Connecticut Department of Children and Families Differential Response System

EXECUTIVE REPORT

Submitted by Casey Family Services

TABLE OF CONTENTS

INTRODUCTION

The State of Connecticut's Department of Children and Families (DCF) has been working with a Statewide Steering Committee over the past three years to redesign Child Protective Services through the development of a differential response system (DRS). DCF contracted with Casey Family Services, the direct service agency of the Annie E. Casey Foundation, to assist in designing the community partnership component of a differential response system. Casey was asked to coordinate a community readiness planning process in each of the five DCF regions of the state, producing a plan that provides a proposed design of a community partnership and service delivery model for implementing a regional differential response system.

Each regional plan documents the Planning Team's perspective on the following:

- Strengths and service gaps in the region,
- Proposed service coordination model,
- Referral and coordination, and
- Ongoing community oversight of the implementation of DRS.

This Executive Report provides an overview of the outreach and planning process and sets the context for DRS in Connecticut and nationally. The report highlights common themes across the regional plans and provides a set of conclusions about implementing DRS. This information was drawn from the collective regional plans, feedback from diverse audiences throughout Connecticut, and consultation with states that have implemented differential response systems. In addition, Casey Family Services formed a National Advisory Committee of leading experts on the subject, including Marc Cherna, director, Allegheny County, Pennsylvania, Department of Human Services; Theresa Costello, director, National Resource Center for Child Protective Services; Caren Kaplan, director of child protection reform, American Humane Association; Holly McNeill, consultant and trainer, North Carolina Division of Social Services; and David Thompson, program manager, Minnesota Department of Human Services.

By commissioning this very inclusive planning process, DCF demonstrated its commitment to deepening its partnership with Connecticut's communities. The community readiness planning process began shortly after the reorganization of DCF from a structure of 14 area offices to five regions. Each new region included two to three area offices per region and a new management structure. Under the DCF regional structure, community readiness activities were conducted within a regional context, which presented some challenges to developing a locally responsive service delivery model within regions that are geographically broad and very diverse. In most cases, the new structure brought together communities that historically had not worked together. The benefits voiced by many members of the Planning Teams were the opportunities to get to know these new communities, develop new partnerships, and increase understanding of the various populations in each region.

This process supported the development of regional plans representing views of many stakeholders across the state. It also provided an opportunity for local organizations that had not been connected with DCF to actively participate in a planning process, while learning more about DCF's operations and explore how they might offer support to families involved with DCF. It has generated goodwill with representatives from organizations that work with DCF who were pleased that the community – particularly consumers – was participating in the planning process. This inclusive approach to planning has built broad-based community support for DRS across the state. Members' consistent attendance at meetings provided opportunities for increased networking, and generated excitement about DRS and anticipation for its development. Finally, as a result of this process, over 250 people representing agencies, coalitions, and community organizations are now informed about DRS and can be supporters of its implementation.

CONNECTICUT'S FRAMEWORK AND THE IMPORTANCE OF DRS

As with any system reform effort, planning for differential response has many distinct parts that need to be connected and integrated. The planning began over three years ago with the development of a Statewide Steering Committee composed of a diverse group of stakeholders including DCF representatives and consumers, parent advocates, and community providers from across the state. The group provided recommendations about a policy and practice framework for the implementation of DRS. The Steering Committee, together with DCF, considered various models of DRS and made a series of important systemic recommendations needed to support its implementation.

A status-of-work matrix was developed to outline major planning areas that will impact implementation, including:

- Program models;
- Workforce and organizational development and training;
- Communications and outreach strategies;
- Legal, legislative, and policy additions and/or updates;
- Information technology and data development;
- Data, research, and evaluation;
- Community readiness and service array; and
- Fiscal and personnel impact and business operations.

This work led to the next important step in this pre-implementation phase. DCF issued a Request for Information (RFI) soliciting community feedback about several different service delivery models. The model most widely endorsed by community members was a public-private partnership. Building on these efforts, DCF issued a Request for Quotations (RFQ) to conduct a community planning process in each of the five newly formed DCF regions. The scope of Casey Family Services' contract was within the community readiness and service array planning area of the work matrix. Concurrent with the work of Casey Family Services, the Department and Steering Committee continued activities related to the other major planning areas; they have been updated regularly on the community readiness process to inform those activities.

The development and planning for DRS has been happening in the context of many important changes designed to improve outcomes for families and children. In recent years, DCF has made tremendous strides towards a more integrated, family-focused, and strengths-based approach to their work—the very tenets integral to a differential response system. This is exemplified in key initiatives, including the Better Together Initiative, Reconnecting Families Program, and Family Conferencing. Guiding these and other initiatives has been a focus on family strengthening and community building that appreciates the strengths and expertise families bring to any process and understands that children are best served within their families and their communities.

In August 2008, DCF partnered with Casey Family Programs to develop and implement a training model called Better Together. The core of this program is training birth parents, child welfare staff, and community allies together to learn more effective ways of engaging and partnering through the treatment planning process. Casey Family Programs previously had implemented this model predominately to strengthen the foster care system. Connecticut was interested in piloting this model to focus on working together with birth parents. Four components of the Better Together model drive the outcomes and approach for this project:

- Partnering effectively,
- Recognizing expertise,
- Practicing respect and equality, and
- Exploring culture.

DCF also established the Reconnecting Families Program administered by community-based providers to provide intensive support and services to children and families with a goal of reunification. The design includes strong pre-reunification components – parent education, skill-building, and therapeutic visitation – as well as post-reunification supports.

DCF began implementing a family conferencing model in 2005. The primary goal of this initiative was to increase the level of family involvement in case planning by engaging parents and their networks in problem solving and identifying the strengths and needs of each family. DCF acknowledges that this area of practice continues to evolve and has not yet been fully adopted statewide. The introduction of a differential response system will further promote the use of family conferencing and build on the Department's growing experience in this area. These two initiatives complement one another and will work in concert to optimize family engagement.

Embedded in DCF's guiding principles is a primary focus on ensuring that families are allies in planning and service delivery and the critical need for community partnerships that inform DCF's 2010-2014 strategic plan. The first outcome notes that "prevention services will strengthen families and reduce the need for DCF involvement"; the second outcome states that "children will remain safely at home with their parents or guardians" (Connecticut Department of Children and Families, 2009, p. 6). This change in practice philosophy led to the planning and implementation of a statewide differential response system. Much of the work and the relationships that have been developed through other initiatives and this community readiness process have primed the system for this bold move towards greater access to services and supports for families and a strengths-based approach to working together with families and communities.

