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Engagement

“The first contact is so important! I always make it a point to be warm, and to listen intently to what the potential participant is sharing with me. **I want them to feel no judgement because most of the time that is all they have experienced** in society around addiction.”

– FAMILY RECOVERY SUPPORT SPECIALIST



Summary

The process of engagement often requires a significant investment of time to build trusting relationships.

We use the initial engagement period to show potential participants how peer-led services may look and feel different than other services they have previously received. We carefully explain our services, provide the time to ask questions, offer participants the opportunity to join groups or receive other interim supports, and start thinking together about their goals for themselves and their families. Engagement looks different for each family, depending on how ready they are to seek support and actively participate. We may build rapport over days, weeks, or even months. When parents are ready to commit to participating in our program, we then begin the intake process. This includes seeking consent for participation, data collection, and screenings. We begin to gather participants' history and explore their current needs, working with the parent to create participant-driven goals and deepen the provider-parent relationship.

INSIDE

[Initial Engagement](#)

[Service Agreement](#)

[Data Collection](#)

[Use of Screening and Assessment Tools](#)

[Tobacco Cessation](#)

[Ongoing Engagement](#)

Initial Engagement

We are mindful to approach every interaction with potential participants in a meaningful way, starting with the first contact.

We believe the time and resources spent making initial connections and building engagement with families is a benefit to them, even if they decide not to continue with our program at that time. These exchanges plant a seed of possibility for those who are not yet ready to enroll in services. Even a brief contact makes parents aware that support is available to them if and when they choose to pursue it. From the moment parents first interact with our program, we strive to make every potential participant feel heard and accepted.

The engagement period begins when we make an initial connection either with a parent interested in our program or with a referral source reaching out on a potential participant’s behalf. This process looks different depending on each family’s needs. If a parent is eager and ready to enter the program, initial engagement may quickly lead to the intake process.

Alternatively, **parents may not be ready to join the program for many reasons. In these situations, building the trusting relationships that will become the foundation of our work together may take longer.** In some cases, we try to connect with potential participants for many weeks or even months, depending on the family’s needs and responsiveness. This may include phone calls, follow-up text messages, or deliveries of diapers, baby clothes or other supplies.

Connecting with a new provider can be anxiety provoking, especially for families that may have had difficult experiences with service providers in the past. This is a time that using our lived experience is especially helpful. Thoughtfully sharing from our own lives can be a source of connection and commonality, while normalizing being a parent in recovery and building trust between the FRSS and the family.

For example, an FRSS shared that she had a family who was referred by Child Welfare Services. The parent was not returning her calls to schedule the screeners and appeared to be hesitant to engage. The FRSS was able to use her own past experience with Child Welfare Services to convey that she understood how it can feel like a risk to share about substance use struggles and parenting. She reassured the parent that she was there to support her and would stand by her to work together during this challenging time for her family. The parent shared she felt more at ease and willing to engage because of how the FRSS had acknowledged and normalized her feelings.



We are always very quick to reach out to families shortly after the referral comes in, and we maintain a strategy of outreach that allows for there to be uncertainty in the relationship formation and “getting to know you” phase of things. This allows for the right for self determination and space to consider options.”

- PROGRAM SUPERVISOR

Some FIRST Steps Together staff attend joint meetings with parents and their current or referring providers. Many sites also offer to connect interested families to program alumni or invite them to attend groups prior to committing to regular home visits.

We recognize that often referring providers have a sense of care and responsibility for the families they refer. It is important to us that parents and their providers understand the services we offer and especially the supportive and empowering culture of our program. We take care to engage in collaborative communications around referrals. This practice helps ensure families have a smooth and supportive transition to our program. (More on warm handoffs can be found on [page 218](#).)

Some agencies may not understand how or why our program places such an emphasis on building trust and providing consistent support to parents even before enrollment. We believe the potential for the impact of our services is dependent upon building a meaningful connection in this initial engagement period. We must be patient and comfortable with participants engaging intermittently and reluctantly. This may look like expressing and then losing interest, enrolling and participating inconsistently or withdrawing from and then re-joining the program. We recognize this can be the nature of our work, in supporting families impacted by substance use.

