MINUTES
Family First- Programs and Service Array Workgroup (PSAWG)
Meeting Date: February 6, 2020: 1:00 pm- 4:00 pm
Beacon Health Options, Rocky Hill, CT.

Agenda:

- **Welcome and Introductions**
- **Review minutes from 1/23/20 Meeting**
- **CT Families First Workgroup Updates**
- **Review Workgroup Charter**
- **Review defined Candidacy target populations**
- **Continue Service Array Alignment**
- **Open Discussion**
- **Follow-up Actions**
- **Next Meeting**

Welcome & Introductions

- The group co-leads Elizabeth Duryea and Dr. Elisabeth Cannata, began the meeting around 1:05 pm and welcomed everyone. Any first time participants to this meeting were asked to introduce themselves through the use of name tents.
- Desired results of the meeting were reviewed.

Minutes from 1/23/20 Meeting

- Minutes were accepted and approved.
- Finalized minutes will be posted on the Family First website: CTFamilyFirst@ct.gov

CT Family First Workgroup Updates

- JoShonda Guerrier spent time updating the group on the status of the three workgroups (Fiscal and Revenue Enhancement, Kinship and Foster Care, and Community Partnership and Youth and Family Engagement) and Governance.
- The **Fiscal and Revenue Enhancement** Workgroup chaired by Cindy Butterfield and Dr. Alison Blake was scheduled to have a conference call on January 22nd. They elected to not hold the conference call, because they recognized that the Candidacy group was close to having a defined definition. They are scheduled to resume on February 10th.
- The **Kinship and Foster Care** Workgroup chaired by Tina Jefferson and Randi Rubin-Rodriquez, had a meeting on January 12th. They spent the majority of their meeting reviewing the group's charter for the second time and attempting finalization. They spent the remainder of the time focusing on specific data exploration. The group wanted to ascertain information regarding kids in the community that are being served by Probate. A representative from Probate was present. They also looked at data specific to Careline Engagement, Voluntary Services Placements, Family arrangement data, Caregivers support teams, and licensing. This workgroup hopes that the data exploration process will inform their next level of work. This includes starting to refine and enhance the barriers they need to respond to in the systems they have identified, as well as opportunities to start to frame out a Kinship Navigator Program.

- The **Community Partnership and Youth and Family Engagement** Workgroup chaired by Beresford Wilson and Tim Marshall met for four (4) hours on 1/5/20. The majority of their meeting focused on:
    1. Changing their meeting cadence. This group has been meeting once a month. Due to their meeting cadence and the meeting frequency of the other workgroups, this group is receiving information later. As ambassadors for Family First they had hoped to have more input into the work that is occurring. Discussed was the need to have either every other or weekly meetings. They've decided to meet weekly for one hour.
    2. The group looked at the last set of questions that would elicit additional input and feedback from individuals in the community, who cannot participate in the meetings. They have finalized three questions to be given to providers and to the families and youth. We are hoping to utilize the plan4children.org website that has been used for behavioral health, by adding another page that would be specific for Family First to allow input and feedback to those questions.
    3. Reviewed updates from the other workgroups. The definition for Candidacy was provided. Also shared were the populations that were under consideration from the Candidacy workgroup, specific to the broader five (5) year prevention plan. This allowed the Community Partnership group to weigh in on the information and to provide feedback on populations they felt were missed. This information will be sent back to the Candidacy group.
- **Governance**. An overview of Family First activities was shared. Ken Mysogland set expectations around time commitments and the next Governance meeting. Updates on the Workgroups were provided. The balance of the meeting, almost two hours, was spent discussing the proposed definition for Candidacy. Governance had reactions to some of the recommendations. Executive decisions were made around at least two of the buckets that triggered group division. The Governance Committee directed the Candidacy workgroup to revisit two specific issues: Interpersonal Violence (IPV) and a more refined definition specific to infants born substance exposed. The Candidacy group met and focused on the recommendations from the Governance Committee and provided a response to their instructions. JoShonda stated that since there were no additional comments or objections from Governance, the Candidacy definition is approved.
- The Candidacy update will be provided later, when the Candidacy specific topic on the agenda appears.
- Ken expressed the point of how much external partner influence and involvement there is on the Governance team and on the other committees. There are over 220 external partners that are part of the workgroups. The split of external vs. internal stakeholders is 80% (external) and 20% (DCF staff). The Governance committee represent a 70% (external) vs. 30% (DCF staff). Ken provided a break-down of the representation on the Governance committee. This group ultimately recommends to Commissioner Dorantes the Candidacy definition, services to be implemented, the supports to kin, and all of the recommendations from the other workgroups.

