database that would be accessible to their community partners and feed directly into CWS/CMS. They are also examining possible correlations between the needs and strengths identified in the referral and the services the family needed, and why or why not the family was connected to services.

d. Lessons Learned

- The relationships between CES and community case managers are instrumental to success in engaging families.
- Community service providers benefit from the connection to families in DR even if they are not a contracted part of DR. They are able to work with families in a more holistic manner and have a positive impact on the success of DR.
- It can be challenging to work with faith-based organizations, but it is worth the effort.
- Truly listen to your partners to develop mutual trust and respect.
- It is important that CES and case managers be culturally and linguistically competent.
- Bringing together community service providers to present services offered gives community case managers knowledge of the wealth of resources available to children and families.
- Be cognizant of your audience when preparing communication materials to ensure getting your message across.

Stanislaus County: May 2006

In September 2003, Stanislaus County formed a Child Safety Team comprised of community members, public agencies, community-based organizations, members of Child Abuse Prevention Council (CAPC) and Preserving Safe and Stable Families (PSSF) committees, Family Resources Centers, community collaborators and Child Welfare/Community Services Agency (CWS/CSA) staff to develop a vision for implementing DR. This team worked for 2 years to reach the point where a “nuts and bolts” group could take over and gear up for implementation. In June 2005, the Differential Response Team was formed for this purpose. In September 2005 a Multidisciplinary Team (MDT) was created through a collaborative process involving Family Resource Centers (FRC).

Stanislaus County began countywide Path 1 implementation in Sept. 2005 and Path 2 in May 2006. Referrals are made based on availability of services in a particular area of the county.

a. Model

Stanislaus' emergency response team consists of 6 intake social workers (2 were added for DR), 21 daytime ER social workers, 2 nighttime social workers, 5 admin clerks, 4 supervisors and 1 manager.

Stanislaus utilizes several different and complimentary models of DR:

- Health Services Agency Model: at-risk infants, Paths 1 and 2 based on level of risk to infant; family visited by Public Health Nurse
- StanWORKS Model: Welfare to Work families
- FRC Model (AmeriCorps workers) – all other referrals, Paths 1 and 2
- Hutton House Model: teens/parent-child conflict (just beginning at time of visit)

For Path 1 referrals, a letter and flyer are sent first to the family prior to a visit from the FRC community worker.

The county has 8 FRC sites covering 14 communities. Areas of the county are divided geographically based on the number of calls from that area, rather than zip codes. The FRCs are school-based, grass roots and community based organizations. DR staffing outside CWS/CSA consists of Family Resource Center staffs from 5 Centers; 2 of the centers have multiple sites (total 10). AmeriCorps workers help staff the centers.

In addition, Public Health staff work with families with high-risk infants and a StanWORKS Integrated Services Social Worker works with families needing employment – welfare to work.

The Multi-Disciplinary Team meets with FRCs twice per month to discuss families with whom they are working. These meetings are required for individuals contacting DR families. Their purpose is to discuss cases, problem-solve and improve the entire process through suggestions and sharing of ideas.

b. Funding and Sustainability

DR is funded through PSSF, CAPIT, CBCAP funds. \$500,000 in funding from CSA and \$1 million from First 5 per year provided 3 years of funding that began in 2005, for service provision distributed through an RFP process. The county has a strong partnership with First 5.

c. Data Collection and Evaluation

Stanislaus County uses “Outcome Based Scorecards” provided to us during our visit. Data is collected separately for DR children and ages 0-5 non-DR children, because the FRCs may serve both populations. They list two main outcomes:

1. Reduce child abuse and neglect in families receiving services at FRC
2. Reduce child abuse and neglect in families receiving caregiver education and support services

Long-term measurements for outcomes 1 & 2: Reduce the incidence of child abuse/neglect in families served by the FRCs. Data is collected to obtain the following information:

