Minutes
Family First - 24/7 Intensive Treatment (QRTP) Workgroup
Meeting Date: September 25, 2020 | 2:00 - 3:30 pm
Microsoft Teams Meeting

Agenda:

- Welcome and Check-in (Group)
- Overview of workgroup's planned deliverables (Linda Dixon and Alyssa Goduti)
- Survey discussion and related opportunities (Linda Dixon, Alyssa Goduti, and Group)
    - Aftercare conversation
    - Family search and engagement and family advocates
    - Connections to resources post-discharge
    - What workforce training opportunities may be part of this work?
- Certification process - draft (Ted Sanford)
- History of applying best practices in rightsizing in CT (Linda Dixon and Group)
- 60-Day Judicial Review process
- Lessons learned during COVID
- Next meeting, cadence, and review of next steps

Welcome and Check-in

- There were about 30 people on the line.
- Linda and Alyssa, the co-chairs for the QRTP Workgroup, reintroduced themselves to everyone and reminded them where the group left off. The workgroup's first meeting was in March, on a Tuesday, where the group learned more about Family First and the role of the QRTP workgroup. The group was also reintroduced to statewide Family First co-leads, Ken Mysogland and JoShonda Guerrier. These co-leads discussed Chapin Hall's role in helping the Department research and draft its Prevention Plan.
- Linda and Alyssa reiterated that the goal of residential treatment is to provide a pathway to a family home. It is not meant to be a permanent placement for children and youth.
- Chapin Hall went over the timeline for the planning process - the Department plans to submit their Prevention Plan in April 2021.

Overview of Deliverables

- Linda explained that they would review the deliverables and if at any point in the meeting, there were any recommendations related to fiscal, those should be tabled and brought to the fiscal workgroup led by Cindy Butterfield and Dr. Alison Blake.
- At the last meeting, the group did a self-assessment survey on QRTP readiness and the responses were crosswalked with services to identify what components of QRTPs our providers may need to develop further. A few takeaways were:
    - Aftercare: some programs offered some supports post-discharge, but none provided the six months of aftercare that are required.

    - Outreach to family and maintaining contacts: this is another area for growth.
- After the survey, the group had some follow-up questions. The co-leads of this workgroup did reach out to Bob Cavanaugh, Administration for Children & Families, but they have not heard back yet. There is still some lack of clarity on whether respite could be reimbursable.
- Alyssa asked that the group members think about what lessons they have learned from COVID, as this will be discussed later in the call.
- One member wanted more information on the details of aftercare. Does the aftercare support component need to be run by the QRTP themselves or is it possible to enlist another organization to provide the aftercare? Linda responded that to her understanding, she thought the QRTP had to be the one to provide the aftercare, but it is not clear what the aftercare needs to entail. We are waiting on an answer for what this looks like, especially whether it is possible to do monthly meetings or via virtual/phone options.
- Another participant agreed that they assumed the provider would be the one responsible for the aftercare. They have been seeing the child/youth and seeing improvements, so they should continue with that. That being said, they feel the aftercare should be child specific. The QRTP should stabilize the child, with other interventions in place after. She expects flexibility in that respect. For example, an ICAPS program.
- Alyssa explained that there is an expectation of six months of contact, but she expects some level of flexibility.
- The co-leads asked the workgroup whether they could think of other opportunity areas that could warrant a subcommittee. The suggestions were:
    - Workforce training
    - Family search and engagement

Certification Process

- Ted looked at other states to get an idea of their certification process and developed a draft, which he agreed he could share with the workgroup once it is finalized.
- There are four main components:
    - Accreditation
    - 24/7 access to a clinical nurse
    - Must have trauma-informed treatments
    - Provide six months of aftercare - Ted spoke to Bob Cavanaugh about this and determined that this is somewhat flexible. The QRTP must be involved and touch base with the youth and family throughout the aftercare period.
- Alyssa agreed that she would like to build some flexibility in, and Ted said that the fiscal workgroup would need to figure out exactly how it would be built in. First, they will need to define the practice model approaches and then bring it to fiscal.
- One participant emphasized the importance of programs that include self-direction and cultural responsiveness.

