REPORT TO CONTRA COSTA COUNTY
SUMMARY FINDINGS FROM STUDY OF DIFFERENTIAL RESPONSE

This report summarizes findings from a two-year study of differential response in Contra Costa County. The study was funded by CalSWEC with the intent of producing an evidenced based curriculum on differential and alternative response to be used as an educational tool for social work students and new child welfare workers throughout the state of California.

The study included analyses of three different data sources. First, in 2006-2007, staff from the Center for Child and Youth Policy (CCYP) conducted in-person interviews with 29 direct and supervisory staff from Children and Family Services and the participating community based organizations. Second, in 2007-2008, CCYP staff conducted telephone interviews with 51 participants receiving DR services through Path 1 or Path 2. Case managers were asked to give all of their current clients information about the study along with a consent form for participation, which the clients could submit directly to CCYP if they were interested in participating. Finally, the county provided CCYP with basic quantitative data on clients who received services during the 2005-2006 fiscal year, including one-year follow-up data on re-referrals, case openings, and child removal.

The CCYP staff is extremely grateful to the staff of CFS and the participating CBOs for their assistance and support in conducting this study. We especially want to thank Pat Harrington and Patricia Wyrick. Without their support, this would not have been possible. Finally, we extend our great appreciation for the families who took the time to share with us their thoughts about, and experiences with, the Differential Response Program. Thank you!

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Analysis of Data from Staff Interviews

Following are highlights from interviews with direct line and supervisory staff involved with the planning and/or implementation of differential response. In person interviews were conducted with 13 staff from Children and Family Services (CFS) and 16 staff from community based organizations (CBO). The CFS staff included ER workers and supervisors, hotline screeners and supervisors, and community engagement specialists. The CBO staff included 5 case managers and supervisors from Path 1, 10 from Path 2, and 1 involved with both Path 1 and 2.

Strengths & Challenges

Staff from CFS and the CBOs mentioned the following key strengths of the DR system:

- Providing services to families who wouldn't otherwise receive them;
- Availability of support for families 24-7;
- Combined expertise of different agencies;
- Collaboration and building of trust with the community and CBOs; and
- Changing perception of CFS in the community.

Additionally, although staff generally felt very positively about the DR system, they identified the following weaknesses or challenges of DR:

- Need for clearer communication about the transition from ER worker to community case manager in Path 2, as well as quicker response from the CBO.
- Need for more bi-lingual (Spanish speaking) case managers.
- Increased workload for the ER worker.
- Providing feedback on family outcomes: ER workers want to know what happens to families after they are passed onto the CBO, and, conversely, case managers want to know what happens to families (and often want to continue working with them) when they are referred back to CFS.
- Need for more clarity about the re-referral process.
- Inadequate resources in the community—families need more help than what DR alone can provide.
- High caseloads for community case managers.
- Need for clarity regarding the role of community case managers in TDM.

Staff Training

In general, community case managers felt much more prepared and better trained in DR than ER workers. Case managers generally felt that the DR overview and trainings were helpful, but that they could use more training in how to work with families that have alcohol and drug problems. Yet, there was a general feeling that CFS is responsive to their training needs. In contrast, most ER workers could not recall receiving any formal training on DR; however, one noted "I don't know that there is anything that would have prepared me, other than just having the experience."

Staff Communication

Overall, staff from CFS and participating CBOs felt very positively about their communication with each other. Many CBO staff cited the CFS-coordinated monthly and quarterly meetings as very helpful to communication, and a few noted the joint transitional visits as helpful. Other CBO staff indicated that relationships among CBOs already existed—that the network was already in place—but that this has helped to strengthen it.

> *"This has been a really perfect arena to establish a non-competitive spirit of helping families, which is what we've been trying to do all along. But now we're not competing for money, now we're at a point where we're just coming together to help families."*

Another case manager said,

> *"What I was pleased to see is how thorough the planning was, and then how the follow-through was there. And people also being willing to say 'we don't have the answer, this is a new process, and it's evolving.' And being supportive of the worker if they were in a situation that was new, and also getting back to us."*

Only one case manager suggested that the CFS administration is out of touch with what the case managers do.

Several child welfare workers noted having better relationships with some CBOs than others, and a few ER workers expressed concern about case managers not informing them when their caseload is full. Additionally, most CBO staff in West County and some in Central County reported that there was a lot of initial resistance because ER workers felt threatened by DR. CBO staff felt that they had to establish credibility with the ER workers. Several case managers and supervisors noted that being invited to unit meetings by the ER supervisor helped all the players get to know each other and eliminate the ER workers' initial feelings of threat.