Initial engagement can be a time-consuming process. We recommend that our staff document time spent on initial engagement, prior to enrollment. The benefits of documenting this process include demonstrating to funders and agency administration the time and resource commitment needed to successfully engage participants. This kind of documentation also provides data for program and service improvement.



PAGE 16

1.1

PAGE 44

1.2

PAGE 67

1.3

PAGE 108

1.4

PAGE 123

2.1

PAGE 149

2.2

PAGE 187

2.3

PAGE 213

2.4

PAGE 238

3.1

PAGE 262

3.2

Release of Information

Releases of information (ROI) are both best practice and legally required documents, designed to protect parents and empower them to decide when and how their personal information is shared.

In the medical and social service fields, there are many power differentials between providers and program participants. FIRST Steps Together works to ensure that when participants give their consent for contact between providers, they feel informed, empowered, and aware of their rights.

Before we ask a participant to sign any release of information, we:

- Discuss their wishes in detail
- Respond to any questions or concerns related to the release
- Determine what specific information they want to share or keep confidential
- Consider whether the release will allow for one-way or mutual information sharing
- Identify whether verbal or written updates or records will be shared
- Ask if the participant wishes to be present for these contacts or be involved in collaborative meetings
- Clarify if, and under what circumstances, staff members are permitted to make contact

It is important that releases specify which information can be shared, with which providers or programs, and when the permission expires. We train our staff on the laws that mandate the protection of health and substance use related information, including HIPAA and 42CFR. This training helps staff recognize the importance of following agency processes aligned with these governing laws. When a participant signs a release, staff members provide them with a copy for their own records. Participants are reminded that at any time they may withdraw their consent. Whenever possible, we encourage colleagues and collaborative agencies to offer and accept dual consents. This eases the burden on participants and minimizes delays in communication.

We take the time to talk with participants about the many benefits and potential drawbacks of open communication between providers. One complex issue is the importance of perception. We work with families to help them understand that appearing forthcoming and transparent can be to their benefit, whereas opting not to allow any sharing of information between providers may result in negative assumptions. We share this perspective not to pressure participants to give consent, but rather to help parents understand the complexity of care coordination particularly when



Child Welfare Services is involved. We show participants how allowing even partial communication between providers can result in smoother service delivery, which can improve their experience as service recipients.

Waitlists

Waitlist management is a process that balances prioritizing the most urgent needs while also ensuring that families feel supported until they are able to fully enroll.

Sometimes a program is at capacity when someone new is referred, and it is necessary to add them to a waitlist. Even if we are unable to immediately enroll new families, we conduct initial screenings and explain and review services at the time of referral. This helps us identify if our program is right for the family before placing them on a waitlist. If we are not the right fit, we take the time to connect and refer the family to a service provider or program that can better meet their individual needs.

For participants placed on our waitlist, we make sure they feel connected and supported right away. This may include helping them access concrete resources like diapers or baby items, offering participation in groups or events, or following up with regular check-ins.

There are many factors to think about when managing and enrolling participants from a waitlist. Many sites prioritize pregnant and expectant parents, those at higher risk for overdose, and those who have urgent needs related to Child Welfare Services.



We have heard from participants that **they are so glad to be connected right away with a group even if they have to be placed on a list to wait for an opening for an FRSS.**

- SUPERVISOR



Service Agreement

Early in the engagement process, we explore with potential participants the support they are seeking and how it compares with what our program offers.

We clearly communicate to parents that while our program is voluntary, once they decide to participate, they will benefit by making a commitment to regular participation. One way to clearly communicate expectations is through a clear and easy to understand Service Agreement. Service agreements should be clear and contain easy to understand language. Staff should take the time to go over the agreement together with the participant and answer any questions they may have.