Review Workgroup Charter

- Elizabeth D. asked if members had an opportunity to review the Charter and if they had any comments or suggestions? Since there were no comments placed on the website and none from the members present, Elizabeth asked for a motion that the Charter be accepted. A motion was made and second to accept the Charter as drafted.
- The Charter is final and will be posted on the website.

Review Defined Candidacy Target Population

- JoShonda began by providing an update on the Candidacy Workgroup.
- The Candidacy workgroup had two additional meetings (1/24 & 1/30) since this group last met. In these meeting the group went through exercises of data exploration, detailed conversations, discussions, etc. to figure out how should Connecticut's definition for a candidate at risk for entry into foster care, based on Family First legislation, be defined.
- A list of the identified populations, were presented to PSAWG. At a later date, this group will be presented with a list that includes the broader five (5) year prevention plan. The list being discussed today is the narrow definition. This definition focus on all the children that will be in the potential pool of candidates for Family First. Eligibility around need would first be considered and if eligible, the youth (family) will be matched to an Evidenced Based Program. If matched to an eligible program, then the service would become eligible for the 50% reimbursement under Family First.
- JoShonda outlined the Candidacy Recommendations:
  1. **Families with accepted Careline calls**.
     - These are not calls made to the DCF Careline for information or referral.
     - Someone had a concern, a call was placed and DCF determined that further exploration was needed. The group wanted to pull this population into the candidate definition, irrespective of which track the intake traveled: FAR vs. investigations; whether the report was substantiated or not. The group was interested in the entry point of being accepted as a call to the Careline.
       - Question: Will this be inclusive of kids with ID? Those kids will be included in #6. Will the Careline accept calls if the kid has ID? DCF/ Careline will accept this type of call if the child has been abused/neglected. In this category, any child that comes to our attention who is alleged to have been abused or neglected and we make the decision to commence an investigation that child would be in group #1.
     - JoShonda stated that there seems to be confusion about placing someone in the Candidacy definition will require more DCF intervention. That's incorrect. Keep in mind that Family First is a fiscal tool that reimburses for services. By placing children here, we are attempting to help families get services sooner so they do not have to go down our traditional dependency tracks. We are looking for opportunities to work with children and families sooner to assist them.
  2. **Families who have been accepted for Voluntary Services**.

- Youth with diagnoses whose families reach out to DCF to request assistance and have not abused or neglected their children. Acceptance for Voluntary Services through the Department or through Beacon in the future once Voluntary Services transitions, will be included in the Candidacy population. Keep in mind that the whole family would be eligible, but the child is the driver of services.