- % of families receiving a substantiated allegation of abuse within one year of initial assessment
- % of reduction of children in foster care
- % of reduction of children with substantiated referrals
- % of families that completed case management

d. *Lessons Learned*

- SC has 3 specific areas of focus (other than FRCs) that are based on availability of services and families' needs: Public Health, CalWORKS and Hutton House that works on teen/parent conflicts. This helps families get exactly the type of help they need
- SC has a strong partnership with First 5; recognizes the overlap in service provision to DR/non-DR families
- It is important to engage and involve child welfare staff in the planning for DR and get their ideas on what is needed for implementation
- CSA also works on capacity building with FRCs, including assisting areas in developing FRCs and bring in services
- Stanislaus took 2 years to plan for CW redesign to ensure a broad base of participation and support for implementation; the process was very inclusive

Sacramento County: May 2006

Sacramento County is one of the 11 pilot counties, which received funding to design and pilot child welfare improvement strategies, including DR. They set up a large Redesign Steering Committee consisting of approximately 200 people, with staff, community partners, union, parents, and youth representation. Sacramento has management staff dedicated to CWS Redesign including a program manager and a program planner.

Sacramento began in one zip code area, Del Paso Heights in April 2005. This is a very diverse community of 10,000 people: 30% Hmong, 30 % white, 20% African American, 5-7 % Russian, 5-7% Samoan. At the time of the site visit, they were getting ready to expand to additional roll-out areas.

a. *Model*

Sacramento set up a DR Unit, with a supervisor and social workers that volunteered to pilot DR. They used one community provider, Mutual Assistance Network (MAN) for Path 1 and Path 2 services. MAN has 10 home visitors, 7 AmeriCorp staff.

The county utilized a home visitation, short-term intervention case management model. Average length of DR service is three months, which allows for stabilization, growth, and referrals to other community services. MAN operates a

Family Resource Center which also offers services such as parent education, life skills, job training, money management, self-sufficiency, etc. that families can access. A family can reopen its case through self-referral if needed.

Sacramento utilizes a Resource Specialist Team (RST) that meets every two weeks to go over referrals. Team members include representatives from Public Health Nursing, CalWORKs, Family Maintenance, ER, Mental Health, AOD, and MAN Home Visitors. RST reviews occur only after family has signed consent forms for the sharing of information. Cases are presented during initial assessment and service planning, reassessment (every 90 days), if there are new indicators of risk or safety, or at the request of any of the service providers. The RST is very helpful in problem-solving difficult family situations from a team approach.

Due to confidentiality, CPS contacts Path 1 families by telephone to obtain verbal consent to refer family to MAN. If a Path 1 family declines services, the family is asked if the agency can mail out service information. Social Workers are also calling ahead of Path 2 referrals, requesting consent to bring MAN home visitor for joint *assessment* (as opposed to investigation) visit. Sacramento staff feels that that calling ahead has worked very well, resulting in family being more accepting, empowered, and feeling a part of the process.

b. Funding and Sustainability

As a pilot county, Sacramento had funding to plan and pilot DR. To sustain the initiative, they are looking at ways to utilize existing community resources more effectively based on the tenet that everyone is responsible for child safety. They already partner with Public Health, Mental Health, AOD, and education, and the First 5 with “Birth and Beyond” program. They are starting a Linkages program to partner better with CalWORKs. They do utilize some PSSF funding for DR. Advocacy is needed for state to allocate funding for DR.

c. Data Collection and Evaluation

Sacramento uses an ACCESS database and, at the time of our visit, was just starting to evaluate the pilot data. They use 43 special projects codes for DR in CWS/CMS. Information coming back to CPS from the database includes: outcome of referral (accepted services, declined, referred to other services, couldn't be contacted); date of referral, date received, date letter sent, # children in family, home visitor name, date of first contact, contact notes, # of attempted contacts, referrals made, plus additional information if family accepted services. MAN does quarterly reports that include overall summary of progress (none, minimal, significant), reason for closure (completed services, moved, declined, withdrew), summary of contacts (how many contacts, home visits, classes), and a detailed annual report.

d. Lessons Learned

- Communication—can never do enough; needed at every level; have feedback loop for staff; be responsive to issues; honor the process; ensure social workers and home visitors have input in decision-making process
- Culture Change—involving parent leaders and foster youth in all policy and practice changes
- Trust building with community partner
- Take the time to develop the team and relationships
- Need workload relief to do DR well

San Mateo County: August 2006

San Mateo County piloted DR in select zip code areas in January 2005, and expanded countywide in July 2006. So far, the system seems to be working successfully.

a. Model

The Human Services Agency has a staff person dedicated to DR at 50% time. In addition, there are 3 Community Liaisons that are employed by the Human Services Agency and are functionally located at central office. Through an RFP process, San Mateo County has contracted with 4 community partners (regionally based) to provide DR services.