One state initiative focused on strengthening vulnerable families and reducing child poverty is the Child Poverty and Prevention Council. In June 2006, Governor Rell signed Public Act 06-179, An Act Concerning State Investment in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty councils. The Council, comprised of representatives from multiple state agencies, including DCF, has been charged with:

- Developing and supporting the implementation of a ten-year plan to reduce the number of children living in poverty by 50 percent; and
- Establishing prevention goals and recommendations and measure prevention service outcomes to promote the health and well-being of children and families (Genuario, 2010).

Each of the Planning Teams discussed in detail the importance of prevention services and concrete supports most often needed to strengthen and support vulnerable families. They specifically discussed the need for appropriate housing, employment, heating assistance, and poverty-related programs to be available to families, recognizing the significant stressors that negatively impact overall family and child well-being when these needs are not met. Although Connecticut's child poverty rate of 12.5 percent in 2008 was below the national child poverty rate of 18.2 percent, it increased from the previous year of 11.1 percent (Genuario, 2010). The statewide number does not tell the full story about many communities within the state. The overall poverty data from 1999 (the most recent data available by town) illustrates significant socioeconomic disparity ranging from 0.7 percent in Killingworth to 30.6 percent in Hartford (Connecticut Economic Resource Center, 2010). Planning Team members reported their belief that these numbers have increased over the last 10 years, given the current economic crisis and based on their contact with consumers.

NATIONAL CONTEXT

The differential response model for responding to reports of child abuse and neglect is one of the most promising reforms in the child welfare field today. This approach provides different pathways or tracks depending on the severity of the allegations. Those allegations with greater severity would receive a traditional investigation response, which is most often perceived as adversarial by parents, involves the court, and can lead to temporary or permanent custody of children and placement in foster care. Allegations that do not indicate a high level of severity would follow a different path, which involves a family assessment and a service plan developed in collaboration with the family to address their needs and the factors that can cause risks to child safety.

Differential response systems are particularly promising for addressing cases defined as child neglect where poverty plays a primary role in compromising the safety of children. According to a federal report of 2007 data on child maltreatment (U.S. Department of Health and Human Services, 2007), 59 percent of maltreated children experienced child neglect, while only 10 percent experienced physical abuse. The definition of neglect varies by state. It can be very broad and similar to definitions of poverty that include nutritional, shelter, and clothing deficiencies. The

Connecticut definition is "the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education" (Connecticut Department of Children and Families, 2007).

The link between poverty and child maltreatment has been well documented. Child welfare workers have had limited options, other than foster care, to keep children safe. The majority of federal funds for child welfare services support foster care. There is significantly less funding to address safety risks through family support and preservation services that allow children to remain in their own home.

Differential response offers an opportunity for child welfare systems to fulfill their mission of child safety, while respecting the critical parent/child bond. Forced separation from parents is traumatic for children and can result in behavioral, emotional, and physical problems. Nationally, approximately 52 percent of children who exited care in 2008 were reunified with their parents. For the children who exited care in 2006, almost half were in care for less than one year (U.S. Department of Health and Human Services, 2008). These data raise the question of whether there are better ways besides removal for child welfare systems to ensure safety for children who are eventually reunified or who are in care for a short period of time. Differential response systems offer a promising approach to protecting children by engaging families and involving the broader community in supporting families.

Differential response systems across the country may operate somewhat differently, but they generally share many commonalities. In an article describing the National Study of Differential Response Systems of 2005-2006, the authors cite core values shared by differential response systems, such as:

- Engagement vs. adversarial approach – in differential response systems, families are treated as partners in reducing risks and maintaining child safety.
- Services vs. surveillance – families are more receptive to services when treated in a non-accusatory manner.
- Identification of needs vs. punishment – as workers proactively engage families in identifying strengths and needs, families perceive them as supportive rather than threatening.
- Continuum of response vs. one size fits all – differential response systems tailor the child protection response to the circumstances and needs of the individual family (Kaplan & Merkel-Holguin, 2008, p. 7).

In 1994, Missouri and Washington were the first states to implement DRS. Since that time, the number of differential response systems has been steadily increasing. According to a survey conducted in 2008 by the National Quality Improvement Center on Differential Response in Child Protective Services, 18 states are currently implementing Differential Response (DR) and eight more are planning to implement it in the future. Five states reported they had implemented DR but have ceased implementation. Reasons given for ending programs include change in leadership, staff turnover, expense of implementation, and a decision to focus on prevention rather than incident-based interventions. Of the 18 states with DR, 11 reported statewide implementation, while six are operating in multiple jurisdictions but not statewide, and one did not report (National Quality Improvement Center, 2009).

Studies are reporting promising results on costs, reduction of foster care placement, and maintenance of safety. For example, results from an evaluation of Missouri's system indicate recurrence of child abuse and neglect reports decreased relative to comparison counties and that a larger proportion of families were linked to community resources (Loman & Siegel, Missouri, 2004). An evaluation of Minnesota's system indicated that services were shown to reduce future reports; families were more satisfied under the differential response approach; substantially more services were received by families in the assessment track; and over a follow-up period, the reductions in later reports and later placements led to reduced costs (Loman & Siegel, Minnesota, 2004). Early findings of an evaluation study of Ohio's alternative response system indicate positive outcomes similar to those realized in Minnesota and Missouri with regard to reductions in recidivism and the number of children entering care (Gilbert & Hanson, 2010). As this pioneering approach to assisting vulnerable children and families continues to evolve, Connecticut will add to the growing body of knowledge and creative strategies.

In an average year, Connecticut accepts about 28,000 reports of child maltreatment for investigation. Of the accepted reports, about 80 percent had a previous child protective services investigation. If families are repeatedly coming to the attention of the child welfare system, it can be assumed that their needs have not been met. A differential response approach has the potential to dramatically reduce the number of repeat reports. Connecticut will use family team conferencing as part of the model, which will increase opportunities for creating a network of informal and formal help that can support families over time. Clearly this will be a more effective way of keeping children safe within their families, reducing the costs involved in repeat reports, and creating positive partnerships with families and communities.

PLANNING PROCESS

Early and continued work of DCF and the Statewide Steering Committee generated the outreach efforts of the community readiness planning initiative. Casey began increased efforts to assemble each of the five teams. Participation in the planning process required a significant commitment of time. The process ran for five months, one meeting per month, with individual or joint meetings in between. This process was borrowed from Casey Family Services' Permanency Teaming Approach, which uses a combination of individual, joint, and large team meetings at the case level, with young people involved in their own planning, and at the systems level to guide and shape program change and service delivery. Preparation and engagement were to be key components in creating a successful team.