Discussion of the service agreement includes:

- **PARTICIPATION IN SERVICES** | We take the time to explain the various services we offer. We talk about which services are expectations for those enrolled in our program, versus those that are optional supports. For example, a typical commitment means regularly meeting with a FRSS for weekly home, community, or virtual visits. Participants may also choose to take advantage of other opportunities, including care coordination, group attendance, events with other parents in recovery, and individualized clinical support. This is explained with the context that we always work to meet the parent where they are at, understanding that engagement may ebb and flow and needs may differ depending on the family’s circumstances. In times of higher need, phone and in person support may be frequent throughout the week. At other times less support may be needed, particularly as the family branches out to other community and natural supports and nears graduation.
- **EXPECTATIONS AROUND SCHEDULING AND CANCELLATIONS** | We communicate our expectations and policies around scheduling, rescheduling, or cancelling. These policies typically pertain to home visits and individual clinical sessions, as well as groups that require a regular commitment. As part of this conversation, we also explain what participants can expect from us regarding scheduling, rescheduling, or cancelling visits, for example in the case of inclement weather, illness, or otherwise.
- **CONFIDENTIALITY** | We talk about how we keep participants’ personal information confidential. This includes not sharing their information with other providers without their specific permission and written consent, except in cases that require mandated reporting.



When I first met with my FRSS I wasn't even sure what I was signing up for. He took the time to go over the program and what we would be doing together. I felt better knowing what I was committing to and that it was based on what I wanted and what my family’s needs were.”

- PARENT IN RECOVERY

- **MANDATED REPORTING** | We explain what mandated reporting is and what the process will look like if we do have safety concerns. (For more information about mandated reporting, please read the Child Safety Concerns section on [page 64](#).)
- **AVAILABILITY AND COMMUNICATION** | We explain that we are generally available for support during work hours. We make note that FIRST Steps Together is not a crisis response service and we will provide additional resources and contacts for any emergencies or issues that occur outside of work hours. This reflects our belief in the importance of building participants’ natural support systems and modeling healthy boundaries. We inquire about communication preferences, such as: Do participants prefer to talk on the phone or by video? Is it easier to connect by phone or by text? How long does it typically take us to respond to a message? We talk about who they can reach out to if they cannot reach us.
- **COMPLETION, GRADUATION, AND DISENROLLMENT** | We discuss our process for helping participants make progress toward their goals and how we will together determine when they are ready to complete or graduate from our program. We also discuss reasons that we may need to disenroll them from our program.



FIRST Steps Together Service Agreement
Go to [page 146](#)



Data Collection

Data collection is essential to capturing the impact of our work. It provides important information that is used to sustain and improve our program.

Data collection results in a better understanding of the services we provide, including how effective we are in reaching underserved populations. It also helps us to capture and share information about our program’s impact with funders and other partners.

We recognize that the data-collection process can be time-consuming and at times may feel uncomfortable for both staff and participants. Starting off with data collection may feel disruptive while trying to build an intentional, supportive relationship. It can also lead people to feel that this is “just another treatment program.” We prepare our teams to effectively and thoughtfully gather data in a trauma-informed/healing centered manner. This requires significant time and training. We want staff to feel informed and confident with the data collection process and for parents to feel empowered and comfortable about the information they choose to share with us.

Data collection begins with informed consent. We explain why this information is being collected, who will have access to it, how it will be used and how we will protect their personal health information. Although most participants, once provided with this information, decide to give their consent, we want them to understand that they have the right to refuse. Staff should have a thorough understanding of what options are available for those who choose not to give consent to participating in data collection.

For example, in FIRST Steps Together, some data collection tools and screeners are required to determine eligibility for participation in our program. If potential participants do not wish to consent to these screeners, we would work with them to refer them to another service or program. Other data collection tools that we use allow for personally identifiable information to be de-identified.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a thorough resource that outlines specific recommendations for conducting interviews and guides service providers through the process of trauma-informed data collection and appropriate follow-up care. **A Guide to GPRA Data Collection Using Trauma-informed Interviewing Skills:**

ddap.pa.gov/Documents/GPRA/SAMHSA%20GPRA_Data_Collection_Using_Trauma-informed_Interviewing_Skills.pdf



Data collection can be overwhelming, that’s why I always carve time out of my day to make sure I can get this done. The sooner the data is put in, the more accurate the information will be. **This is essential to capture all the amazing services we provide to each and every family we have contact with.”**

- FAMILY RECOVERY SUPPORT SPECIALIST

The screening and data collection process can be challenging for parents if the questions bring up past trauma. Given this, many sites decide to complete the initial intake process and then wait a period of time before conducting more thorough data collection. The benefit of this approach is that more sensitive questions are asked once participants have established a strong and supportive connection with their home visitor.