Client engagement

The most persistent theme among respondents was that relationships are key and need to be developed over time. As one person stated, "when you work in this field you don't do anything without relationships. You don't make a dent in their life… until you establish a relationship with that person." Another case manager pointed out the importance of first impressions:

> *"Entering the home is the most important key to the success of that caseworker. Enter wrong, you'll always be trying to play catch-up and apologizing, and explaining and stuff. But if you enter right, … I think it's paramount to the success of the intervention, because the family relaxes quicker and they trust. . ."*

Other recommendations included the following: Don't ask about sensitive issues (e.g., domestic violence) right away—wait until the relationship develops; don't take notes; frequent contact is good, but not so much that families feel they're being watched; provide clear explanations of DR's role in order to establish trust; keep an open, honest relationship with families; it helps to visit families in their homes, but respect families' homes and schedules.

Family Assessment and Services

In general, case managers seem to focus on the strengths of the family; whereas ER workers focus primarily on the needs of the child and safety of the home. When asked about the effectiveness of the CAT as an assessment tool, some expressed concern that it is too broad and vague and needs to be more culturally competent. As one worker pointed out, the CAT tool includes race, but not culture, and race doesn't capture culture. The worker provided this example: a person can be from Nigeria, but CAT would only have an option for "African-American," when the person isn't really African-American.

When asked about clients' service needs, several case managers noted that, because many families have low educational levels, things need to be presented/explained at a 6th or 7th grade level.

Overall, the greatest needs noted by workers were emotional support and help navigating systems. Additionally, case managers identified the following typical services that they provide:

- bus & BART tickets,
- referrals for food and parenting classes,
- crisis support,
- advocacy,
- information about services, and
- referral to services such as domestic violence counseling/help, substance abuse treatment, mental health services, housing, childcare, jobs, clothing, diapers, high chairs, tutoring, bilingual services, transportation.

At the same time, case managers noted insufficient availability of housing; substance abuse treatment (especially residential treatment that allows children to come with the mother); childcare—in general and during parenting classes and mental health appointments; transportation; information about services; and bilingual services (particularly bilingual staff and Latino specific services).

Finally, it was noted that one's own values shape judgments, including risk, safety and needs assessments. One worker cautioned others not to impose values on the family, and to realize that some cultures have many sub-cultures, as in different regions of a country, or different countries that speak the same language.

Analysis of Data from Client Interviews

This section highlights findings from the 51 phone interviews conducted with clients receiving Path 1 or Path 2 services during 2007-2008.

Agencies Providing Services

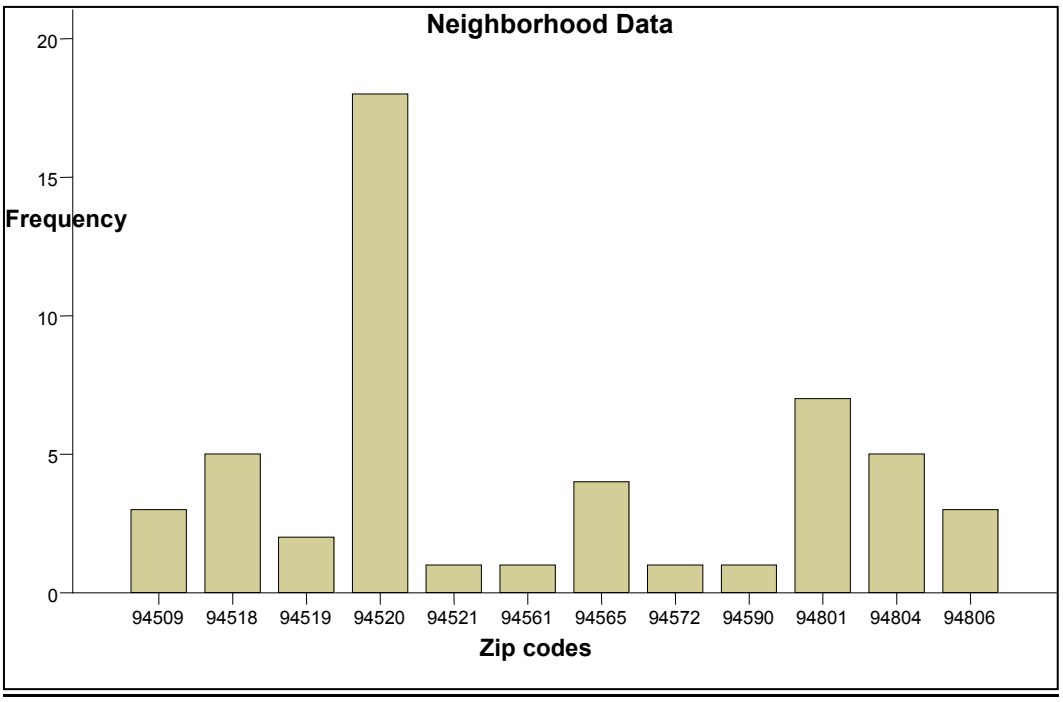
Participants were referred from eight different agencies located throughout Contra Costa County. The largest percent came from Families First, which has case managers in each region of the county and provides path 1 and path 2 services. Generally, families were evenly distributed among the three regions of the county, although about 35% lived in Concord within the 94520 zip code area, and 20% lived in Richmond in the 94801 zip code area. About three-quarters of the study participants were in Path 2, and one-quarter in Path 1.