3. **Pregnant and parenting youth in foster care**.
   - This language was taken directly out of the federal legislation. This is the only exception to an in foster care arrangement.
     - Question: Does this exclude teen parents in school? It does exclude them, they will be picked-up in our broader description that will be made available to this group at a later date. Here we are not talking about kids who come to our attention through the schools, law enforcement, hospitals, and primary care physicians, they can receive services through the broader prevention plan, but not Family First specifically.
   - The federal government will only provide reimbursement for the narrow "in foster care" group of pregnant or parenting teens. It will be important for the Department to message this information the correct way, because that doesn't mean that we are not going to serve the other pockets of this population.
     - Comment: The more we talk about this issue raises concerns about how much further this can bifurcate our system. Are we setting up barriers where families are not eligible? It feels as if we are moving backwards from what we have tried for years. It's important to think from a fiscal stream point. From a practice point, it jeopardize some thought patterns that we are creating a bifurcated system. The way we pull it all together will be important.
4. **Siblings of children in foster care**.
   - While the child in foster care is not eligible to be a candidate, siblings who remain in the home may be at risk in some way and will have access to services.
     - Question: A member asked if a family could qualifying for services, if a child in the family has already been removed, and is in kinship care or in an outside placement, and there are other children remaining in the home that are at risk? JoShonda stated children remaining in the home would be covered under this bucket-#4. If the child is in a kinship arrangement, they would be served by the Kinship supports that are being amassed by the Kinship group.
5. **Youth exiting to permanency or youth aging out of DCF foster care**.
   - Permanency is broadly defined as adoption, guardianship, reunification, transfer of guardianship, independent living arrangement, and youth aging out of the system.
     - Question: Is there a particular age range? It will be 21.
6. **Families with certain characteristics who are identified through the community or neighborhood pathway**.
   - JoShonda stated that through this group, we are trying to do the opposite of creating a bifurcate system. The Candidacy group will be looking at how to frame

the eligibility tools, infrastructure capacity, and how the track services within the system for reimbursement. This grouping reflects the broader community or neighborhood pathway.

- **Children who are chronically absent from preschool/school or are truant from school.** Reviewed definitions and legislation around the terms of absenteeism and truancy. We are aware that there is not equity in all the towns and schools, so we will be looking at how to be broad and inclusive.
    - Question: Does the definition of Preschool include Infants and toddlers? We will clarify this issue.
- **Children of incarcerated parents**. This addresses children whose parents are incarcerated irrespective of where the parent(s) is in their journey. Broadly intended.
    - Question: Does this pertain to one or both parents? It's either parent.
- **Trafficked youth**. By virtue of calls placed to the Careline, these youth will be presented in bucket #1. This if for those youth, who do not rise to DCF attention, but present somewhere else in the community.
    - Question: Are 18-21 included in this group? Not discussed, but will follow-up on this issue.
- **Unstably housed/ Homeless youth**. Unstably housed was used to be broad and to represent any child or family experiencing unstable housing, who should have access to services.
- Ken stated that this issue crosses over to another category. Families with unstable housing (i.e. living in a car during the winter) may lead to coming to DCF's attention, via the Careline as a neglect or abuse report.
    - Question: Will unstable housing be looked at as service target population? (i.e., case management, vouchers or places for these families and youth to live), in terms of evidence based practice that align with the families? Based on the Candidacy requirements, the services would have to be an evidenced based program for Title IV-E.
    - Question: Will unstable housing include families in shelters? Yes.
    - Comment: There's concern about criminalizing poverty.
- **Families experiencing Interpersonal Violence (IPV).** This objective was initially presented to Governance as being in the broader bucket. This was done, because the data indicated that IPV was not a high indicator of a child being at risk of removal.
- Even though the IPV data stated that less than 3% fall within this category, Governance sent the group back to rethink this issue.
- Mary Painter (Director of IPV) brought data about service interventions, outcomes, and other indicators. Conversations based on additional information led the group to agree to pull this population into the narrow definition.
- **Youth who have been referred to the Juvenile Review Board (JRB) or who have been arrested**. Everyone agreed that we needed to serve youth that were juvenile justice or delinquency involved. The difficulty lied in how far does one go upstream to intervene with these youth in a way that's divergent without the

youth being already too far in the system? Based on the data currently known, the JRB seemed to be the best solution for now, until we do our first edit and update to the plan.

