Summary Notes from 9-16-15 SSAC Direct Services Committee meeting: Verbal Report and Discussion with DFCS and Differential Response providers on outcomes, services and issues concerning the Differential Response Program.

Members in attendance: Betty Siemer, Betty Barajas, and Steve Baron from the SSAC. Becky Manchester with the Child Abuse Council. Penny Blake from the Juvenile Justice Commission and Child Abuse Council. Differential Response Mangers representing Gardner, EMQ, and Unity Care. Eleven representatives from the SSA and DFCS.

Central points:

1. There is a high degree of collaboration, cooperation, and cross training among the providers especially with regard to how to successfully engage families and overcoming barriers to the families' ability to participate in and receive needed services.

2. There are two main reasons why the "successful enrollment/engagement" rates have decreased for Path I (decreased from 25.3% to 15.5 %) and Path 2 (decreased from 48.1% to 41.6 %):

a. "Touch and refer" cases (where there is any kind of contact made and the family may be given a referral to other services but there is no service plan signed) are no longer counted as successfully enrolled/engaged.

b. As reported by the providers, the families being referred are becoming tougher to engage and serve, i.e., more serious problems and more resistant.

{Comment: Other data indicates that while the percentage of CAN Center "answered calls" has significantly increased, there has been no increase in the percentage of calls being referred to ER for investigation, and that the % of cases being referred to ER for investigation continues to decline: The percentage of answered calls being referred to ER for investigation decreased from an 3 month average of 55% in fall of 2013 to 45% in the fall of 2014. Note: Families that have received an ER investigation have a 63% greater probability of successfully enrolling/engaging in DR services than families who have been "evaluated out" but referred to DR. Finally, the % of cases referred to investigation that are substantiated continues to decrease from approximately 19-20% in 2006, to 13.6% in FY 2015.

3. In 2014 when all the existing DR slots were filled and the waiting time for enrollment rose to 10 weeks, which compounded the difficulty for successfully enrolling referred families, the number of available DR slots was doubled with the availability of additional funding. Between FY14 and FY15, the total number of referrals significantly increased for all Differential Response services by 61% from 1,262 to 2,032 referrals. For approximately a year after that there was no significant waiting list. Now the waiting list has re-emerged and is at approximately two to three weeks and is expected to escalate as referred families are presenting with more significant problems as reported by the providers and require an extensive period of service provision time in order to effectively address child and family safety and family functioning issues. [Comment: Unless additional slots are funded it is reasonable to expect that waiting times will again reemerge as an additional barrier to successfully enrolling families.].

4. Much of the of the information requested by the committee regarding DR (e.g., # of families receiving/successfully completing each offered intervention, average length of involvement, reasons for termination of services, # of families "successfully/partially/not" completing service plans) is currently not captured by the existing data collection system, but a new logic model data base developed in collaboration with FIRST 5 which hopefully will go into operation by the end of 2015 will capture that data. Two of the three providers stated they are informally capturing that data now. Note: The decision about how to determine whether a family has "successfully" completed services is based both on a quantitative and qualitative

assessment by the involved case manager often in consultation with a supervisor, and currently might be best described as a family achieving a majority of goals regarding safety and family functioning.

5. The providers reported they are all using the same evidenced based assessment instruments and child safety assessments and that assessment is ongoing during the entire period of service provision.

6. The providers reported that a primary service goal in a large number of cases is trying to work towards the provision of family therapy. Whenever families are referred to collateral services it is done via a “warm handoff” where the case manager personally assists the family in connecting with that service. A fundamental problem has emerged in that while there is a very high need for therapists qualified to serve these families, there are an insufficient number of therapeutic services available.

7. The providers estimate the average period of case involvement for enrolled families to be approximately 5 months with those involved in therapy tending to be involved for the longer periods of time. Services are limited to 6 months but extensions may be obtained.

8. Both the Agency and providers reported that DR services are not, of course and due to changing circumstances and variables, expected to stabilize a family indefinitely, and so when data related to recidivism is being collected, it will be limited to covering the period of one year following completion of services.