CT Family First – Candidacy Workgroup

Date of Convening: January 14, 2020

Agenda

- Welcome and introductions
- Review of initial agreed-upon candidacy groups and discussion of items needing clarification
- Feedback on remaining potential candidacy groups
- Feedback on broader prevention plan target population
- Strategize additional data needs
- Action Steps

Housekeeping

- Before the group began its discussions, the co-leads expressed their gratitude to the workgroup members for their dedication throughout this process. This workgroup had a particularly tight turnaround and required a lot of time from its members, but they feel it could not have gone better.
- The group reviewed the flipcharts that were posted around the room:
  - The parking lots continue to be posted for any good discussion points that are raised but not within the charge of the Candidacy workgroup.
  - The graphic identifying the difference between Phase I and Phase II of the workgroup was posted.
  - A flipchart from the Programs and Service Array workgroup was also displayed; it identified service gaps, considerations, and service continuum needs from other agencies. These flipcharts are summarized below:

Identified Gaps	Considerations	Need Service Continuums of:
• Respite for all families w/ ASD or ID children • Services for youth w/ cognitive limitations (autism in particular) • Lack of after-hours services	• Exclusionary/inclusionary criteria • Capacity/access • Social determinants of health • After-hour service availability	• OEC • DMHAS • CSSD • DSS • Housing (DOH) • DPH

• School readiness support/service • Complex medical social welfare • LGBTQ community	• Cultural competency/language capacity • Eligibility restrictions (especially for undocumented families) • Transition from office-based to in-home EBPs • Behavioral health services for parents • Assess/determine where motivational interviewing is being done • Level of care access to EBPs	• Youth Services Bureau

- Members were asked to share any questions or comments about the process:
    - One member shared that they were pleased with the process. In particular, she highlighted the way Connecticut split and assigned workgroups. She has seen this process happening in other states and felt their workgroups had too big a charge and their overly large scope slowed the process down.

Review of Initial Candidacy Groups and Discussion of Items Needing Clarification

- In the last meeting, the group discussed several populations and decided on a few groups that would be included in the recommendation for Connecticut's Family First candidacy definition. However, there were a few points within those populations that required clarification. Discussion questions helped orient the conversation and further refine these groups.

Children screened in and accepted as meeting criteria for DCF involvement (including voluntary services).

- The group discussed what the timeframe should be for this. Does this include people who had an accepted Careline report years ago, or only recent calls? Are we bounding this group by time in any way?

- Before these questions were answered, the group was reminded of the “funnel” concept from the last meeting. Right now, the group is focusing on the top of the funnel, which is anyone included in the candidacy definition, but not every person in the definition will automatically get services. A screening tool will be developed to determine eligibility, and then a candidate will need to show that there is a need for a specific EBP (in the approved plan). As prospective candidates go “through the funnel,” we will end up with a much smaller group of people accessing services through Family First versus the total population are actually included in our definition. Another reminder is that Family First is the “payer of last resort.”
- Some people felt that only active cases should be included in the definition; that is when we should begin our assessment.
- Others in the group felt that it made sense to include a short timeframe of perhaps 6-12 months after a Careline call as well. This is because families whose case has recently closed are still at risk for another call; perhaps by giving them access to services, they could avoid touching DCF again.
    - Two DCF workers called back to some of the data we previously looked at and pointed out that the risk for subsequent involvement is highest at six months after a case is closed, then it gets progressively lower until a year out, then is extremely low after one year. With that in mind, 6-12 months seems like a timeframe worth considering.
- At the same time, we don’t want that eligibility to last for too long as we don’t want DCF to stay a presence in families' lives for longer than necessary.
- Stigma and DCF’s reputation both played a role in the discussion. One person brought up that many parents are terrified of DCF, but ideally, that fear will go away; this opportunity to start providing services and resources might help the community’s perception. Along with that, another member explained that there is also confusion in the community regarding DCF’s practices. For example, in situations where a child has been removed from the home, then a new baby is born who stays in the home, the community is unclear about why each child ended up with a different result. They feel like this is the result of inconsistent practice and generates more confusion. Similarly, one person stated that oftentimes, though DCF says something is voluntary, the community gets the sense that it is mandatory just

by virtue of DCF being the one suggesting it. Due to that, it would be beneficial to have the messaging done by a community, another department, or third-party of some kind. Making someone else the "face" of this would help families feel less stigmatized and more likely to seek help.