- **Caregivers who have, or have a child with, a substance use disorder, mental health condition or disability that impacts parenting**. The wording is such, because we did not want to project that by virtue of having a diagnosis or disability that you cannot parent your child.
- The Candidacy group was split about who should and should not be included in these populations. Debate lasted at least two meetings.
- Governance made the decision that the population listed in this grouping would be included. It was recommended to frame this around what drives the parents' struggles.
    - Question: Would the use of the term disability include a child with significant medical issues? This will be clarified, but likely yes.
- **Infants born substance-exposed** (as defined by the state CAPTA notification protocol). Governance asked specific questions about words used in this description. This was taken back to the Candidacy group for consideration.
- Connecticut has its own CAPTA definition that is different than the Federal definition. It was decided to utilize the Connecticut version to ensure alignment.
    - Question: This seems like a pretty broad group, who did you decide to leave out?
        - Response: We left out calls that were screened out at Careline, families with employment issues, kids age 5 and under, families that transition out of our CFS programs, and families identified in need of services by medical, school, community, legal, and law enforcement representatives.

Continue Service Array Alignment (Small group exercise)

- Group members were asked to identify a subgroup for the purpose of a break-out exercise to build on the mapping completed at the January 23rd meeting.
- Break-out groups ranged from Groups A-F, with each group having an identified facilitator.
- Break-out groups were asked to identify Candidacy needs by:
    - Identifying characteristics and intervention needs of the Candidacy groups.
    - What existing programs and services address those needs of Candidacy groups?
    - Review and discuss potential gaps.
    - Assess Family First Clearinghouse programs/services that may address gaps
    - Discuss additional information and data needs.
- Each facilitator was equipped with a series of questions to guide the discussion and each group was asked to provide a report of their discussions.
    1. **Group A** (Marcy). *Focus- Potential trauma and need for a potentially wide range of services from parenting to more complex behavioral needs.* Most broad group.
    2. **Group B** (Jennifer). *Focus- Services for individuals with foster care experience. Most likely teens.*

3. **Group C** (Ana). *Focus- Services for youth at high risk for law enforcement contact/system involvement*.
4. **Group D** (Kim). *Focus- Families and youth with very specific needs.*
5. **Group E** (Karen). *Focus- Families and youth experiencing substance use disorders or other mental health conditions/disabilities impacting parenting.*
6. **Group F** (Mary). *Focus- Families with targeted behavioral health or other health related need.*

- Dr. Cannata informed the groups to not expect to address every question today. These questions will be revisited.
- Each group was asked to report:
  - What was helpful as a group?
  - Challenges of the task.
  - What information is needed to continue the work started?
- Group A (**Potential Trauma, Range of Services, Supports & Complex Behavioral Needs**):
  - Able to identify the needs and risk factors easily.
  - More desired outcome as it affected our workforce: the availability, location, and accessibility of services in communities for families.
  - How do we prepare a competent workforce?
  - How do we create local hubs that are convenient for families to access (i.e. supports)?
  - Regions to follow the same catchment area.
  - Matched early childhood (secure parenting and child attachment); services specifically for dads.
- Group B (**Foster Care Experience- Teens**):
  - This is a unique group, especially given where they are developmentally. At a time when they need support, they tend to push the system away.
  - Engagement. How do we create a system that is effective in engaging this population?
  - Dr. Cannata noted as an example, that based on that identified need it will be important when selecting model(s) or services to consider how these models include engagement training, attention, and feedback because of the unique need of this population.
  - How do you create an intervention that will address teens around their needs, keeping in mind where they are developmentally?
  - Identified information needed- What are other states doing for 18-21 year olds?
    - Question: How do we address kids in foster care coming back into the home? This is a vulnerable period for parents, who may not be prepared, at an incredible difficult time for young children. Dr. Cannata stated that this focus happens in both the yellow and the blue boxes which have not yet been a focus of this workgroup.
- Group C (**Youth at High Risk for Law Enforcement Contact/system involvement**):
  - Helpful: For this population the services available do not address complex needs. These youth have academic needs and these academic needs lead to truancy.