Differential Response services are based around a short-term case management model that coordinates services with families for a period of 30-90 days. Caseload is 25 families. Families are visited about every other week. Once families have been successfully engaged, there is no operational distinction between how Path 1 and Path 2 families are served. The community case manager completes assessments (FAST tool), develops case plans with each family, and arranges for services with other providers in the community in addition to the services available at their family resource centers. There is regular follow-up with the families by the community case manager, and the frequency of family contact may be as often as once-a-week depending on family needs. Engagement rate is about 36%. They are applying for Path 4 funding. Path 4 is aftercare when children are returned home from foster care.

b. Funding and Sustainability

San Mateo County received \$1.3 million in state funding for 2005-2006. All of these funds went to the community partners (the 4 agencies selected through the RFP process) to provide the direct services to the families and to build partnerships with other agencies in the community. In 2006-07, San Mateo received approximately \$500,000 less from the state for DR. There is no additional internal funding. However, they received a grant from the Lucille Packard Foundation to support the mental health clinician. One strategy implemented to address funding and sustainability has been the convening of quarterly meetings with local funders to inform them about DR.

c. *Data Collection and Evaluation*

San Mateo participates in the CARES System and was instrumental in its development. The CARES System is a web-based database used by all partners (Human Services Agency and community agencies) involved in DR. This database contains all the referral information, assessment information, case plans and service detail. In addition to serving as a “container” of data, it serves to regulate and control the appropriate flow of information between the county and the community partners.

d. *Lessons Learned*

- Relationship building is important between child welfare services and community workers (team-building, joint training).
- Relationship building is very important in the community.
- Focus training on skill development, and assessments.
- In the pilot period, no time limit for case management was strictly established. Now that DR is countywide a 30-90 day limit was been established.
- Engagement is much higher with a joint response for Path 2.
- DR workers do not go to schools with CPS workers.
- Sex abuse cases are never Path 1 or 2.
- They are setting up protocol to handle sensitive cases.

Alameda County – Future Visit

Alameda County has been implementing DR longer than any California county. They piloted DR from 2002 - 2004 in a program called “Another Road to Safety” (ARS) and have written a replication guide for other sites that details the program’s history, procedures, lessons learned and potential for replication.

Early data indicates that ARS is successfully meeting its goals of reducing child abuse reporting. The guide describes procedural elements that have emerged from their pilot:

1. Partners must share a vision of supporting families
2. Investing in an in-depth planning process to solicit a variety of perspectives provides a solid foundation for a new program
3. Certain administrative functions, such as holding the program vision, providing technical assistance and training to staff and managing data collection, are crucial and must be assumed by one of the agency partners.

According to their report, “ARS can potentially be an organizing tool for communities, bringing together community members and service providers to combat child abuse and neglect. Choosing an ARS model puts a high priority on community.” They believe that community is the cornerstone of ARS, and that promoting connectivity among community providers has proven benefits to the families served.

VI. Recommendations for Phase II Implementation

The ACTION Council, in consultation with DSES/FCS and the Differential Response Planning Team has formulated a series of recommendations for Phase II implementation of DR. These recommendations are the result of the 11-month planning process and draw from the insights gained through the focus groups, research, pilot and site visits. It relies heavily upon the experiences of the staffs from FCS and the community partners who participated in the local pilot, in addition to lessons learned through site visits to other California counties.

This section presents a timeline that begins in October 2006 and carries through to June 2009. As might be expected, the details for later years are less well formulated and the expectation is that, as we proceed through this next phase, experience will dictate those future details.