- Another idea was that we should recommend a narrow door for now, then include a recommendation that this be expanded later.
- One person said that perhaps we should include the extra 6-12 months only for certain age groups who are more at risk (e.g. for 0-6-year olds).
- It was also suggested that we set the timeframe at 6-12 months but also let anyone with a past Careline call (regardless of how long ago) opt in if they so choose. That way, we are using our energy screening those who are more at risk but not excluding anyone who would benefit from services.
- At this point, it seemed that the group was leaning towards allowing folks with an accepted Careline call in the past 6-12 months into the Family First candidacy definition, but there was still no agreement on the exact time frame.
- One member asked why we were seeking a timeframe at all (why not allow anyone with a past accepted Careline call, regardless of time?), but the group seemed to agree that a limit was necessary. Someone with a call ten years ago is probably no longer very at risk, and therefore we should not include them in the definition.
- A point of confusion may have been whether the time frame was meant to start at the call or the closure of the case. Some folks thought we were saying six months after a case was closed, not after a call; however, JoShonda clarified that we were saying 6-12 months after an accepted Careline call.
  - The group realized that perhaps this conversation was getting a bit muddled and it would be better to streamline this population into entries.
- One person wanted to know whether this is a high-risk group; are they at imminent risk for foster care? Group members did not respond to this question.
- Another member wanted clarification on what services are being provided and where in the process they are provided, as this might help determine whether the population should be included.
  - The workgroup leads explained that we currently do not know what services will be provided, as this is something the Programs and Service Array

workgroup will need to determine. As far as where in the process they would be provided, a family would need an assessment before they receive services. Essentially, because of [parameters], either DCF or a community provider would be involved and this family should be screened to identify their needs.

  - Another member also reminded the group that Family First allows for a relatively narrow pool of services (all are EBPs, trauma-informed, and meant to address a specific set of issues), and additionally, through the screening, eligibility, and matching processes, this means that only a small group of people will end up receiving services.

- One person asked if we have already discussed the screening-in process, hoping that might lead to more clarification. In a previous meeting, the group had considered taking a "look backwards" approach and start by drafting the screening tool then working from there to identify a population, but they decided against this.
- A member explained her hesitation in including this group in our definition: they felt that a lot of cases should not have been DCF-involved in the first place; there is a disconnect where clients are doing the right thing but their worker does not seem to see that. With this in mind, they hesitate to put people who may have ended their involvement with DCF back into DCF's attention.
  - The co-leads clarified that one very important thing we need to remember throughout this process is that being a candidate for Family First <u>does not mean</u> there will be CPS involvement.
- One person asked whether Family First services are available for kids already in foster care.
  - The answer was "Kind of." The siblings of those in foster care can be eligible, but the children actually in foster care generally are not. Technically they are not "at risk" anymore, so they are not really able to be part of the candidacy definition.
- At the end of this conversation, it seemed the group felt that these families should be part of the broader prevention plan but not part of the Family First candidacy definition. The group likened it to a "forward-looking" or "backward-looking" approach; for Family First, we are trying to prevent future involvement rather than

looking back at the previous DCF-involvement. The group seemed to generally agree with no noticeable dissent.

Siblings

- The group was asked to consider whether we wanted Family First services to be child-specific or whether we should extend it to siblings of a child for whom there is an open case or siblings of those in foster care.
- Immediately, several workgroup members voiced their support for extending it to siblings. The legislation is called Family First—if we are truly focusing on the full family, then all family members should have access. We cannot look at children in silos. "To do less flies in the face of trauma research," stated one member.
- One group member asked to clarify whether we are talking about siblings of open cases or all screened-in calls. Another member felt if we are comfortable with including all accepted calls, then why would we not also accept their siblings?
- One person thought siblings were already eligible under our other populations; however, as we have currently defined it, they are not eligible. If there is a call regarding one child, that child is eligible, but their siblings are not necessarily in the definition as-is. Also, each individual child would need their own prevention plan.
- It was suggested that we set an age range for siblings (0-5 years old, for example) so that only the most vulnerable siblings would be included.
- A member asked if someone could walk through a scenario that this would apply to; they were having trouble visualizing what this population is.
    - Ex. Mom with 12-year-old child in Waterbury and also a 2-year-old child in Norwich. The 12-year-old gets called in. The 2-year-old is now also a part of our definition, whereas before, they were not.
    - Some group members were unsure of whether this was going too broad. The 2-year-old has little to do with the call; does it make sense then that they would also receive services?
- After hearing the example, someone wondered if we could limit it by timeframe or living situation (e.g. only siblings living in the same household), but the group felt that living situation/custody situations could have a bearing on families' need for services.