Name of agency where client received services

Agency	Frequency	Percent
Catholic Charities	4	7.8
Community Violence Solutions	6	11.8
Families First	13	25.5
Family Stress Center	7	13.7
First Baptist Church	3	5.9
Neighborhood House	2	3.9
New Connections	12	23.5
YMCA	4	7.8
Total	51	100.0

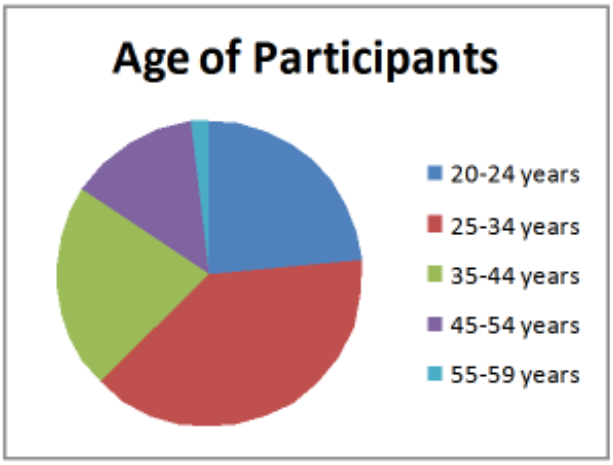
Differential Response Pathway

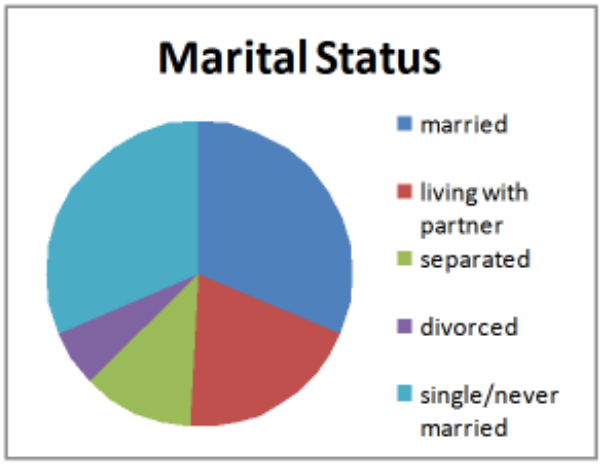
	Frequency	Percent
Path 1	13	25.5
Path 2	38	74.5
Total	51	100.0



Description of Participants

Clients who participated in the interviews ranged in age from 20 to 59; more than two-thirds



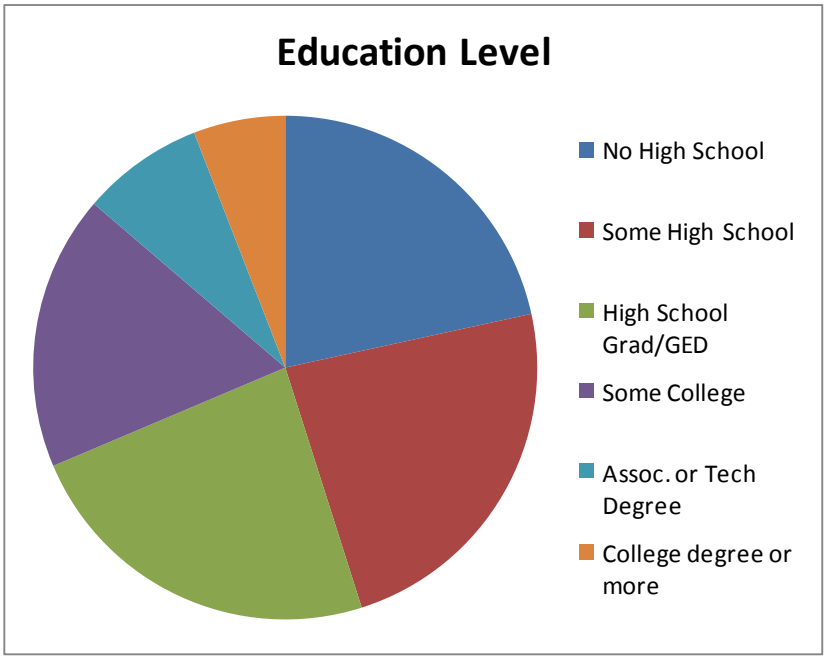


were younger than 35. Almost two-thirds were either married or living with a partner.

