CT FAMILY FIRST - INFRASTRUCTURE PRACTICE AND POLICY WORKGROUP
MEETING MINUTES | December 18, 2020

Agenda

- Welcome
- Existing tools and processes:
  - Family Assessment Tools (Marry Ellen Hass)
  - Case Plan and Family Strengths and Needs Assessment (DCF)
- Breakout session
- Discussion
- Next steps

Existing Tools: Mary Ellen Hass

- Mary Ellen Hass went through some of the tools used by her agency and others in the Norwalk area, including their Universal Referral System.
- The Universal Referral System was developed to streamline the home visiting system. A group of providers use this so that they have the ability to scale up in care or down to a less intensive program without the family having to navigate this themselves. The family can self-refer, but providers also go to hospitals and WIC centers to find families who may be in need. If the family's needs are high enough, they may be referred to the Department.
- Providers work closely together to determine the best place for the family and can then scale down once the family is stable.
- The questionnaire format increases engagement and reduces barriers. There are also group events. This helps to seamlessly blend levels of care, whereas Department services are often time-limited and short. This system has touchpoints during adjustments and stepping down, which helps to make transitions easier for families.
- The group discussed the 211 process - when calling 211, you start with a generalist and then move on to a specialist. They are good at routing the calls. Ken pointed out a nuance between the general number that a person calls vs the infrastructure in the organization that makes sure families end up in the proper place. Mary added that 211 has their form and can triage with it.
- The form has screening questions related to basic needs, developmental disabilities, behavioral health, education, IPV, etc.

Family Assessment Tools

- The Protective Factors Survey is a tool for IFP and CST that helps with reunification and supportive housing for families. There is a child welfare-based section for providers and caregivers, and it is available in English and Spanish.
- Families tend to rate themselves higher in the beginning and lower later; this is because they may feel more honest as they build trust with providers. This makes the tool good for identifying needs but not an ideal assessment of functioning. This issue with accuracy in the beginning is a weakness.
- The North Carolina Family Assessment Scale (NCFAS) is another tool administered with caregivers during home visiting after a relationship is already established. There are eight domains on a 6-pt scale where the center is the baseline.

- This tool allows for more opportunities for interactions. These programs are around 4-5 months long. "Weakness" in an area is subjective. One limitation is that it is self-administered, which means it should not be used with parents with cognitive limitations or low literacy. The staff prefers the NCFAS as an assessment tool.
- There is also an ASQ which helps to gather data - this gets families on board early to refer so that they can follow them more closely; however, this is used more for data than for assessment.

Why Focus on Screening and Eligibility?

- Ensure we effectively engage and assess the intended children and families identified within Connecticut's candidacy population
- The workgroup will review existing screening tools and mechanisms to determine:
    - What modifications are needed to align with Family First requirements?
    - What modifications are needed to align with effective family engagement and assessment?
    - What from current practice do we want to embed in the new community pathways engagement, screening, and assessment process and what new strategies are needed?
- We want to examine each candidacy population and determine how families are screened; how needs are assessed; where this is documented; how to track and extract this data; what information exists about the quality of the screening, assessment, and documentation process; and which part of the candidacy populations might be missed.
- 211 - user-friendly resource
- State/DCF-sponsored - would families be open to that?
    - A few months ago, DCF created the Talk it Out line, which was somewhat successful at first but saw calls drop down, possibly because the line was affiliated with DCF.

Existing Tools and Processes

- Initial Careline assessments (discussed at a previous meeting)
- Ongoing services - DCF assessment tools for in-home or removed supports
- SDM Family Strengths and Needs Assessments
    - This allows for assessment and consistent reassessment
    - All ongoing services cases receive this
    - For in-home cases, this occurs within 45 days of disposition or within 45 days of removal. The three highest priorities of parents and the child are included in the case plan.
    - This uses a family-centered, trauma-informed approach, although the Department is still working to achieve certification on this. For a child in out of home care, after six months, the plan is reviewed with the child, caregiver, parent, attorney, and other partners. The plan for the next six months is developed in concert with these partners.