Outreach began with both DCF leadership and the Statewide Steering Committee. Guided by the Request for Quotations, DCF management identified key stakeholders to build the regional Planning Teams, which were then enhanced by Planning Team members' recommendations and additional outreach. A primary objective of the Planning Teams was to bring together a diverse group of traditional and non-traditional partners. Diversity was defined in a variety of ways: cultural, ethnic, geographic, as well as varying roles and responsibilities. Members of Planning

Teams included: birth families who had previously been involved with DCF, members representing the Systems of Care (SOC)/Community Collaboratives, Community Action Agencies (CAA), the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), local education authorities, mental health providers, Supportive Housing, Workforce Alliance, family advocates, faith-based communities, education, youth service bureaus, and law enforcement. Some of the identified stakeholders acknowledged they did not represent traditional DCF partners. It was with these partners in particular that additional individual and joint meetings were helpful to provide an orientation to DCF, the planning process, and the DRS initiative. Feedback from these partners was extremely positive, noting that "this was a great opportunity to meet other providers across the region who enriched my knowledge and experiences." Meeting locations were determined by each team. Several of the regional teams opted to change locations for each meeting so they could better understand the size, scope, and disparity within these newly formed regions."

Additional outreach occured based on requests from various audiences who wanted to hear more about this initiative. This largely was due to the early momentum that had been built and the genuine interest and investment of many to see a differential response system implemented in Connecticut. Outreach efforts included:

- Individual meetings with key regional stakeholders who could not commit to an ongoing role on the Planning Team but whose perspective offered great value;
- Various local Systems of Care and presentations to the Children's Behavioral Health Advisory Council (CBHAC);
- Trade associations and their members, including the Connecticut Association of Non-Profits and the Connecticut Community Providers Association (CCPA);
- Connecticut Hospital Association;
- Office of the Child Advocate;
- Citizen Review Panel hosted by FAVOR;
- Regional funders meetings; and
- Ongoing participation at the Statewide DRS Steering Committee.

After the early identification of key stakeholders, letters of invitation as well as phone calls were made to each participant to begin orienting them to the process. They were asked about their perspectives on the strengths and the challenges facing each community and what they thought differential response could mean to their area. Individual contacts with birth parents were especially important, because many of them had not participated in such a process before and were less than confident that their voice was an important one to have at the table.

As the Planning Teams were formed and the meetings scheduled, each group established ground rules for working together, acknowledging that each party came to the process as subject matter experts, and recognizing that all were equal and active planners in this process. At Casey, we believe, children do well when their families do well and families do better in supportive communities.

Because strong networks of services and supports are an integral part of strong communities, it was critical to engage a diverse array of partners to develop a community-specific implementation plan. An added benefit to these diverse groups was the recommendations that came from group members for others to join the discussion, enriching the results.

Each Planning Team was charged with creating a comprehensive, community-specific plan that reflected the collective thinking of the group. Given these new regional structures, it was important for the teams to develop a community profile. Planning Team members brought their own experience and knowledge to build these profiles, examining cultural issues within the region, the diversity among the suburban, rural, and urban areas, and the disparity of wealth and poverty in their respective regions.

Each meeting was structured around the following key areas:

1. *Core Services*: Linked closely to the criteria for the service coordination model are the details surrounding the array of services in a community and exploration of what may be missing. Understanding the most pressing and emerging needs of community members and trends specific to referrals informed the planning process. Like families, each community has its own cultural strengths and challenges. The large team was intended to work collaboratively to identify strengths and challenges and develop a plan that would outline the most important services to meet the unique needs of families. This process and resulting plan was cognizant of the diversity within each region. All members worked in concert to ensure the development of a culturally competent plan.

2. *Service Coordination Model (Referred to originally as the Hub in the RFQ)*: Identifying and describing how services would be delivered to families in a strengths-based and responsive way was critical. Negotiating large systems is a daunting task for most people and even more so in the midst of a family crisis. A Service Coordination Model (SCM) had to be designed in a way that would solidly connect to the Connecticut service provider network, which represents a rich array of services and supports.

3. *Referral/Coordination*: Of utmost importance was the development of a comprehensive, responsive, and seamless service delivery model. The process by which a link to a community partner would occur, moving with a family from its early involvement with DCF to a community partner was discussed and outlined in each plan. Recognizing that families often have multiple needs, referral/coordination mechanisms would need to ensure timely, responsive, and accessible service delivery.

4. *Oversight*: Oversight is critical to evaluating the various components of an implementation plan and ensuring a detailed quality assurance plan. The planning groups discussed various ways in which members of the group and beyond could remain involved and/or informed about regional implementation. Although each group had some nuances to their proposed oversight body, key elements were similar:

- Local groups would include many of the key stakeholders involved in the development of the plan, as well as others that represent advisory groups in the region.

- Connections would be maintained between the regional Planning Teams and the Statewide Steering Committee.
- The role and participation of these groups would depend on the timing of each region's implementation.

EXISTING SYSTEMS

Connecticut is very fortunate in that there is a number of collaboratives and networks throughout the state. Each Planning Team considered how a differential response system would connect with existing statewide systems; e.g., the Human Service Infrastructure (HSI), Community Action Agencies, and the Systems of Care (SOC).

According to the Connecticut Department of Social Services (DSS):

> "The HSI was designed to be a coordinated system of services that people could access easily – regardless of whether or not they are Department of Social Services clients. It was created to help people access concrete resources to support their efforts toward improved self-sufficiency. The vision focuses on a social service system that is coordinated, outcome conscious, and adequately funded. The system was designed to be responsive to people within their cultural context, and sufficiently flexible to meet emergent needs" (State of Connecticut, 2009).

Community Action Agencies (CAA), federally designated anti-poverty agencies, offer a range of critical services and supports to improve circumstances for families. These services include: early care and education, specialized care and education programs, youth development and after-school services, nutrition programs, food pantries, employment centers and vocational skills training, financial education, holistic case management, obtaining and maintaining home ownership, and housing and supportive housing. The CAAs utilize the Human Service Infrastructure approach to streamline service identification and delivery for families. The use of a universal intake form creates efficiencies in determining eligibility criteria and identifying the most needed services and supports.