More than half of those interviewed were Hispanic or Latino, and almost a quarter was Black; the remainder was White (primarily), Asian, or "other." Almost one-quarter (22%) of all the participants spoke only Spanish. Another 13 described themselves as bi-lingual, speaking Spanish and English, although the majority of these clients spoke very limited English.

Race/Ethnicity	Frequency	Percent
Black/African American	12	23.5
White	6	11.8
Hispanic/Latino	30	58.8
Asian	1	2.0
Other	2	3.9
Total	51	100

As illustrated in the chart, almost half the participants had not graduated from high school, with 22% reportedly having no high school at all. This latter group was comprised completely of mono-lingual Spanish speaking participants who reported a range of education from none to 8th grade, obtained mostly in their home country. In contrast, almost one-third (31%) of participants had some college or some sort of degree (e.g., associates, bachelors, technical).



Participants are raising an average of three children, with a range of 1 to 12 children; and more than one-quarter of the participants (29%) live with extended family. Participants reported living in their current residence an average of 33 months, with a range from 1 to 216 months. The mode was 24 months, but about half have lived at their current address for a year or less.

Engagement

The vast majority of participants reported learning about the program from Children and Family Services (CFS). One participant, from Path 2, reported learning about it when the case manager came to her house, and a few noted that they learned about it from the CFS worker and case manager together. One participant reported learning about it from the victim witness program. In a couple of cases, participants said they were offered DR services instead of a formal report and an open child welfare case. Overall, regardless of how they learned about the program, more than three-quarters (77%) of respondents reported feeling like they had a choice of whether or not to participate; 16% felt that they needed to check with other family members before participating.

The reasons participants gave for participating fell into three general categories. The most prominent reason given by more than half the participants was that they needed help and saw this as an opportunity. The other two reasons were that they felt they *had* to participate, or because their case manager convinced them—either through information and encouragement or because of certain qualities (discussed more below). For instance, one participant said, "I felt like I had a choice in getting a tool for my toolbox and it was voluntary. [My case manager] sitting down with me offering her help and not judging me also helped."

Almost two-thirds of participants were "somewhat confident" (16%) or "very confident" (48%) that the program would help. Almost a quarter said they didn't know, and the remainder were "not at all" or "not very" confident that it would help. The most commonly cited reasons for lacking confidence were fear, uncertainty, resentfulness, and distrust. One person, for instance, noted uncertainty based on being a black person and previous experiences with organizations saying that they could help. Another stated that she had reached out for help in the past and was never helped. However, most of those who had a negative first impression of the program eventually changed their mind about it. Nearly half of the participants who indicated that they lacked confidence in the program stated that they "didn't know" or were unclear about what the program entailed.

At first I wasn't so sure about it, but after the first couple of weeks, I realized that [the case manager] was trying to help me be a better parent.

At the beginning, I thought "what the heck do I have to do this for." But because of [my case manager's] patience and understanding, and the breadth of services that were offered, I realized they were there to help.

I didn't like being forced to meet regularly. Later I felt it was comforting and [the case manager] was helpful with tips and advice.

Opinions of and Relationship with Case Manager

The vast majority (more than 90%) of participants indicated that their case manager understands and shows respect for their culture/ethnic background. When asked about their case managers, one person said "I don't like [my case manager] very much at all." All the other participants had positive things to say about their case manager, and identified numerous qualities. Most commonly, participants described their case managers as nice, good listeners/attentive, helpful/resourceful, and trustworthy/dependable/on time. Participants also stated that their case managers are like friends or family members; and that they're understanding, easy to talk to, patient, supportive, and nonjudgmental. The following sample statements illustrate some of the qualities clients liked in their case managers:

It seems like she really wants to do what she's doing and that instills confidence in me.

She's very friendly and makes me feel comfortable.

She supports the decisions I make.

She's kind hearted, understanding, available, and helps me out 100%.

My case manager is a real person who comes to me as a regular person and doesn't assume what I need, but talks to me about what I need and makes me feel comfortable.

My case manager listened to me before giving opinions.

When asked about certain characteristics, all 51 participants reported that their case manager was knowledgeable, respectful, truthful, organized (7 said "somewhat organized"), helpful, warm/caring, encouraging, supportive, good listener, and flexible (6 said "somewhat flexible"). As indicated in the tables below, most felt that their case manager was aware of and helped them address their needs.