Breakout Sessions

- The workgroup split into two smaller groups to discuss the strengths and gaps of the tools we have discussed.
- Breakout 1:
  - Strengths:
    - All the tools described are well-known, used, and have evidence behind them
    - We are currently assessing families
    - The tools covered the family's protective factors (support, family functioning, etc.)
    - DCF tool covered the appropriate domains
  - Gaps
    - Dependent on who administers the tools - may need to think about ongoing re-training for assessment administration/ensure fidelity of the tool (consider training and QA)
    - Ensure training embeds a trauma-informed and antiracist framework to limit bias at screening decision point
    - Enhanced family engagement training for initial and ongoing work
    - Ensure that a tool is done *with* a family, not *on* a family
    - In different communities, there are cultural nuances and trauma-informed aspects, so protective factors may vary culturally/environmentally (concern is that we may penalize families and identify needs that may not exist or be a priority for a family)
    - Do we have systems set up for latency age/older youth that might mirror existing systems for under 5?
    - DCF tool is still an arm of the Department
  - What could we build on?
    - Opportunity to test out existing tools and determine whether they are really working for families
    - Ensure we are asking families what they need
    - No matter the candidacy group, ensure we have one place to collect the information and determine where to filter each group (211 moving from generalist to specialist)
    - There is a well-defined system to identify a high-risk population, what other systems like this are already available across the state to build upon?
    - Strive together networks/communities (cradle to career); national funding from foundations to support this
  - What questions are still remaining?
    - Are the screening, assessment, and services broad enough to meet CT's broad prevention goals?
    - What happens if we identify a need and do not have service/resources to address those needs? (Screening needs to accompany a robust service/resource array)

- Breakout 2:
  - Strengths:
    - The Norwalk work generalizes and normalizes families through home visits from the beginning
    - Strengths-based
    - Follow to age 8, outreach - went to where the families are
    - Partnership and collaboration - a team behind families
    - Access to evidence-based programs
    - Tools and measures, Circle of Security - all issues the families face
    - Manualized, standardized - objective (the intention)
    - Available in Spanish/English
  - Gaps:
    - Some tools discussed might not be as manualized/standardized - are they objective? Room for improvement
    - DDS is not at the table - treating children birth-3, developmentally impacted parents; there is a gap as this does not focus on these families.
    - DSS - financial stability and poverty - how is that addressed?
    - 211 can have a long wait time or put callers on the wrong track if they do not follow the right command when dialing in
    - Only available in English/Spanish, not other languages (self-assessment would be harder)
    - Including employment services/education in the work too?
    - Guiding to school, medical communities, community health centers
  - What could we build on?
    - Capacity of 211 - intake calls in a family-friendly way - route to appropriate specialist depending on the family's needs (mobile crisis)
    - Extending the community outreach - build on time frames of services (more flexible depending on family's needs)
    - National 988 - moving crisis calls, mental health needs out of 911
    - Opportunities to build on the strength-based approach
  - What questions are still remaining?
    - Coordinated network approach - is there a network management component?
    - How do we take the inherent focus on safety and collaborate with families? We want to be trustworthy and take a family-friendly approach. How does DCF balance that approach?
    - How do we link other community-based efforts through a system-wide approach?
    - A gap for in-home trauma services for the 6-10 age range, at least in the Willimantic area. We go from Child First to having to wait until the age of 11/12 for other intensive in-home services unless IICAPS, for which not all children meet the criteria. Also, in-home services aside

from Child First and JRI-IDP are not trauma-focused; what is available in rural and metro areas?
        - Is it possible to do a diagram with the family in the middle and all the systems we need to connect, as described by Mary Ellen? There are so many that it would be helpful to see what we have and need.
- Ken pointed out that the Department has a hard time letting go of certain populations, such as newborns, who have the highest risk. We need to shift the messaging so the community is able to care for these families rather than the Department. A tool is only as good as its administrator - how do we ensure fidelity to the tool?
- An example of a recent change was the creation of a 988 phone number through federal legislation. This broad number is for mental health crises as an alternative to 911. It was shown to be cost-saving, as a mobile crisis response was more effective than a law enforcement response. In July 2022, this will be implemented in Connecticut, with DMHAS leading the work.
- Commonalities:
    - Easy access
    - Tool = fidelity, bias, anti-racist
    - Who administers? (DCF probably should not)
    - Consider looking at where housing comes up - where is it highlighted in tools?
    - Should the Department's name be attached to this? Stay away? Attach a provider's name?
    - Lift up other efforts that are happening and determine how to reduce fragments and create something cohesive and streamlined
    - Food, fuel, housing - how are these needs addressed?
    - Many people need and want work - how do we integrate employment?
    - Should interface with school-based health centers and other programs
    - Should address health needs
    - Much better linkage - warm hand-offs
    - 6-10 age range = gap in trauma services
        - A lot of children and families are dealing with trauma, but there are very few services for children past age six. Even some that claim to serve this age range do not always work for these ages. One member from Willimantic said they just do not have enough programs in that area.
    - Geographic parity - what is available in rural communities?

Next Meeting

- The workgroup will meet again on **January 8,** where we will review requirements for the child-specific prevention plan.
- Ken thanked everyone for helping children and families statewide. We appreciate the workgroup and hope you have safe, healthy, and happy holidays.