Many sites have also shared success stories of having an FRSS and Clinician jointly conduct these initial intakes. This shared meeting can better support the parent and familiarize multiple team members with the family's needs. This also proactively builds relationships with program staff which can help participants feel supported even if their usual provider is unavailable. This practice also helps build connections with program Clinicians, increasing the likelihood of parents being open to receiving future clinical support if needed.

Use of Screening and Assessment Tools

Screening tools offer a shared perspective for the provider and parent to understand child development and any needs for additional support.

Screening and assessment tools are designed to give a better picture of families' strengths and needs in several key areas. These areas include child development, parental mental health, depression, life skills, intimate partner violence and tobacco related needs. We understand it may be hard to talk about sensitive topics due to shame or stigma. We touch upon these topics in the beginning of the relationship, to normalize the open discussion of sometimes challenging issues, such as substance use during pregnancy, mental health concerns, homelessness, intimate partner violence, food insecurity and trauma. We hope that by having these conversations early and by regularly using tools and screeners with our participants, they will feel more comfortable asking for help when they are ready to do so.



The child development screeners help parents to be curious about their child. They can discuss any concerns that they might have. It also helps create a time as the provider to share about other services that might be able to come in and help address some of the concerns they might be having.”

– FAMILY RECOVERY
SUPPORT SPECIALIST

The Center for Disease Control and Prevention has helpful resources around developmental milestones and screenings, including **Milestones In Action**, a free library of photos and videos showing developmental milestones.

<https://www.cdc.gov/ncbddd/childdevelopment/screening.html>

Child Development Screening

Much of our work is dedicated to helping families build confidence in their parenting skills and strengthening their knowledge of child development.

Helping parents better identify and respond to their children’s needs is a primary protective factor, as identified by the **Strengthening Families Framework**. Developmental screeners build parental awareness around child development, attachment, and the importance of nurturing relationships. We have open conversations with parents about their questions, observations and worries about their child’s strengths and vulnerabilities.

Strengthening Families Framework:

cssp.org/resource/about-strengthening-families-and-the-protective-factors-framework/

Many parents in recovery fear that their substance use may have a long-term impact on their child’s development. Regular developmental screening provides an opportunity to address those feelings together and we invite parents to share any anxieties they may have. Making space to explore these feelings and normalize these concerns is an important piece of our work together.

Use of childhood development screeners:

- Provides a structure to support staff and parents in discussing child development,
- Empowers parents to be the experts on their own children,
- Identifies child strengths and areas where additional resources can benefit development,
- Helps parents identify questions that they may want to ask their children’s other providers such as their pediatrician,
- Facilitates referrals to Early Intervention,
- Help address racial inequities, given significant research that documents that developmental delays are identified later among children of color,



The screeners are used to help participants both raise concerns about their children’s development and to bring awareness to areas of development the child might need to build. For some participants, who are very nervous about their children’s development due to substance use during the pregnancy, the screening has provided reassurance.”

- PROGRAM SUPERVISOR

- Creates a common language with other service providers, and
- Enhances our ability to use data to better support the families we serve.

Additionally, developmental screeners may help parents who do not have physical custody of their children to feel more connected to their child's development. Collaborating with families on these screeners allows for parents to be the experts on their own child and can provide a structured focus for Family Time. Home visitors should weigh the costs and benefits of using these tools with families who do not live with their children. For some, this process may be upsetting. Asking parents to complete a questionnaire when they may not be sure how to answer, may feel frustrating or bring up feelings of guilt and shame. Offering parents the opportunity to share or reflect on a moment or experience from their Family Time, builds confidence and knowledge around their child's development. We determine what is comfortable for each parent on an individual basis.

We complete the first developmental screen within three months of entering the program, or within three months after birth if a parent joins FIRST Steps Together during their pregnancy. We repeat the screening every six (6) months, or sooner if there are developmental concerns. If a family has already completed a developmental screener with another provider or is involved in Early Intervention, we can determine how best to collaborate to offer support and resources.

The assessment process is more useful when we build an understanding of a family's culture. We must also be mindful of their access to resources, such as books, developmental toys and safe spaces for exploration that promote child development. Certain sites lend out "Family Time" backpacks, which include many of these materials and activities, to support child development and the parent-child relationship. Other sites create monthly activity packs or themes and provide materials to families during visits or events. Our funding allows us to provide families with resources such as age-appropriate books, toys, and activities for supporting child development.