How much is case manager aware of client's needs

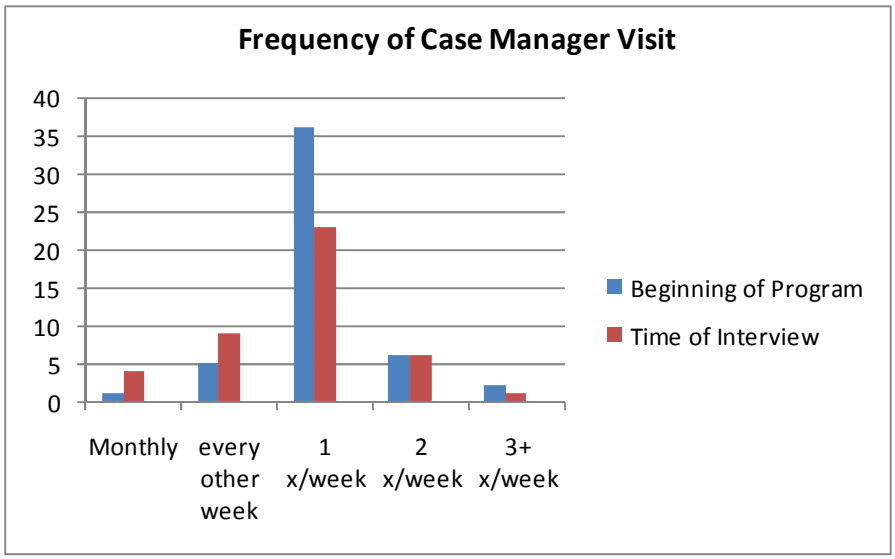
	Frequency	Percent
Not much	2	3.9
Somewhat	7	13.7
Very much	42	82.4
Total	51	100.0

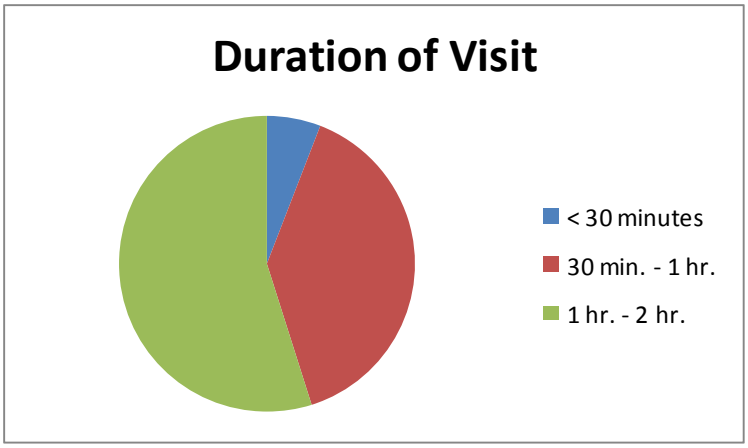
To what extent does case manager help client address needs

	Frequency	Percent
Not much	1	2.0
Somewhat	7	13.7
Very much	42	82.4
Don't know/neutral	1	2.0
Total	51	100.0

At the time of the interview, participants had been receiving services for an average of 8 months, ranging from 1 to 24 months, with a mode of 12 months. The majority (70%) of participants reported that their case manager visited them once a week at the beginning of the program. The frequency of visits decreased later in the program with 45% of participants

reporting weekly visits by the time of the interview (1-24 months later). Although a few participants indicated that the frequency of visits was too much or too little at both points in time, the majority (88% in both cases) felt that it was just right. Whereas most of the visits took place in the client's home, 35% reportedly met elsewhere as well. The most common other meeting place was the case manager's office. Additionally, clients reported meeting their case managers at restaurants, the hospital, the CFS building, the police department, and the courthouse. In general, visits tended to last between 30 minutes and two hours, and most participants (94%) felt that this was the right amount of time for them. All of the participants felt that they could call their case manager with a problem or question. In fact, three-quarters reportedly called at least once, and about 10% reported calling more than a dozen times.





Type and Availability of Services

The most commonly cited service received was concrete support (e.g., money, food, transportation, clothing, toys), with slightly more than half of the respondents identifying these types of support. This did not include housing assistance. Close behind concrete services was counseling or therapy. This included therapy or counseling for a child, parent and/or family to address a variety of issues including anger and domestic violence. General support was mentioned by more than one-third of the respondents. In fact, most of the Spanish speaking participants identified having someone they could talk to as the most important "service" provided. More than one-quarter of all participants mentioned parenting education and general services linkage or referral as important services. Other less frequently noted services included advocacy, child care, benefits assistance, employment or education assistance, health care, housing assistance, and child care.