- At this point, one of the members felt that we had started "going down the rabbit hole," and getting too into the weeds on this issue. By narrowing the pool right at the candidacy definition stage, we are getting rather ahead of ourselves.
- Several members reiterated their desire to create a definition based on a holistic understanding of the family. The whole family is impacted by these issues and should be eligible.
- With that, the group agreed to broadly include siblings in our Family First candidacy definition. One person briefly mentioned their concern that this would now involve family members who were not relevant to the call; however, the group felt that the assessment tool would prevent any unnecessary involvement. Family First services would only be provided if they were needed by these siblings; if there is no need for services, then the family would not receive services. If there was a need for services, then the family would be helped, and this would likely prevent the family from getting more involved with the child welfare system. Therefore, with an emphasis on the importance of an effective screening tool, the group decided to include siblings of anyone with an accepted Careline call as well.

Children who have exited foster care to permanency—not through DCF means

- At the previous meeting, the group decided that they wanted to include post-permanency youth in their candidacy definition; however, the group was asked to consider whether to include children in guardianships or adoptions arranged outside of DCF (e.g. international adoptions or probate system).
- One member said they were leaning towards no unless there was a safety factor (which would likely mean the family would come in through another door).
- One person needed clarification on what was meant by "exiting foster care." The issue stemmed from different definitions of "foster care," as DCF generally uses it to mean any kind of out-of-home care (congregate care, placement with kin, or placement with a non-kin family), whereas many providers understand it to mean placement with non-kin family only. Because some providers use a narrower definition, they thought the congregate care population was not included in our definition, but DCF members clarified that it was. The group agreed that this might need to be more explicit or clearly defined in the recommendations so this confusion can be avoided later.

- There was a discussion on whether families who go through the probate system have the same access to services that DCF-involved families do. This was the main point of disagreement in this conversation.
  - The group was reminded that the Kinship group is currently working on developing a Kinship Navigator Program, which would support many of these families.
  - One member disagreed that the Kinship Navigator would necessarily be enough to support these families; a lot of them may be dealing with the same issues as DCF-involved families (trauma, substance abuse, etc.), but they go through probate specifically to avoid involvement with DCF.
  - A question arose: does the Kinship Navigator also allow access to EBPs? The answer is that it helps kin access existing services by providing centralized help and information. In that respect, it does allow access, but only to those that already exist. It would, however, likely include referrals that would hopefully be paid for by the Kinship Navigator (but not necessarily Family First).
  - One person continued to disagree with excluding this group from the definition, arguing that 6,000 kids go through probate each year, many of whom have few resources and would benefit from Family First services.
  - On this subject, another member brought up the home studies that DCF conducts during probate cases. The local DCF area office does a home study (probate study) after the filing of a petition. Perhaps this would be a good place to include screening and add these folks to candidacy? Probate cases are currently not part of our definition, as it is not the same as an investigation and it does not involve a call to the Careline unless during the study, a safety factor is identified.
  - Others in the group disagreed; they pointed out that any safety issues would result in a call the Careline because the social workers conducting the home study are mandated reporters. In that case, the group would already be part of our definition. The group did not seem to feel that probate cases should be included because of this.