The majority of our sites use the Ages & Stages Questionnaires® (ASQ). These tools can be used with infants, toddlers and young children.

The **ASQ-3** "screens and assesses the developmental performance of children in the areas of communication, gross motor skills, fine motor skills, problem solving, and personal-social skills. It is used to identify children that would benefit from in-depth evaluation for developmental delays."

The **ASQ:SE- 2** "is a set of questionnaires about behavior and social-emotional development in young children. There are nine questionnaires for different ages to screen children from 1 month to 6 years old."¹



Sometimes a parent doesn't know what to bring every week or wants to switch it up. We put together "visit backpacks" which have developmentally appropriate toys, books and games. This takes the pressure off the mom to scramble to come up with what to do in this one hour period of time."

- FAMILY RECOVERY
SUPPORT SPECIALIST

More information about **Ages & Stages Questionnaires®** can be found here:

[agesandstages.com](https://www.agesandstages.com)

By completing these screenings, we can identify potential developmental or behavioral challenges and connect families to appropriate support services. We also use the information gathered from developmental screens to help parents identify areas of growth for themselves and their children that can be incorporated into goal setting and activity planning. If there are questions about a child’s health or development, we encourage parents to speak with their child’s pediatrician. We may also refer participants to their local Early Intervention program, which supports children birth to age three who have developmental delays or are at risk of developing delays. If a child is older than age three and deemed eligible, they may qualify for supports through their local school system.

Equity and Cultural Considerations for Developmental Screening and Early Intervention Efforts

While screening tools can be useful for gathering information, we understand that all developmental screeners have their limitations; for example, developmental milestones can vary by culture and some screening tools give examples that may not be universally recognizable across cultures. When conducting developmental screenings, such as the ASQ/ASQ-SE, we train our home visitors to take into account the culture, environment, and unique context of each family.

We know that risks of stereotyping and unconscious bias can be high in cross-cultural interactions.² When working with families whose cultural backgrounds may differ from our own, we bring self-awareness of our own cultural assumptions, values, and beliefs and a willingness to explore the cultural knowledge of others in the full context of their personal and shared histories, assumptions, goals, beliefs, and practices.³

For example, American cultural norms may emphasize goals related to “self-maximization” like happiness, confidence, independence and assertiveness balanced with qualities of “lovingness” like kindness, and compassion. Other cultures may emphasize goals related to “proper demeanor” such as being respectful, appreciative, and accepted by the community.⁴

A literature review conducted by the Massachusetts Early Childhood Comprehensive Systems Impact Project Team in 2018, shows us some of the ways that development is viewed within cultural contexts. Some of the key findings presented in the review included:

- One study found that in some cultures there is no corresponding word for “development” in the language and that the concept of



From the very beginning, focus first on establishing a respectful relationship and understanding the family’s cultural values and child-rearing beliefs. Be prepared to set aside your own biases and try to see through the lens of the family. If you encounter practices that you don’t subscribe to (such as parents carrying their children all the time), recognize those as cultural judgments and set them aside.”

– [AGES AND STAGES](#)

PAGE 16

1.1

PAGE 44

1.2

PAGE 67

1.3

PAGE 108

1.4

PAGE 123

2.1

PAGE 149

2.2

PAGE 187

2.3

PAGE 213

2.4

PAGE 238

3.1

PAGE 262

3.2

“developmental milestones” is not recognized, including the language and context to identify areas of concern.

- Beliefs and practices around child development and disability are strongly influenced by religious and spiritual traditions that vary between cultural groups.
- Only a very small number of standardized developmental screens were validated for use in non-Western cultures and languages.
- Long-term socialization goals for children differ among cultures and can influence how parents report on developmental screens and how they identify concerns.
- Age expectations for milestones differ by culture. The assumption that there is one universally “correct” set of ages at which children should attain milestones is inaccurate. Making this assumption may lead to parents being judged for lacking knowledge of the “correct timetable” and thought of as being at risk for poor parenting practices and in need of parenting education.