The majority of participants indicated that most or all needed services were located in their neighborhood, and that needed services were always (69%) or sometimes (22%) available. Four

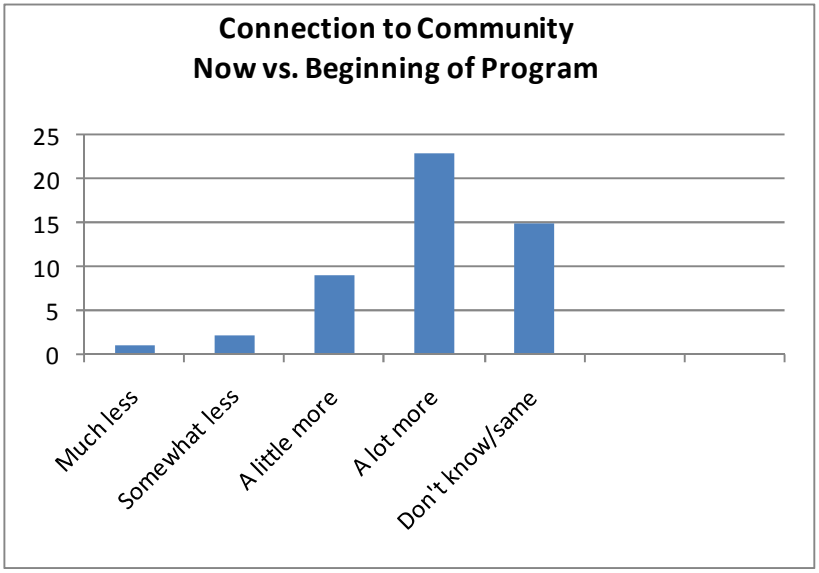
people cited wait lists as the reason for unavailability; and the following reasons were each cited by two people: no transportation, didn't qualify, inconvenient hours, and too far away.

How helpful was the program?

The table below illustrates the percentage of participants that said they learned "a little" or "a lot" in the respective areas listed in the left-hand column.

	Learned a little	Learned a Lot
Parenting	12%	61%
Counseling Services	10%	63%
Community Services	22%	47%
Child Care	12%	57%
Health Care	16%	47%
Food/Nutrition	18%	43%
Transportation	16%	41%
Household Management	16%	37%
Legal Assistance	12%	41%
Child Development	14%	37%
Domestic Violence	6%	41%
Anger Management	12%	35%
Financial Assistance	14%	28%
Budgeting	8%	33%
Family Recreation	14%	24%
Employment Services	12%	22%
Housing	8%	26%
Alcohol/Drug Services	6%	24%

Almost all the participants (94%) noted life changes as a result of the program, and they credited their case managers as helping them make these changes. They also reported an improvement in overall quality of family life; 20% reported a little improvement, and 73% said it's a lot better. Additionally, more than 75% of participants reported feeling more connected to the community now compared to before receiving Differential Response services. Many of the Spanish-speaking clients noted that access to a Spanish-speaking case manager increased their sense of connection to the community. The following statements illustrate some of the life changes reported by participants:



Before I was overwhelmed, but the program helped me see my kids' strengths and got me to participate more in their lives.

I've learned that there are programs out there for you and there's always someone there to help if you need it.

The weight on my shoulder is not so heavy.

All but one participant were either "somewhat satisfied" (12%) or "very satisfied" (86%) with the program, and they all said they would recommend it to a friend.

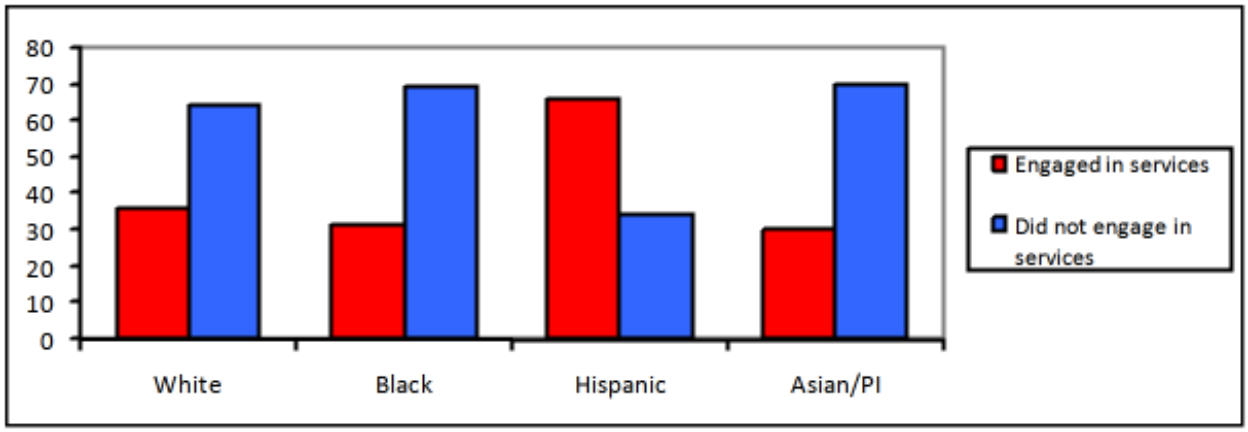
Analysis of County Data

Contra Costa County provided data for 1,800 children eligible for and referred to the DR program between October 2005 and September 2006. These data were obtained from administrative records completed by DR service providers and CWS/CMS. For purposes of this report, the sample was reduced to 499 for the following reasons: (1) We omitted children older than 12 years of age to avoid at least some duplicate data due to siblings already in the system; and (2) We omitted all families initially referred to path 2 or path 3 because there were no data indicating whether or not services were actually provided.