- However, this opinion was not unanimous and around two to three people still strongly felt that these families should be included. One argued that going to probate sometimes means trauma, substance abuse, and/or neglect; why can't those children access these services? We are currently only catching those involved in DCF, but if the children's needs are aligned with services, it seems like they should be eligible. The home assessment could be a good place to add a screening assessment. In particular, social workers could examine "what got you here?" rather than just "what's going on here?" This would mean examining the family's history and what led to the current arrangement, not just looking at the current living situation. This would help identify trauma and unmet needs that put the family at risk for future DCF involvement. Another member agreed with this and felt this should not be an ignored population.
- Some in the group still felt uncomfortable generalizing this population and one person described the number of reasons why families go to probate court. One of the more common reasons is parents going for their child with disabilities to keep getting kids support (guardianship is used in these cases). This also includes situations where parents still have access to kids' financial benefits.
- Those that wanted to include this population said that the home study provides a very convenient place to add a screening tool, and although not all probate cases need Family First services, if we do not include them in the definition, they cannot access these EBPs unless they go through the Careline or Voluntary Services.
- A DCF employee clarified the probate home visit process. If there is abuse or neglect, the social worker will include this in the report and contact the Careline. Past abuse/neglect is generally included in the overall assessment, but this does not trigger further DCF involvement.
- The folks that wanted this population included emphasized that past trauma is not covered under Family First when we do not allow this population to access these services. They strongly felt that not wanting DCF involvement should not mean they do not get access to these services.

- The DCF employee added that the home visiting process often also refers families to services through community supports, so these families do have some access to services.
- One of the folks who did want to include this population felt that the group had pretty much settled on not adding them to the definition and came up with a compromise. If we do not include them now, we ought to recommend further data collection to see if they should be later added. The biggest two points to examine would be 1) whether the Kinship Navigator successfully provides these families with the supports they need and 2) whether these families are in need of services that Family First provides. If we collect data throughout implementation and discover the Kinship Navigator is not meeting their needs and they could benefit from Family First, we can add them to our Candidacy pool in later iterations of the Prevention Plan.
- The discussion ended here. There was no formal vote, but the group seemed to be in general agreement that we would not include probate cases or international adoptions in our candidacy definition, though there was some strong dissent from a couple people.

Children in informal relative placement outside of formal care

- The group was also asked to consider children who were in informal relative placement outside of formal care.
- The group felt that this was a high-risk population but questioned how we would find these families outside of DCF and probate.
  - Co-lead Jeff Vanderploeg explained that we would need a robust community pipeline—partners who say they are willing to make these referrals. Without a robust pipeline, it seems like this would better fit under our broader prevention plan.
- One member expressed some frustration that so far in our discussions, we have been building this system around what we already have, which ignores the fear that many families have of DCF involvement. We are missing an opportunity to include an alternative pathway for those outside of DCF (especially different cultural groups and certain populations).

- Co-lead Jeff Vanderploeg agreed that this was an important point and explained that on the docket for discussion is "Community pathway to services." This is something we want to talk about as a group, but it is #7 on our agenda list (the group was at #3 at this point).

- Another person suggested taking a 2-tiered approach to our recommendations. Perhaps we should recommend certain populations for inclusion in the initial candidacy definition, then create a list of populations we would want to add to the definition in subsequent revisions.
- The group did not reach a definite conclusion on this population because several members were concerned about a population that had been agreed-upon last week. The group shifted gears to revisit the substance-exposed infant population.

Substance-exposed infants who are referred to DCF or are so identified by other programs (e.g. home visiting)

- The reason why the workgroup member brought up this group is that they felt that perhaps we were being too broad here and might cause unexpected harm. Only a small group of these infants become DCF-involved—is putting them in this group going to suck up more folks into the system?
- One point of clarification was what was meant by "referred to DCF." Some folks thought this meant referred through the Careline and were confused as to why we would single out this population when they were already covered under the inclusion of all accepted Careline calls. The co-leads explained that this is referring to the CAPTA portal, not the Careline.
- One person described the efforts that have been made over the past five years to create and implement the CAPTA portal. They were very afraid that this could have unintended consequences that harms this population. They specifically felt this population should not be included without talking to the folks who created and run the portal.
- Another person agreed and said that we keep arguing for less DCF involvement and yet this seems to broaden folks' involvement.
- Although some members had these concerns, many in the group did not agree. Specifically, these infants are extremely high-risk and including them in the

definition would be the first step in getting them access to Family First services which seem to address exactly their concerns and safety issues.