There are 25 Systems of Care operating throughout the state. For over a decade, local Systems of Care have existed in communities across Connecticut and incorporate a continuum of services for children with significant mental health issues. They also provide a structure for communities to come together to address issues in the children's behavioral health system. Core values and principles of the Systems of Care call for all treatment, support, and care services to be provided in a context that meets the child's psychosocial, developmental, educational, treatment, and care needs. The treatment environment must be safe, nurturing, consistent, supervised, and structured. Successful intervention with children requires an atmosphere that encourages normal development, is the least restrictive necessary, fosters respect for others, and is nonjudgmental.

Core values for the Systems of Care/Community Collaboratives (Connecticut Department of Children and Families, 2001) mirror those of differential response and include:

- Services should be child-centered, with the needs of the child and family dictating the types and mix of services provided

- Services should be community-based, with the focus of services as well as management and decision-making responsibility resting at the community level
- The Systems of Care/Community Collaboratives should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations that serve.

In addition to these statewide efforts, regional specific systems were discussed.

REGIONAL PLANNING TEAM RECOMMENDATIONS

I. Core Services

Each of the Planning Teams was asked to identify the services they thought would be most important for families in differential response and, therefore, should be available and easily accessible. Not surprisingly, there was a great deal of similarity in the "core services" identified by the five teams.

Evaluations of Minnesota and Missouri's differential response systems described services most often received by families in differential response. These services were strikingly similar to the "core services" identified by the Planning Teams and included services such as:

- Basic needs: financial assistance, food stamps, food banks, clothing closets, diaper banks, utilities assistance, transitional and subsidized housing, furniture, health care, public benefits enrollment, and coordination;
- Mental health (chronic, situational, trauma-informed);
- Alcohol and drug abuse treatment;
- Employment and training assistance;
- Child care (drop-in, after school, special needs, hours to accommodate shift workers)
- Transportation;
- Parenting education and skill development/life coaching and mentoring;
- Parent leadership, peer support, parent advocacy;
- Social supports, enrichment, and recreational activities; and
- Legal services.

II. Service Coordination Model (SCM)

A. Characteristics and Functions

Each of the teams identified essential characteristics to operate an effective service coordination model. The characteristics that were identified by two or more teams included the following:

- *Community-based*: An SCM that is community-based would have greater awareness of both formal and informal resources and would be more knowledgeable and reflective of the character and diversity of the community.

- *Strengths-based, family-centered*: The SCM should engage parents in developing their own goals, identifying family strengths, and building the family's capacity to achieve their goals despite challenging life circumstances.

- *Culturally competent, skilled staff*: Key to the success of any service provider is the competency of its staff. Planning Teams emphasized the importance of employing case management staff that is skilled in engaging and developing trusting relationships with families. All the teams identified a range of diverse cultures in the regions and a broad array of needs experienced by low-income families. SCM staff needs to understand cultural customs and beliefs of the populations they work with and know how to draw on various resources specific to different cultures. Staff also must be skilled at engaging families and supporting them with information, tools, and resources they need to develop new competencies and become their own advocates.

- *Availability of family advocates*: The concept of a family advocate or parent navigator was discussed by multiple teams and determined to be an important component of an SCM. Generally described as a former recipient of service, the family advocate would help to engage families particularly those most distrustful of service providers, provide information about services, and help them to connect with both formal and informal community supports. In discussions with Minnesota, it was reported that several counties have used past consumers of services to provide support to current consumers. They also have created a Parent Leadership Advisory Council, where parents are involved with policy and program development subcommittees. The concept of "nothing about us without us" drives this work.

- *Seamless coordination, timely access to services*: The major function of the SCM is to ensure that the family is connected to the services they need to meet their identified goals. The SCM will need to develop memoranda of agreements with a pool of community resources that will make every effort to ensure timely services. If a service is not available when needed by a family, the SCM will work creatively with the community to assist the family on an interim basis until the family can be connected to the service.

- *Identifying community resources*: The Planning Teams have stressed that one of the key responsibilities of the SCM will be to identify and build relationships with both formal and informal resources in the community. Meeting the immediate service needs of the family will be the first priority, but what the teams believe is unique about this model is the opportunity to educate the family about the short- and long-term community services that are available. Assisting the family to develop an individualized network of supports to achieve social, emotional, and financial well-being is essential.

A range of suggestions were made about how the SCM can build on its own knowledge and experience in learning about and connecting with a wide range of informal and formal community resources. Clearly, one of the best places to start is by contacting the members of the regional Planning Team, which include a broad cross-section of the community. In addition, each member has connections across different sectors of the community. United Way's Information and Referral Resource, 2-1-1, provides a comprehensive list of resources in communities across the state. The various networks and agency collaborations that exist in every region in Connecticut also can provide a wealth of resource information.

The SCM should act as the bridge to the many resources and supports that could be helpful to the family's current situation and future development. Educating the family on what services are available, helping them to be comfortable accessing services, and teaching the family how to navigate service systems for future needs is one role of the SCM.

- *Data and accountability*: The SCM will be accountable for collecting data, developing reports, and assuring the quality of service coordination. Planning Team members stressed the importance of examining data specific to:
    - Program delivery,
    - Strengths and challenges of implementation, and
    - Identification of emerging trends related to populations and service needs.

Each of the regional plans emphasized service delivery at the local level and identified informal and nontraditional supports, in addition to the more formal and traditional services.

B. Types of Service Coordination Models

Although five different Planning Teams brought very diverse perspectives to the planning tasks, there were surprising commonalities in how they envision a service coordination model that demonstrates a community partnership with DCF. The following is a summary of the teams' perspectives on the models they examined.

- *One-stop Shopping*: This model involves colocating services in a space that is convenient to the consumers. The Planning Teams eliminated this model early in the deliberation process. The number of one-stop shopping sites needed to be community-based and convenient to families in DRS was seen as unrealistic in today's economic climate.

- *Lead Agency with Out-stationed Staff*: In this model, a lead agency hires staff that is out-stationed in a variety of locations in communities across a region. Planning Teams decided that this model would entail many challenges in recruiting the right staff that would be comfortable being out-stationed and working very independently. If a staff person left the agency, their knowledge of community resources and the relationships they built would be lost. Additionally, no single agency could provide the range of services needed by families in a region and would still have to sub-contract.

- *Lead Agency Connecting to Existing Service Network*: Planning Teams recognized the range of networks across the regions and believe that they can provide important support to DRS.

Some serve a specific population, such as children with serious mental health problems or families experiencing domestic violence. Some are more involved in planning and public policy than service delivery. To meet the needs of DRS families, existing networks would likely need to expand their scope of services and their current eligibility criteria.