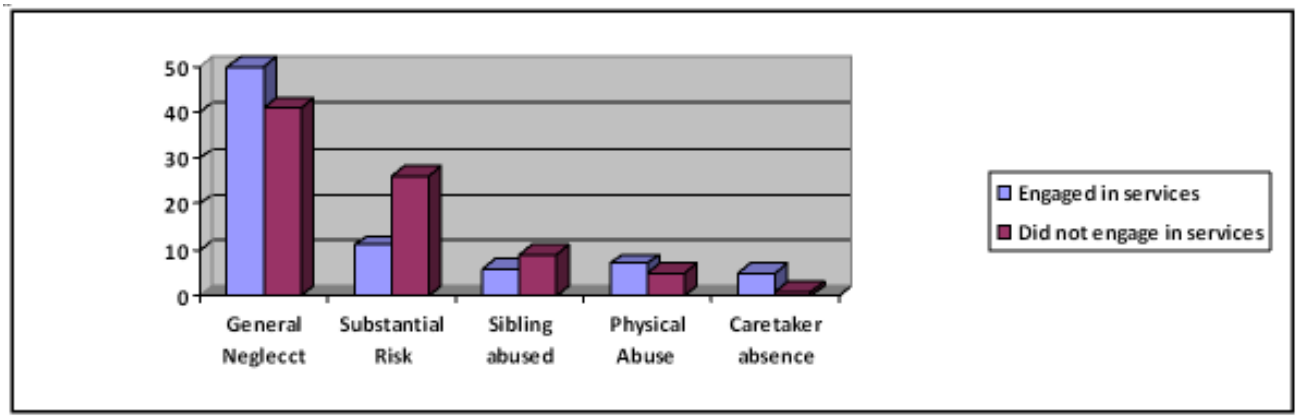
Engagement

Of the 499 children referred to Path 1 between October 2005 and September 2006, families of only 164 children (33%) were offered services. The remainder was not served due to lack of capacity (59%) or inability to contact the families (8%). Of those who were offered services, approximately half (49%) actually engaged in (i.e., received) services. In an attempt to better understand possible predictors of engagement, we looked at the following factors for these 164 children: ethnicity of the child, age of the child, type of allegation, and prior referral history of the family.

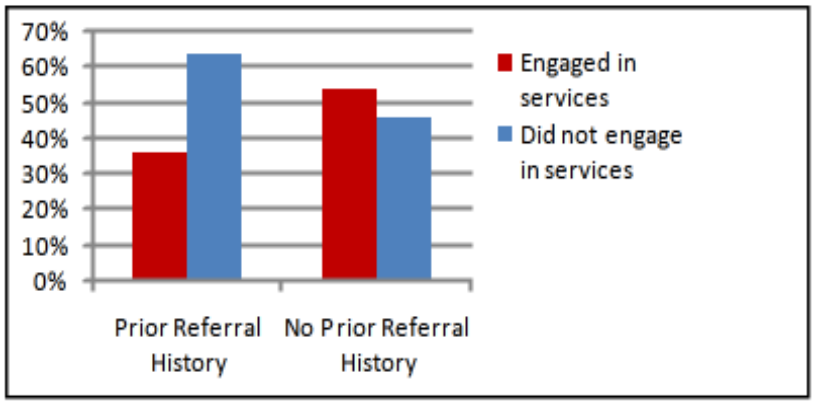
The ethnicity of the child was recoded into the following categories: White, Black, Hispanic or Asian/PI. Ethnicity data was missing for 21 children, so these cases were not included. Of the 143 children for whom we had ethnicity information, 15% were White, 36% were Black, 41% were Hispanic, and 7% were Asian/Pacific Islander. There was a significant difference observed in engagement rates of Hispanic clients as compared to clients from other ethnic backgrounds. As illustrated in the chart below, Hispanic families were more likely to engage in services (66%) than families of any other race/ethnicity. Based on anecdotal information gathered through the client interviews, this may be due to a variety of factors. For instance, Hispanic clients may have been more likely to feel that they had to participate; they also may have welcomed support due to inadequate existing supports, particularly those offered in their language. However, more research is needed to fully understand these differences.