- Another person liked the idea of using a light touch approach when possible. It will be necessary to have many types of aftercare that address varying needs.
- Linda pointed out that we as a state are starting from a good position. We don't want to create what we already have. In 2011-12, the Department worked with Casey to "rightsize" and developed best practice principles for family engagement and support, increased kinship care, and improved foster parent recruitment. Many providers stepped up and provided more specialized programs so that the Department was able to lower the number of youth going out of state to residential treatment facilities. There was also an increase in the utilization of EBPs (evidence-based practices). Family First is the natural next step of this work.
- Linda said that there are several practices (RRG assessments, Beacon determining levels of care, etc.) that put the Department in a good place, despite the fact that the planning process is happening later than expected.
- Alyssa agreed with Linda, feeling that we are in a good position to hit all four pillars. Two of them (having accreditation and nursing staff on hand) are already common. She also highlighted that there are 4-5 agencies that are currently following up on becoming accredited, which is a heavy but good process.

60-Day Judicial Review Process

- Linda explained that there is currently no judicial review in place, but this is something that will need to be developed. The Judicial Branch wants in-person reviews. She asked the group whether they have any recommendations for this process.
- Alyssa pointed out that an in-person judicial process is not very kid-friendly, worsened by the fact that many courts are still closed or limiting cases.
- One member expressed concern that the courts are not prepared to oversee clinical care and suggested a subcommittee be formed to address this topic. They explained that the probate court used to oversee voluntary service cases, but now that this is handled by Beacon, the courts are not involved. If a workgroup is formed, it should involve court personnel and possibly a lawyer - they have seen the court make decisions on clinical affairs and wants them to be well-informed, not just rubber stamping.
- Linda agreed with creating a small group to address this issue. She did reach out to judicial, but they have not been responsive. Ken agreed that they should be included in the small group.
- Ken also noted that the legislation provides for either a judicial review or an administrative review, but the Judicial Branch specifically chose to handle it in house. There is legislation being drafted right now to outline the process. He agreed that the workgroup should reach out to Sue Hamilton, the AAG, Beacon and Vinny Russo, DCF's Legislative Program Director.
- Another member suggested checking with Judicial to make sure they have not changed their minds after COVID and still want to be the ones handling the process. Ken

confirmed that Vinny Russo checked with them and they do still want to take that on. It was reiterated that they need to understand the process. The Superior Court would be the one handling this - they must be well-positioned.

- The group agreed to create a subgroup that would come up with recommendations.

Lessons Learned from COVID

- Alyssa discussed some of the things they have learned over the past six months. There have been several changes that have improved care, especially through better engagement using tele-visits or tele-therapy. The ability to make quicker decisions has also been helpful. She asked what lessons the group has learned that could better help our youth.
- One member brought up a challenge that COVID has amplified: the ability to retain staff. In residential treatment facilities, the face-to-face contact puts people at greater risk, and this had led to concerns over safety. It is not a money issue; it is a safety issue. They have seen children purposely breathe on the staff, which has increased staff's concerns.
- A workgroup member described their staff as "lowkey heroes" - they are keeping children healthy during an increased demand for care (due to lack of resources and general stress). In-home teams are often working remotely now, but we still need people for the residential components.
- One barrier brought up was access to technology and the internet. This is necessary for school and for services.
- Another person brought up that along with technology, phone services are important. Some families do not have internet access, so telephone-only services need to remain in place.
- The OCA is considered to be involved with youth/families at the "deep end" of child welfare, and they have seen greater demand recently. Kids do need institutional support at times, but we must always consider the purpose. A child may need to be admitted, which is active, but it should never be considered a placement, which is passive. The level of care can pose a challenge at times, due to families needing to "fail up" to get to intensive treatment. Families may feel hopeless by the time they have gotten to that point and have severe developmental and/or mental health issues.
- One member brought up Family Advocates, which Massachusetts have, to help navigate these systems. It was suggested that this along with aftercare be considered in a staffing subgroup.
- The group reviewed the subgroups they agreed on: 1) aftercare; 2) 60-day judicial review led by Mickey Kramer of the OCA; 3) certification led by Ted Sandford; 4) staffing; and 5) integrating families into treatment.
- Alyssa agreed to send out the list of subgroups to everyone so they could commit to participating on at least one and let her know if they were interested in heading a group. Chapin Hall is able to create Zoom calls with breakout rooms. The next large group meeting will be towards the end of October.

- One person asked for more data on the levels of care. Linda said that some Department members would have information on that. They will provide that information and summarize the programs.
- Another member asked whether any decisions have been made regarding STAR (45-day) or SFITS (15-day) facilities? A QRTP is a long-term residential facility, so it does not quite fall into this category.
- The Bridge is pursuing accreditation, but it is tough to recruit/hire people.

Next Steps

- Information on workgroups will be sent out for next week - please sign up to participate!
- The next large-group meeting will be on **October 30th from 2:00-3:30 pm.**