There are mental health needs, which need to be addressed separate from the academic needs. Evaluation of mental health or trauma to understand their pathway to legal Involvement.
    - Challenges: There are huge gaps in services for this adolescent population. The group identified two existing services, but they do not address academic achievement.
    - They also did not address the pathway to criminal involvement, how to decrease criminal involvement, and increase academic achievement.
    - Information needed: Whether the Clearinghouse is looking at education or restorative justice programs. Are there national models of restorative justice programs that have evaluations that support them being evidenced based? Are their current programs that address truancy and academic achievement and/or mental health and prevention of truancy?
- Group D (**Families & Youth with very specific needs**):
    - In general, this group tried to focus on understanding the social media impact, as well as the need to educate parents and schools systems regarding the "red flags". Lack of family resources was also discussed.
    - Challenges: Housing and what type of evidenced based housing programs are available? Other identified challenges include: work support programs, case management for families, and internet safety. One program identified was Motivational Interviewing (MI). In regards to Housing issues, risk factors including mental health, addiction, kids being thrown out of the home, domestic violence, and housing crises.
    - Information needed: It appears that groups with specific needs may have interventions that work, but they are not evidence based. We should be inclusive and continue to list these interventions.
    - Question: Are there some evidenced based models that we have not heard of that we can add to our list?
- Group E (**Families & Youth with substance use and mental health conditions/disabilities impacting parenting**):
    - Risk factors identified: Housing, treatment and how they access services and create stability for families.
    - Information needed: Long-term services (i.e. care coordination, access for support for life) and how to sustain families in recovery. Parental attunement to the child's need (i.e. physical and emotional). Decreasing parental stigma and workforce development for hospitals, DCF, providers, and other departments working with our families.
    - Children's needs: Respite for parents, pro-social activities, location of services (i.e. clinic, primary care, etc.), advocacy (i.e. educational and legal).
    - In regards to substance exposed infants, the importance of education around having a child exposed to substances and the stigma related to this issue is important. Treatment for parents who may need support is needed. Shared risk and judgment was also discussed. As well as the conflicting message about how

risk is defined by hospitals, DCF, and providers. There's a need for a common definition.

- Group F (**Families with targeted behavioral health /other related need**):
    - Need for early detection, as interventions tend to be reactive. Detection that's integrated into other services, in order to reduce stigmas.
    - Funding issues and how they are accessed, especially for families not DCF and Medicaid involved.
    - Creating support systems that are on-going and easy to access/support.
    - Discussed were specific models and programs currently available: MST, MDFT, care coordination, early screening and assessment, care management, respite, and after school programs (clinical and general level).
    - Information needed: Specific to children or parents with cognitive limitations (trauma informed), behavioral intervention services, parenting support for caregivers with mental health issues, as well as access for their children.
    - Comment: With some of the Evidenced Based Practice (EBP) models, some of the more vulnerable populations (i.e. non-verbal, those with cognitive limitations, etc.) cannot access services. Are there specific EBP'S to serve these population types?

Follow Up Actions

- Dr. Cannata stated that there's a lot of information and commonality among the group reports. She asked that if any of the workgroups feel the need to do additional work between now and the next meeting, an option is to arrange a phone call of your smaller group.
- Elizabeth D. stated that it's important to highlight the collective groups identification of implementation challenges (i.e. stigmas, provide services in more normative settings, case management, care coordination, workforce, etc.). What will be important is how we raise awareness and educate families on what services are available.
- There's a need to identify gaps and determine where we have to do research around what's available at the national level. Also think about gaps in Connecticut and what we need to include in our plan.
- Next steps: Reiterated was the option of groups continuing discussions of their topic via a phone call. Also discussed was Elizabeth D. and Dr. Cannata's support in coordinating an interim conversation prior to the next meeting (February20th) for members who wanted to be involved in multiple group calls.
- Miranda and Olivia from Chapin Hall will be present at our next meeting. If members have questions for Miranda and Olivia, please forward them to Elizabeth D. for triage. We want to make certain that questions and gaps are addressed to move along this process.

Next Meeting: February 20, 2020, 1:00 - 4:00 pm.
Beacon Health Options, 3rd Floor
500 Enterprise Drive, Rocky Hill, CT