When making referrals for additional services based on developmental screens, such as referrals to Early Intervention (EI), we also consider the following racial disparities that were identified:

- At 24 months Black children were almost 5 times less likely to receive services than White children.
- Black mothers report factors such as stigma, fear of blame and child protective services involvement as factors affecting their willingness to discuss their own emotional health concerns with their child’s health care provider.
- Disparities exist in timeliness of diagnosis and referral to developmental services for children of color in North America and Europe, in particular for children with ASD.
- Evidence also shows children of color have 3 times the number of office visits related to developmental delay or behavior but receive a diagnosis of autism spectrum disorder (ASD) one year later than white children.

Given the impact of racial disparities on access and referral to services, timeliness of diagnoses, and the negative experiences many Black mothers report when seeking support for their own health concerns, we make a concerted effort as a program to raise and counter these issues. We are mindful to provide prompt and supportive services, encouraging parents in recovery, particularly persons of color, to speak openly about their experiences and seek support. We normalize the challenges of early parenting and encourage all families to pursue Early Intervention services regardless of a known diagnosis. We offer to facilitate a warm handoff and connect families with their local EI programs to elevate any concerns about their child’s development.



We help families with their assessments by offering to go with them, preparing them to share their individual family circumstances when asked to help with eligibility, and even requesting a one-to-one visit by an Intake professional to make it easier to share sensitive and private information.”

- PROJECT DIRECTOR

Please visit **Tips for screening children from diverse cultures** from Ages & Stages Questionnaire® for more information on screening children from diverse cultures.

agesandstages.com/free-resources/articles/tips-screening-children-diverse-cultures/

Depression and Parental Mental Health Screens

A number of biological, hormonal, and circumstantial changes occur in the pregnant, postpartum and early parenting phases.


New parents are at a greater risk for mental health issues, including the most common diagnoses of Postpartum Depression (PPD) and Post-Partum Anxiety (PPA) ([1.1 Foundational Concepts and Theory on page 16](#)). Parenting a newborn can come with fear and anxiety, hormonal changes, sleep deprivation, isolation and physical and mental strain. Many of these factors can exacerbate or contribute to mental health issues which can make new parenthood even more challenging. We know that expecting and new parents often do not receive the mental health support they may need, which puts them and their children at risk. This is particularly true for parents that identify as Black, Indigenous and People of Color.

Many new parents' fears of shame, stigma, and penalty from the Child Welfare System may prevent them from telling their doctors that they are experiencing anxiety, depression, or intrusive or troubling thoughts. Furthermore, we recognize that the healthcare system is laden with structural and systemic oppression and racism that negatively impacts people of color. Our program makes sure to discuss and assess parents for depression, anxiety and other mental health concerns, and provide healing centered services and supports. Although there are heightened concerns specific to the mental health of those who are pregnant and postpartum, we also screen other parents and partners. For example, when serving fathers, we know that they too may struggle with mental health issues. This is particularly true for fathers in early recovery and when first adjusting to new parenthood. We use several screening tools including the Edinburgh Postnatal Depression Screen and the Yates Paternal Depression Screening Tool.

We are careful to conduct screenings in a confidential and trauma-informed/healing centered manner. This allows us to identify parents' needs, provide additional support, advocate for higher levels of care, or make referrals. Additional support should go beyond medical or clinical services to address social isolation. We recommend referring to "Mommy and Me" groups, peer or mutual aid support groups, and other community resources, while keeping in mind that traditional groups for new parents

may not be the best fit for families in recovery. In response to this need, we offer groups specifically designed for parents in recovery that provide a supportive and safe environment to talk about the challenges of being a new parent in recovery.

Postpartum Support International can be a helpful referral. The mission of Postpartum Support International is to promote awareness, prevention and treatment of mental health issues related to childbearing in every country worldwide. They also offer a variety of support groups. Visit the link below or call 1.800.944.4773 for more information.

 postpartum.net

Life Skills Progression Tool

Assessing participants' life skills progression, using tools sometimes referred to as self-sufficiency scales, helps us better understand parents' areas of strength and need.

While many screening tools are available, the **Life Skills Progression (LSP)1** was created to specifically serve maternal, infant, and early childhood home visiting programs.