Each of the planning teams discussed the important contributions the existing service networks bring to their respective communities, citing the work of the Family Resource Centers, Youth Service Bureaus, Systems of Care, and the Human Services Infrastructure. The teams collectively agreed it would be critical for the agreed upon service coordination model to work collaboratively and to be linked to these important service systems. However, each team, for slightly different reasons, did not feel that any one of these systems alone would be best suited as the service coordination model at this time. The teams outlined the many strengths of these networks, including their long standing partnerships and knowledge of communities, strong engagement of families and their strengths-based approach. All of these are key principles of a differential response system. However, there were concerns that there is a great deal of variability in how active and effective the different systems are. Teams also were concerned that expansion may dilute each group's positive results.

- *Lead Agency with Subcontracts*: This model would feature a lead agency with case management and administrative responsibilities that subcontracts with other agencies to coordinate service delivery with specific populations or in specific geographic locations. Planning Teams believe this model provided many benefits for building strong partnerships, tailoring services to different community needs, and ensuring quality and accountability.

- *Hybrid Model, Multiple Lead Agencies*: This model involves two or more lead agencies in a region that cover a specific geographic area, relative to an area office. Any of the lead agencies may subcontract with or purchase services from agencies that specialize in working with specific populations or that provide a specialized service. This is a variation on the lead agency with subcontract model and involves more effort from DCF because of a higher number of contracts. On the other hand, the additional lead agencies can provide peer learning and support and will have a higher level of investment with greater management involvement than would be the case for a subcontract agency.

C. Regional Service Coordination Model Recommendations

The Planning Teams in Regions 1, 3, and 5 selected the lead agency with subcontracts model in which a lead agency would be responsible for assuring that families are connected with the services they need to help them protect, nurture, and care for their children. Staff of the lead agency would provide case management services to families in DRS referred by a DCF assessment worker. Flexible funds would be available for staff to purchase services, if necessary. The lead agency would subcontract with other agencies in the region because of their experience working with certain communities or populations and be better positioned to provide localized service delivery. (See Appendix A for an example of this structure as outlined for Region 3.)

The Planning Teams in Regions 2 and 4 envisioned a slight variation to the lead agency with subcontracts model with regard to the number of lead agencies. These teams recommended the hybrid model where a lead agency would operate in each geographic area covered by the DCF area offices in a region. Region 2, therefore, would have three lead agencies and Region 4 would have a minimum of two lead agencies. The lead agencies could subcontract or partner with or purchase services from other agencies that might have a particular expertise or longstanding experience working with a particular population. (See Appendix B for an example of this structure as outlined by Region 4.)

Some of the Planning Teams suggested specific criteria that DCF should include in a Request for Proposal seeking a lead agency. One criterion is that a lead agency should demonstrate their experience involving the community and consumers in their work, including policy development and program planning. Another criterion is that a lead agency should have experience developing relationships and working partnerships with informal and nontraditional organizations in the community.

III. Referral Process, Service Coordination, and Funding

A. Referral Process

In the Connecticut DRS framework, when a report is made to the state Child Abuse and Neglect Hotline, the Hotline worker, in consultation with a supervisor, will determine whether a traditional investigation is required or whether the family can be assigned to differential response. This determination is based on the available information and whether the report meets the criteria for DRS established by DCF. If eligible, the family is assigned to a DCF area office for differential response. A DCF family assessment worker will contact the family within 72 hours and schedule a face-to-face contact within five days of the referral to the Hotline.

During the first visit, the DCF family assessment worker will use the Structured Decision Making assessment tool to assess safety and to ensure that the child is safe. The four decisions that can occur based on the assessment at the first visit include the following:

- *Close Case*: DCF may find that the child is safe, there are no service needs and close the case.

- *Provide Immediate Service*: DCF may find that the child is safe, but there is an immediate service need that the worker can address. Ongoing services may or may not be needed.

- *Refer to Lead Agency for Service Coordination*: DCF may find that the child is safe, but there are multiple service needs and the family wants further assistance.

- *Change Track*: DCF may find that the child is unsafe and a traditional investigation is required, rather than an assessment. Similarly, the DCF area office may also make a determination after a safety assessment that a case originally assigned as an investigation can be reassigned to the assessment track (See Appendix C for an example of case flow as outlined by Region 2).

While there were some differences in opinion within the Planning Teams about exactly when the lead agency would be connected to a family, it was clear that the teams wanted that connection to be made early in the process. Some members believe that a representative from the lead agency should go out with the DCF worker on the first visit to illustrate the community collaboration and help the family to be more comfortable from the start. Others believed that DCF should make the first visit alone to assess safety and determine whether there is a need for ongoing services. During deliberations, it was noted that it would not be time- or cost-effective for a case manager to accompany DCF on every first visit because some of the families referred to the assessment track may not require a referral to a lead agency. If a child is safe, but there are service needs, the teams agreed that the lead agency should be brought in as soon as possible to participate in the family team meeting.

B. Service Coordination

According to the Connecticut framework for differential response, if a family with multiple service needs is interested in receiving ongoing services, a family team meeting is held within 15 days of the Hotline receiving the report. Participants in the family team meeting generally include parents, family members and other significant persons who the family invites, the DCF assessment worker, the lead agency case manager, and any other providers working with the family.

During the family team meeting, factors that can cause risks to the child's safety are identified; the family describes their strengths, needs, and goals; services that can address the needs and help the family to achieve its goals are discussed; and a customized service plan is developed. The community provider (lead or subcontract agency), represented by a case manager, becomes responsible for connecting the family to the services outlined in the plan, and monitoring the quality and effectiveness of the services in helping the family address identified needs and achieve the specified goals in the plan. Planning Teams recommended that a family advocate be available to join a family's team, particularly if the family is distrusting of social service agencies, if the parents would be more comfortable with a family advocate who speaks their native language, or if the family needs assistance in accessing and learning how to access services.

At any time during this process, DCF may determine it has no further role and may close its case. The family may continue to work with the lead agency and receive the services identified in the plan. If at any point during service provision the lead agency believes that the child is unsafe, the lead agency, as a mandated reporter, is required to report suspected child abuse or neglect to DCF. When the plan goals are achieved and services are no longer needed, the community provider closes the case. Planning Teams suggested that families be allowed to return to the lead agency for time-limited services if a need arises after the case is closed.