The recommendations are based on utilizing a lead agency, the ACTION Council, to provide leadership and coordination to Phase II implementation. The details of the work are outlined below. APMC will contract with the County and devote considerable staff time to implementing this work plan: .40 FTE overall coordination and leadership, .25 FTE evaluation and monitoring, 1.0 FTE community outreach and development, and .40 administrative support. APMC will also be responsible for developing and monitoring contracts with community partners and be the liaison between FCS and the community. Thus, the initiative will be community-based rather than county-led from the inception of Phase II.

The overall funding for Phase II implementation will be approximately \$522,000, with almost \$400,000 earmarked for community development.

Overall DR Timeline: October 1, 2006 – June 30, 2009

- October 2006: Focus on community capacity building, examine best practices
Lay groundwork for implementation and oversight – Form steering committee
Begin DSES internal capacity building
Research web-based system for data input and outcomes measures
- April 2007: Implement Path 1 - phased in throughout the county where there is service and community partner capacity
- October 2007: Implement Path 2 – phased in throughout the county where there is service and community partner capacity
Implement web-based data input system
- July 2008: Countywide Path 1 and 2 implementation

Roles and Responsibilities

- a. Lead Agency: ACTION Council provides leadership, administration, convening – Phase II “incubation”*
- Formation and education of steering committee
 - Community capacity building
 - Facilitate training to introduce, promote and prepare key community stakeholders for DR
 - Contracting for services
 - Contracting for case management -- specific service needs (substance-abuse, DV, teen services) and general case management by region
 - Referral Process: conduit to community case managers and community based groups
 - Data collection

- Evaluation of contracted services and initiative as a whole
- Creating and implementing flexible strategies for course corrections, model modifications
- Grant writing and resource development; present revenue maximization strategies to local funders to showcase potential community impact of leveraging
- Development of marketing strategies to promote DR to funders, CBOs, interagency partners, public officials and the public

b. Steering Committee: Phase II Oversight

- Representatives selected from ACTION Council board, Monterey County Behavioral Health, Department of Social and Employment Services, CAPC, Community Action Partnership, Employment and Training, community based organizations, funding agencies, Public Health, service population (youth and parent)
- Develop accountability mechanisms
- Oversight of planning, implementation, ongoing review, evaluation
- Develops committees to accomplish tasks
- Possible Committees:
 1. Community development: service needs versus service gaps
 2. DSES: internal capacity issues
 3. Guidelines/Procedures: type of information, protocols
 4. Evaluation: Feedback Mechanisms
 5. Review results of staff innovations from the “Plan, Do, Study, Act” strategies tested
 6. Staff Development/Training
 7. Data management system
 8. Marketing: community education, integration

c. DSES/FCS: Departmental capacity building, staff development and supervision

- Internal capacity building
 1. Staff training
 2. Internal marketing for systems change
 3. Review and refine departmental policies and procedures related to DR
 4. Creating flexible strategies for course corrections
- Contracting with lead agency
- Staffing Steering Committee and sub-committees
- Working with lead agency on protocol development and guidelines
- Partnering with lead agency on implementation process and evaluation

d. Community-based Organizations and Groups: service provision and case management

- Work with lead agency on organizational assessments and plan implementation
- Contract with lead agency to provide services to referred families
- Collaborate with other agencies providing services and other networks of care
- Provide case management, where appropriate

Phase II Timeline:

October - December 2006

Steering Committee

- Determine structure and decision-making process
- Develop accountability mechanisms
- Form subcommittees

Lead Agency

- Analysis of family needs/service needs
- Set up steering committee
- Begin CBO assessment
- Begin development of capacity building plan
 1. What's needed, where needed, funding, look at FRC model where applicable,
 2. Look at possible areas of collaboration with existing networks/programs: First 5, Podar Popular, Mental Health Services Act, schools, churches, clinics
 3. Continue MediCal and Healthy Families outreach for revenue maximization
- Research existing web-based data systems for data input and assessment
 1. Applicability to Monterey County's needs, cost, components, hardware/software needed
- Work with committees, especially Guidelines and Community Development.
- Work with DSES to develop on-going fiscal model