- It was reiterated that including folks in the candidacy definition is not intended to mean more DCF involvement; it is identifying them as a high-risk group and making it possible to assess their needs.
- Furthermore, some participants were surprised that the group wanted to revisit this topic because there seemed to be a lot of consensus last week around this population (see Page 8 of the 1/6 Meeting Minutes). It was acknowledged that "referred to" ought to be revised for clarity.
- One person suggested that perhaps this population should not be included in the definition and we should split the population. High-risk cases would come through our door through population #1 (all accepted calls) and we would also be able to cover those "identified by other programs" by building out more community pathways (#7 on our list of populations to discuss).
- Another member said that their perspective was that children born addicted to drugs should be considered abused.
- One member reiterated their concern about unintended consequences, and particularly the possibility that this might make folks stay away from getting prenatal treatment out of fear of DCF-involvement.
- One person disagreed with this, explaining that right now there seems to be a presumption of certain messaging and pathways. Right now, the assumption continues to be that inclusion in candidacy means automatic involvement with child protective services. They feel that this is an opportunity to build new pathways that do not force families to get involved with DCF to gain access to services. Any pathway outside of DCF is something we should be pursuing.
- On that note, sometimes the Careline is not called. There are a lot of substance-exposed infants who do not go home with their parents from the hospital, and this is a way to lower that number. One of the attendees expressed their hope to reroute these infants and keep them at home instead of in foster care.
- Overall, the group seemed to lean towards keeping this population in their candidacy definition as long as 1) the serious worries about undoing CAPTA work and 2) the

need to build out community pathways were both highlighted in the recommendations.

Next Meeting(s)

- The next meeting is scheduled for **Friday, January 24 at the Court Monitor's Office in Wallingford. The address is 300 Church St, and we will be on the 4th Floor.**
  - This meeting was originally scheduled for 9-11 am but was changed to 9 am-12 pm to make sure the definition could be drafted.
- The group was advised that on January 27, the governance committee will meet for the first time. The workgroup leads' goal is to have a draft of the Family First candidacy definition by this date.
- Originally, when the workgroups started, the hope was to have both the narrow and broad definitions drafted by January 24; however, because the workgroup split its charge, only the narrow will be done by January 24. Members who want to continue with this work are invited to join us for further meetings to draft the candidacy definition for Connecticut's broader prevention plan. Ken, JoShonda, and Jeff wanted to thank everyone for their contributions thus far; while no one has to continue past their original commitment date, they appreciate the insight and perspectives being brought further and are excited for the creation of the broad definition. We look forward to partnering with all that would like to continue.
- Because the broader definition has a less strict timeframe, the group was asked if they wanted to continue their current meeting cadence or change it.
  - The group asked to continue to meet weekly, though one person also wanted to bring these discussions to the families they work with and felt that the time shouldn't be too compact or they would not have time to do this; however, the Community Partnership workgroup should be able to handle most of this.
  - One person also requested that the meetings be three hours instead of two; some folks have to drive a while and if the meetings are only two hours, the time driving outweighs the meeting time. To maximize efficiency a longer meeting is preferable. The group agreed.
  - Following the meeting on January 24, the next meeting will be on January 30 from 1-4 pm at CHR in Manchester.

    - A Doodle poll was sent out to the workgroup for the remaining weeks in February; the meeting dates were decided based on the results of that poll:
        - February 6, 9:30 am-12:30 pm
        - February 13, 9 am-12 pm
        - February 20, 9:30 am-12:30 pm
        - February 28, 1-4 pm
    - Please note that we may not meet on all of those dates if our work ends sooner than expected, but we wanted to have dates sent so members can plan accordingly. We are in the process of securing a location for these meetings, but we will update the group as soon as that is settled.
- The group also made suggestions for the meetings that will comprise phase II of the process:
    - It would be helpful to get more information about what other workgroups are doing. There was concern that groups might be too siloed.
    - Along with that, someone asked if they could specifically get more information on where the Community Partnerships group is reaching out. That way, Candidacy members who wanted to could know and potentially fill any gaps.
    - Folks would also appreciate more advance notice about meetings. Having the agenda in advance and few last-minute changes would be much appreciated.
    - Members wondered if it would be possible to use tech to call in to meetings (for those who cannot be there in person). The co-leads were open to this suggestion but only if call-in options were limited. If everyone can call-in, they likely will, which can be hard to manage both facilitation-wise and technology-wise. If we were to have a limited amount of video call-ins, that would be something we could explore further.