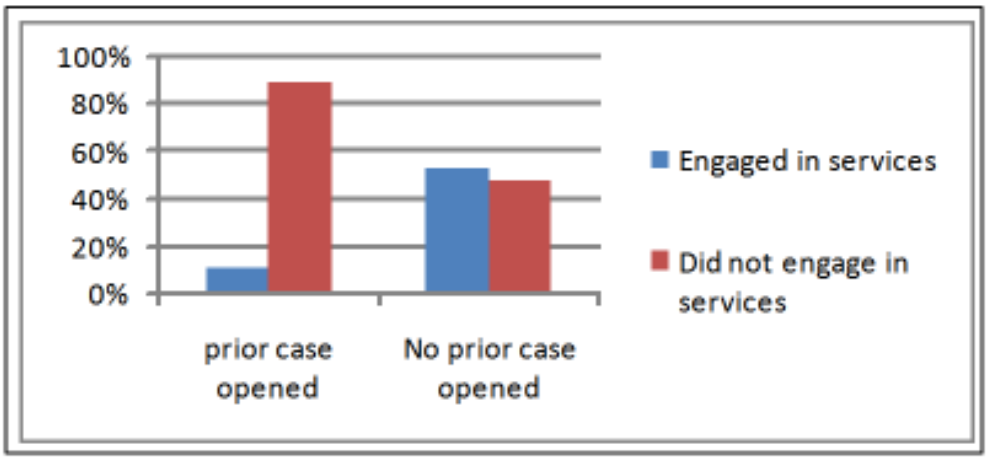


The age of the child did not seem to affect a family's likelihood of engaging in services. However, the initial allegation type did. Overall, general neglect was the primary allegation type for the majority of the cases (55%). Although only 2% of the sample had an initial allegation of Caretaker Absence/Incapacity, this group was most likely to engage in services (83%). Conversely, those with an initial allegation of substantial risk were least likely to engage in services (30%).



Families who had a history of child welfare referral prior to September 2005 were less likely to engage in services than those who did not have a prior referral. Families who had a case opened prior to the current referral were even less likely to engage in services (11% vs. 53% for those who did not have a prior case opened).





Re-Referral

Logistical regression analysis was used to determine the impact of certain factors on the likelihood of re-referral. As noted in the table below, engagement in services did *not* appear to

impact re-referral rates. The only significant predictors of re-referral were ethnicity and prior referral history.

Predictors of Re-Referral

	S.E	Wald	Df	Sig.	Exp (B)
Primary Ethnicity	.786	5.088	1	.024	5.882
Allegation Type	.410	3.436	1	.064	2.139
Child's Age at Referral	.065	1.066	1	.302	.935
Engaged in Path 1 Services	.411	.325	1	.568	.791
Prior Referral History	.480	5.107	1	.024	2.957

In fact, the odds of re-referral for a non-White child were 5.9 times the odds of re-referral for a White child, controlling for all other variables. Specifically, the re-referral rates were 42% and 37% for Blacks and Hispanics, respectively, but only 9% for whites. Additionally, the odds of re-referral for those who had a prior referral history were 3 times the odds of re-referral for children whose families did not have a prior referral history. These findings were consistent with existing research literature that suggests that minority populations and families with prior referrals have higher re-referral rates.

Removal

Logistical regression was not utilized to examine the data on removal because of the small sample size. However, crosstabs analyses showed that receipt of services may have had an impact on the removal rate. As shown in the table below, children whose families did not engage in services were more likely to be removed than those from families who did engage. At the same time, those who were not offered services due to lack of capacity or inability to contact, had removal rates comparable to those who received services. One possible explanation for this is that during the time that these data were collected, the most "difficult/needy" cases were given priority for being offered Path 1 services. Thus the lack of services for these families may have had a greater impact on the outcomes than families who weren't as needy to begin with and therefore may not have been offered services.

	Removal within 1 year		
	No	Yes	Total
Services Engaged	78	2 (3%)	80
Services Not Engaged	74	10 (12%)	84
No Capacity	285	12 (4%)	297
Unable to Contact	36	2 (5%)	38
Total	473	26 (5%)	499

Finally, the data suggest that White and Black children are more likely to be removed than Hispanic children. However, it is important to note that these data include *all* children who were offered DR services. Looking only at the 80 families who actually engaged in services, the two children who were subsequently removed were both Hispanic. The sample size is too small to make any conclusions about this; however, it is something that can be explored further and with greater confidence with the random assignment study.

		Removal w/in 1 year		
Ethnicity		No	Yes	Total
	White	19	3 (14%)	22
	Black	46	6 (12%)	52
	Hispanic	56	3 (5%)	59
	Asian/PI	10	0	10
Total		131	12 (8%)	143