Committees

- Guidelines/Procedures
 1. Develop protocols
 2. Information sharing mechanism
 3. Any forms needed until web based system is ready to be implemented
 4. Process for extending 90 case-management time
- Community development:
 1. Identify agencies and groups including non-traditional providers
 2. Determine/approve organizational assessment tool,
 3. Begin organization assessment
- DSES: internal changes, referral issues resolved
- Evaluation/Feedback Committee evaluation outcomes and tools:
 1. What do we want to look at?
 2. How do we get the information?
 3. Strategies for modifications
 4. Mechanism for ongoing review and implementing changes
 5. Institutionalizing the PDSA strategy

January - March 2007

- Test agreed-upon procedures with intake and referral: DSES to ACMC to community case managers
- Complete organization assessments
- Complete plans for capacity building; determine needed resources
- Form Multidisciplinary Team for case review (examine other counties' models)
- Staff Development and Training Committee
 1. Determine training needed for each role in DR implementation: screeners, community case managers, service providers
- Contracting with agencies:
 1. By January 15: determine process for working with community partners: RFP? RFQ? Varying size grants?
 2. By January 15: determine community contracting costs
 3. By February 1: agencies serving identified needs: substance abuse, domestic violence, teens
 4. By February 1: determine if it is more advantageous to contract with agencies for regional case management or for ACMC to directly employ community case managers
 5. By February 1: implement contracting process
- Joint Training (March) of DSES staff, community case managers and CBOs ready to take referrals – utilize staff from pilot to assist in training, as well as social workers sharing their case management experience
- On-going relationship building with identified community partners
- FCS will present a plan to the steering committee on internal capacity building and culture change to accommodate DR

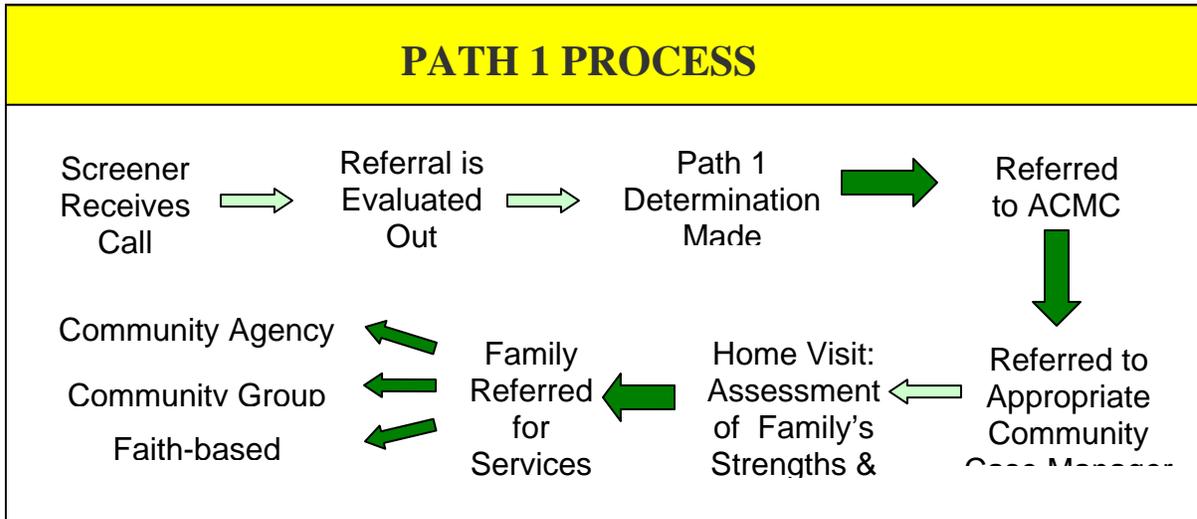
April – October 2007

a. *Implement Path 1*

Based on the evaluation of the local pilot and drawing from other county models, particularly Contra Costa and Stanislaus, the following model is proposed:

Monterey County will utilize community case managers to engage families, develop case plans and monitor their progress. Based on the family service needs identified and feedback from pilot participants, three of the community case managers should focus on specific areas of need: substance abuse, domestic violence and teen services. (Once the service needs analysis is completed by the ACTION Council, these specific needs areas may change.) The community case managers will be employed by contracted community agencies that specialize in such services, similar to the model employed in Path 2 of our local pilot where a group of community workers from Door to Hope engaged with families with substance abuse problems. Three additional community case managers will be employed, either by ACMC or through agency contracts, who will work with those families whose service needs do not readily fall into those listed above. These community case managers will work in specific regions of the county.