C. Funding

Each of the Planning Teams wanted to know if funds would be made available to finance DRS. The teams felt that funding would be needed to hire case managers and purchase the range of services and supports that families in DRS would need to reduce risks to safety and achieve greater emotional and economic stability. Teams were informed by DCF that no new funding was expected in the current fiscal climate to fund DRS. It was anticipated, however, that funds would be reallocated to begin DRS in the first region.

The Connecticut Council for Philanthropy is a regional association whose members include family, independent, and community foundations; corporate (company-sponsored) foundations and giving programs, federated funds, public foundations, and other grantmaking organizations; donor-advised funds; and individuals. These organizations have tremendous impact through the programs they support in areas including education, health, scientific research, arts and culture, human services, religious organizations, and the environment. There are five regional funders roundtables, one in each DCF region, where members of these organizations meet regularly. Representatives from DCF, Casey, and parent advocates met with each of these five groups to discuss the implementation of Differential Response and how it may connect with other projects they are funding in their respective communities. The door was left open for future discussions.

IV. Oversight

A. Evaluation

In advance of this planning process, representatives of DCF examined other state and county DRS systems, including outcome evaluations. DCF together with key stakeholders identified desired outcomes for Connecticut's Differential Response System. These efforts resulted in the development of key domains to be measured across the life of the case including:

- System functionality,
- System characteristics,
- Family engagement and perspective,
- Service delivery, and
- Child/family/system outcomes.

As DCF has been preparing for implementation of DRS, it has conducted an analysis of Hotline data. This analysis, coupled with national findings, informed the development of expected outcomes which include:

- Reduction of the number of repeat reports and/or maltreatment among DRS families;
- Lower rates of entry and re-entry into care;
- Increased family engagement and satisfaction;
- Enhanced effectiveness and capacity of community service systems;
- Increased worker satisfaction; and
- Reduced aggregate child welfare expenditures over time.

Outcome data will be gathered from different sources including the DCF LINK System, satisfaction surveys, case reviews, and a program evaluation to be conducted by the National Resource Center and Walter McDonald Associates.

To support the evaluative component of DRS, DCF has been making changes to the LINK System and preparing the Program and Services Data Collection and Reporting System (PSDCRS) for community-based providers to enter important data. National evaluations on DRS indicate strong consumer and worker satisfaction. DCF has expressed strong interest in evaluating satisfaction and anticipates the use of a survey tool that would be administered by the SCM.

B. Oversight Structure

The regional Planning Teams expressed interest in staying connected to the implementation of a differential response system. Teams discussed the roles, responsibilities, and representatives that ought to be included in an oversight structure. Each team discussed the various structures that exist now, including the Area Advisory Councils (AAC) and Managed/Integrated Service Systems. Teams acknowledged differences in structure, participation, and utilization of these systems across area offices and most did not believe either was the right system to support this oversight body.

Casey Family Services also consulted with other audiences about this initiative. There is tremendous enthusiasm about DRS and a strong interest that it be consistently examined, evaluated, and monitored to determine its impact on children and families.

Planning Teams stressed the importance of examining service provision to ensure families were connected to localized services they most needed rather than services available based on the offerings of a specific lead agency. Teams discussed what they believed would be important roles and responsibilities for an oversight body, including:

- Reviewing data on identified indicators;
- Reviewing reports from the evaluator on quality of service delivery and outcomes;
- Identifying implementation and service delivery challenges and recommending solutions; and
- Providing feedback and recommendations for system improvement based on the team's experience with DRS.

If Connecticut's experience is similar to that of other states, as DRS evolves and staff become more experienced, the number of cases assigned to family assessment will increase, and the eligibility criteria will expand. This oversight body would serve in an advisory capacity to the regional director and his/her leadership team as the implementation of DRS evolves.

Key stakeholders that were identified as beneficial to an oversight structure include:

- Given the regional structure, representation from each of the AACs,
- DCF management from each of the area offices in a region,
- Consumers representing each of the area offices,
- Management from the lead agency(s) and/or sub-contracting entities,

- Providers representing existing service networks,
- Parent advocates, and
- Members of the original regional Planning Teams.

Since implementation of DRS will be staged, teams discussed a tiered strategy for developing the oversight structure. For example, a group should continue meeting in the region where rollout is imminent. Those regions that roll out subsequently would identify an oversight body closer to implementation. The Statewide Steering Committee could be the entity charged with sharing information about rollout with all teams. Recommended mechanisms to do this included the possibility of a newsletter, website, or list serv.

V. Issues for Further Consideration

Several issues were raised by the Planning Teams or other stakeholders that were beyond the scope of this project. However, these should be addressed by the Statewide Steering Committee or internal DCF management.

- *Family Support Services/Pre-DRS*: Some Planning Teams and community stakeholders discussed the need to increase supports to families at risk of being referred to the Hotline and for those referred and screened out. Schools and hospitals are often major referral sources for neglect, which is often poverty related. School-based family resource and family support programs and home-visiting programs for high-risk parents were identified as resources that could enhance a differential response system.

Members of the National Advisory Committee pointed to the California model and the Minnesota Parent Support Outreach Program (PSOP) as examples of models that were designed to provide voluntary supportive services to families at risk of child welfare involvement or those reported for child abuse and neglect (but whose reports were not accepted). Under the PSOP, the largest categories of services provided by workers concerned basic needs – household supplies, transportation, rent and house payments, emergency food, and housing – but also included child care, respite care, mental health services, and parenting support. Minnesota recognized that although the allegations did not indicate child maltreatment, they exposed a series of risk factors that had the potential to negatively impact child well-being. The delivery of these types of services support and stabilize families in a timely and cost-effective manner.

- *Self Referrals*: Questions were raised in Planning Team meetings and with various stakeholders about whether a family could self refer to DRS. Once families understand differential response, its values around family engagement and supporting families to prevent child removal, they may seek out DCF's assistance with problems that threaten family stability or pose risks to safety. Minnesota did not experience an increase in self-referrals, but they did see an increase in calls from non-professionals (family, friends, and neighbors).

- *Training*: While training was not a major topic for discussion, teams offered some suggestions. These included training DCF staff and lead agency staff together, and training members of the Oversight Committee in differential response and outcome measures. The National Advisory Committee also expressed the importance of delivering training to internal and external audiences in various forums. They discussed the complexity in moving from a practice calling for a traditional, forensic investigation to one that is guided by collaboration, strengths, and partnerships. The National Advisory Panel noted that a change in policy was critical but without training, "practice may be driven by the letter of the policy but leave the spirit of the policy behind," thus not fully realizing a practice shift. They suggested that investigations and family assessment staff be trained together to promote similar values and principles across units and a sense of being on the same team with different responsibilities.