The community case managers will work with families for up to 90 days, unless circumstances demand that a longer time is needed. Each community case manager (or group of community case managers) will have a maximum client load of 25 families. All community case managers will be mandated reporters and will identify themselves as such to the families.



Referrals will be made by the intake social workers directly to ACMC, which will delegate the referral to the appropriate community case manager using the procedures tested in the first quarter of the year. Standardized documentation will accompany every referral with information maintained on a database at ACMC.

ACMC will facilitate monthly meetings of intake social workers, community case managers and community partners to coordinate the process, ensure consistency in implementation and discuss challenges and successes. Community case managers will report monthly to ACMC on their level of engagement with families and this information will be inputted into the database. In addition, community case managers will have the opportunity to meet with a multi-disciplinary team comprised of mental health, substance abuse, childcare, public health, child welfare and child development specialists for case consultation. It will be determined during the previous three months how to best utilize the multidisciplinary team.

b. Community Development

ACMC will continue to network with community groups and agencies, and to assist them in building their capacity to provide needed services. In order to have countywide implementation of both Path 1 and Path 2 in place by July 2008, ensuring services are available at times and places accessible to families will continue to be a priority.

c. Establish data Management System

There is a need for a centralized on-line data management system for the DR system. In this phase, ACMC will conduct research on web-based systems, and make a recommendation to FCS regarding the best system and provider. Such a system will allow for standardized reporting, tracking, and monitoring of DR information. The system will also allow appropriate access to the information needed by each DR partner, and contain not only information related to referrals, feedback forms, and case-plans, but also data from assessment tools administered during the case management process.

d. Preparing for Path 2

FCS will decide upon the best internal staffing to facilitate timely joint visits and assessments. Currently the ER Social Workers all handle immediate and 10-day referrals. If they must respond to an immediate referral, then the 10-day assessment visit could be pushed back making it more difficult to schedule a joint meeting with the community partner. FCS is considering assigning specific ER workers to handle the immediate/high risk visits, so that those workers who must schedule joint visits can focus only on the 10-day assessments.

A determination will be made, at this point, if additional community case managers will be needed for Path 2 implementation, depending on the existing case loads and the limit of 25 cases per community case manager.

Joint training will be provided with the community partners and ER workers to build trust, share expertise and understand the DR Path 2 protocols. A further training that also includes the Screeners will be held to familiarize everyone with the data management system. The training will include ensuring a process by which families that are referred to Path 2 and the allegations are deemed unfounded, will still be assigned a community case manager so that community-based services are offered to that family.

October 2007 – June 2008

a. Implement Path 2

The same community case managers that work with Path 1 families will also work on Path 2 with the same responsibilities as detailed in the description of Path 1 implementation. The 25-person caseload limit includes families from both paths.

Referrals determined by the Screening unit to be Path 2 will be forwarded to both the ER workers and ACMC. The Council will assign a community case manager that is appropriate to the family's needs as identified through intake. Joint visits (ER worker and community case manager) for assessment are recommended as the best practice. Once a hand-off is made to the community worker, the case from a child welfare perspective is closed. At this point, the procedures, meeting schedules, case review, etc. outlined under Path 1 apply to all Path 2 referrals.

- b. Continue Path 1 Implementation*
- c. Continue Community Development Process*
- d. Continue FCS Internal Capacity Building and Culture Change Process*
- e. Continue Refining Program*

July 2008 – June 2009

It is the intention of the County and the ACTION Council that in July 2008 there will be sufficient capacity and funding for full countywide implementation of Differential Response. It is estimated that total roll out will cost about \$1 million per year.

In addition, a significant component of Phase II is on-going examination of the processes and outcomes to ensure that implementation is meeting the needs of the families, community partners and FCS. Staff will be encouraged to try PDSAs to test new ideas that improve the process of working with families through DR. Flexibility is essential: if something is not working or can be improved, there will be a mechanism in place to facilitate changing the model and instituting a course correction.