- *Communication*: Some of the teams raised questions about how information concerning DRS would be communicated to the community and within DCF. They cautioned that messages about DRS should be clear and consistent to all stakeholders and that strategic outreach efforts should be made to include those who were not part of the planning process. During discussions with consumers, including a Citizen Review Panel, the importance of ongoing communication was stressed. It was shared by many that a critical component of implementation will be the active participation and ongoing engagement of consumers in the region. FAVOR and the Citizen Review Panel have offered to reach out to consumers to conduct community forums as DRS rolls out in each region.

- *Community Involvement in Proposal Review Process for Selecting Lead Agencies*: Planning Teams appreciated the guidelines DCF must follow specific to procurement and contracting but strongly supported, to the extent possible, inclusion of community partners for these activities. Many people stressed the importance of consumer involvement in these processes.

- *Service Contracts*: A recurring theme was the importance of revising contract language that does not prohibit service delivery based solely on whether or not a case is open with DCF. Planning Team members were pleased that the status of work matrix included reviewing the impact on existing contracted services, specifically around eligibility criteria and capacity.

- *Length of Service by DCF and Community Case Coordination*: The Planning Teams emphasized the need to link the family to the community as soon after the referral as possible. Aware that other states have instituted timelines specific to length of service and being cognizant of capacity, Planning Teams inquired about how long DCF would maintain an open case, how long cases could remain open with the community partner, and what capacity for extensions existed.

SUMMARY

Among multiple audiences, there has been strong, enthusiastic support for DCF's commitment to implement a differential response system in Connecticut. Grounded solidly in data, DRS has demonstrated the positive effects on children, families, and practitioners in multiple states throughout the country. With this system reform effort, Connecticut will join the growing number of states that are creating new methods for joining with families to keep children safe and promote greater family stability.

DCF approached the planning process with the very tenets central to a differential response system, encouraging and creating a diverse and inclusive process. This approach began over three years ago with the creation of a diverse steering committee representing all areas of the state. This group informed the issuance of a Request for Information followed by a Request for Quotations (RFQ). Clearly outlined in the RFQ was the Department's interest in supporting an inclusive community planning process to work collaboratively with DCF to put forth recommendations about the implementation of DRS. Each of DCF's five regions participated in partnership with key stakeholders, including sister agencies, community providers, consumers, grassroots organizations, and members of faith-based communities, law enforcement, post-secondary education, and community action agencies. In addition to the efforts put forth by the Planning Teams, various groups were interested in hearing more about the initiative and the planning process, and in sharing their respective opinions about the importance of such an approach in child welfare, welcoming discussions with Casey Family Services and Department representatives.

The five regional plans developed with this Executive Report outline each Planning Team's own thoughtful process and deliberations to advise the Department on how to move forward with DRS. Each regional Planning Team explored the communities that comprise its region and identified the strengths, challenges, and needs of children and families. Although each region has unique characteristics – geographic challenges, an ever changing population, or socioeconomic disparities – there appeared to be far more similarities than differences.

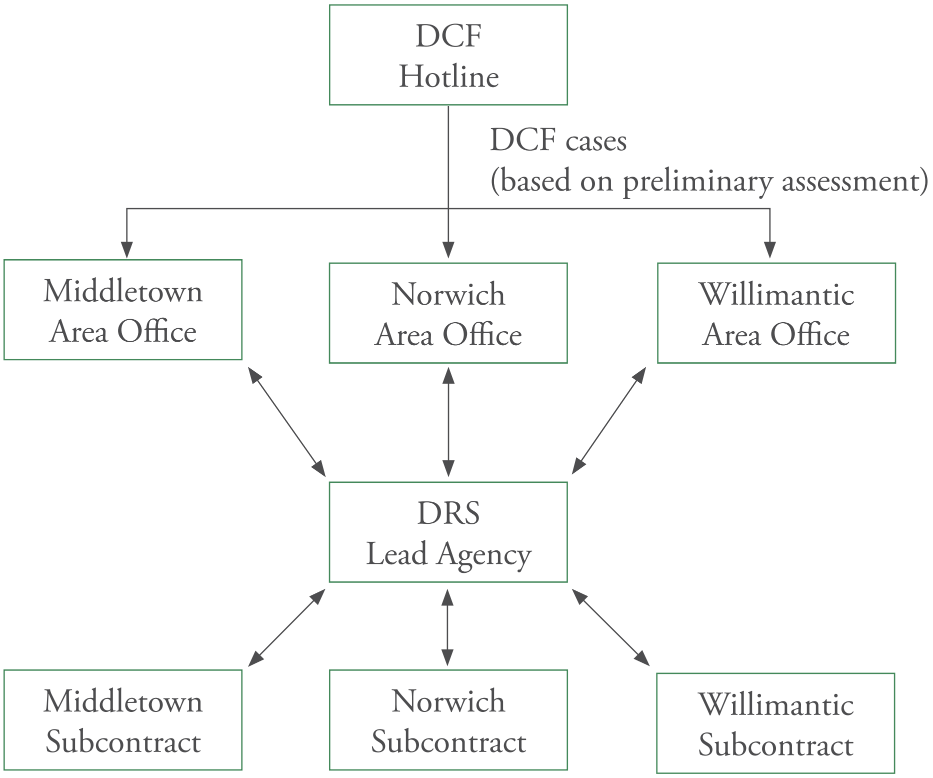
Each of the Planning Teams stressed the need for local and customized service delivery and embraced the concept of working more collaboratively with consumers. Two roles strongly endorsed by all teams were a case manager, who would partner with the family and DCF to broker the services and supports most needed by a family, and a family advocate, ideally a previous consumer who could provide support, role modeling, and guidance to families.

Finally, all groups expressed the need for a strong evaluation component. Each group provided different suggestions about areas to be included in an evaluation, but all believed that oversight ought to be shared by DCF and the community.

Jim Casey, the founder of Casey Family Services as part of the Annie E. Casey Foundation, has said, “Determined people working together can do anything.” This collaborative planning process demonstrated that there are a lot of determined people willing to work together to improve the lives of children and families in Connecticut.

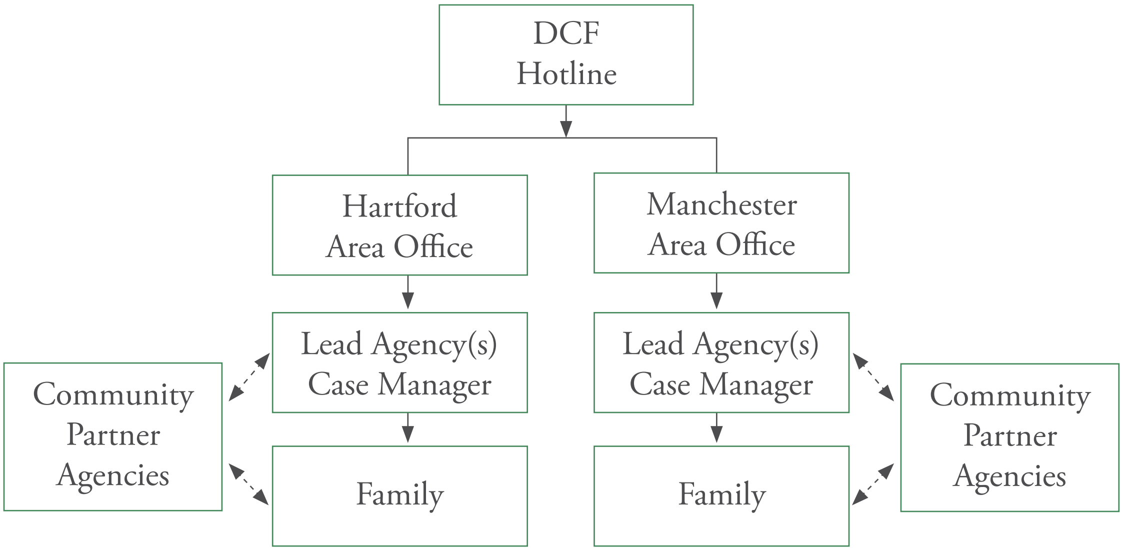
APPENDIX A

Lead Agency with Subcontracts Model (Region 3)



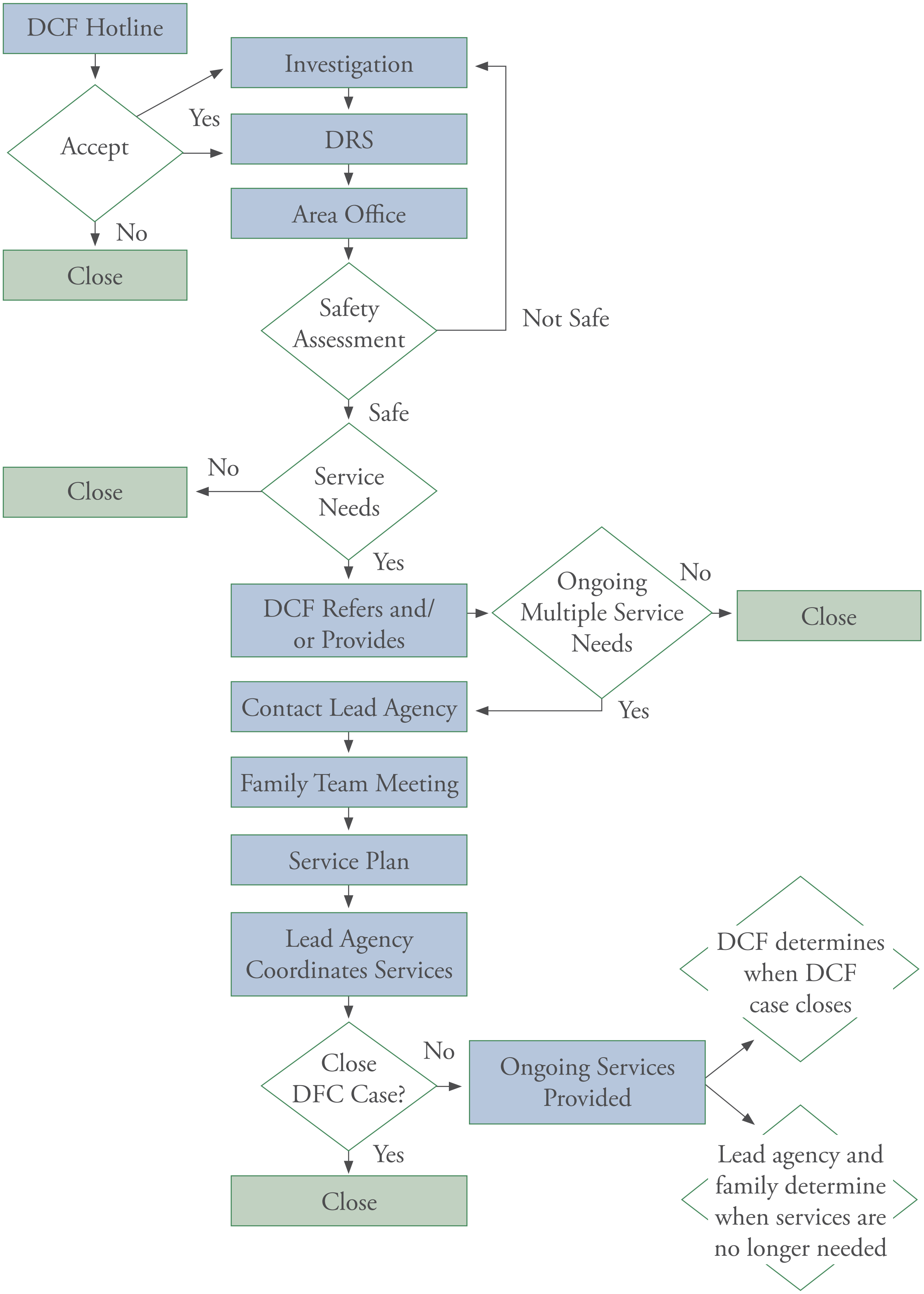
APPENDIX B

Hybrid Model, Multiple Lead Agencies (Region 4)



APPENDIX C

Case Flow (Region 2)



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Casey Family Services, the direct service agency of the Annie E. Casey Foundation, authored this executive report at the request of the Connecticut Department of Children and Families.

The Annie E. Casey Foundation fosters public policies, human-service reforms, and community supports that more effectively meet the needs of today's vulnerable children and families. The Foundation makes grants that help states, cities, and neighborhoods fashion more innovative, cost-effective responses to these needs. Casey Family Services provides a broad range of permanency-focused services to meet the changing needs of vulnerable children and families: foster care, adoption, post-permanency, preservation, reunification services, and family resource centers.

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