“The Life Skills Progression (LSP)1 is an outcome summary tool that home visitors can use to gather and organize information about family competencies obtained from other data sources. The LSP is not intended to be administered via interview or parent self-report. Instead, a home visitor scores the LSP items by considering in-depth information about the family that has been collected through referral information, interviews and conversation, observations of family functioning, formal assessments, and selected screening tools. This information is used to develop a profile of family strengths and needs, service plans, and monitor progress in outcomes.”⁵

Life Skills Progression (LSP)

 products.brookespublishing.com/Life-Skills-Progression-LSP-P608.aspx



Looking at a participant's 'life skills' helps us to come up with short term goals that might improve some of these skills. This also helps us to have an open dialogue when sitting with a parent. **As participants begin to share about life skills, sometimes they open up about past trauma or struggles they have encountered.”**

– FAMILY RECOVERY
SUPPORT SPECIALIST

PAGE 16

1.1

PAGE 44

1.2

PAGE 67

1.3

PAGE 108

1.4

PAGE 123

2.1

PAGE 149

2.2

PAGE 187

2.3

PAGE 213

2.4

PAGE 238

3.1

PAGE 262

3.2

This tool assesses parent and child progress in the areas of relationships, education, mental health/substance use and other risks, basic essentials, and infant/toddler development. These categories are further broken down into the following sub sections:

1. Maternal and Newborn Health
2. Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of ER Visits
3. School Readiness and Achievement
4. Crime of Domestic Violence
5. Family Economic Self-Sufficiency
6. Coordination and Referral for Other Community Resources and Supports

Other scales, including the **Self-Sufficiency Matrix Guidance for Adult Community Clinical Services Providers** cover related areas, such as participant skills and access to resources in the following domains:

- Housing
- Employment
- Income
- Food
- Childcare
- Children's Education
- Healthcare Coverage
- Life Skills
- Family/Social Relations
- Mobility
- Community Involvement
- Parenting Skills
- Legal
- Mental Health
- Substance Use and Addictive Behaviors
- Safety
- Disabilities and Physical Health

Self-Sufficiency Matrix Guidance for Adult Community Clinical Services Providers:

mass.gov/doc/accs-self-sufficiency-matrix/download



We support participants by considering these areas to identify needs and inform the process of goal setting. These scales aid both participants and staff members in understanding how strengths and weaknesses impact families’ ability to meet their basic needs and reach their higher-level goals. This also guides the FRSS and other team members in offering support and providing concrete resources to build trust and engagement in clinical services.

Additional examples of Life Skills Measures include:

Housing & Community Services | Snohomish County, WA—Official Website (snohomishcountywa.gov):

<https://snohomishcountywa.gov/429/Housing-and-Community-Services>

Arizona’s Self Sufficiency Matrix

hudexchange.info/resource/1562/self-sufficiency-matrix-using-hmis-to-benchmark-progress-sample/

Center for Women’s Welfare (CWW), The Self-Sufficiency Standard:

<https://selfsufficiencystandard.org/the-standard/overview/>

Intimate Partner Violence (IPV) Screening

Regularly screening families for IPV brings this issue into the open and communicates to our participants that we are available whenever they feel ready to seek support.

Staff may use brief screens to assess intimate partner or domestic violence and other safety concerns. We also take into account staff members’ intuition and awareness of warning signs. Before intake, we ask participants whether they feel safe to conduct the conversation in-person or virtually. We also ask whether it’s OK to leave a message or send a text or e-mail to their preferred contact method.

The **CDC** offers a wide array of tools, which can be found here:

cdc.gov/violenceprevention/intimatepartnerviolence/index.html

We also recommend viewing **Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings**. This compilation includes existing tools for assessing intimate partner violence (IPV) and sexual violence (SV) victimization in clinical/healthcare settings.

cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf

We maintain an ongoing responsibility to act on behalf of the safety and security of the parents and children we serve. Many families have extensive trauma histories and experience continuing risks associated with their



We screen for Intimate Partner Violence and Safety on an ongoing basis, to make an often silenced and secret issue known and to encourage parents to share these experiences with us when they are ready to do so. We want to communicate that we are aware of the prevalence and complexity of IPV issues, and that we’re here to help without judgement, if and when a family wants to talk or access resources.”

- CLINICIAN

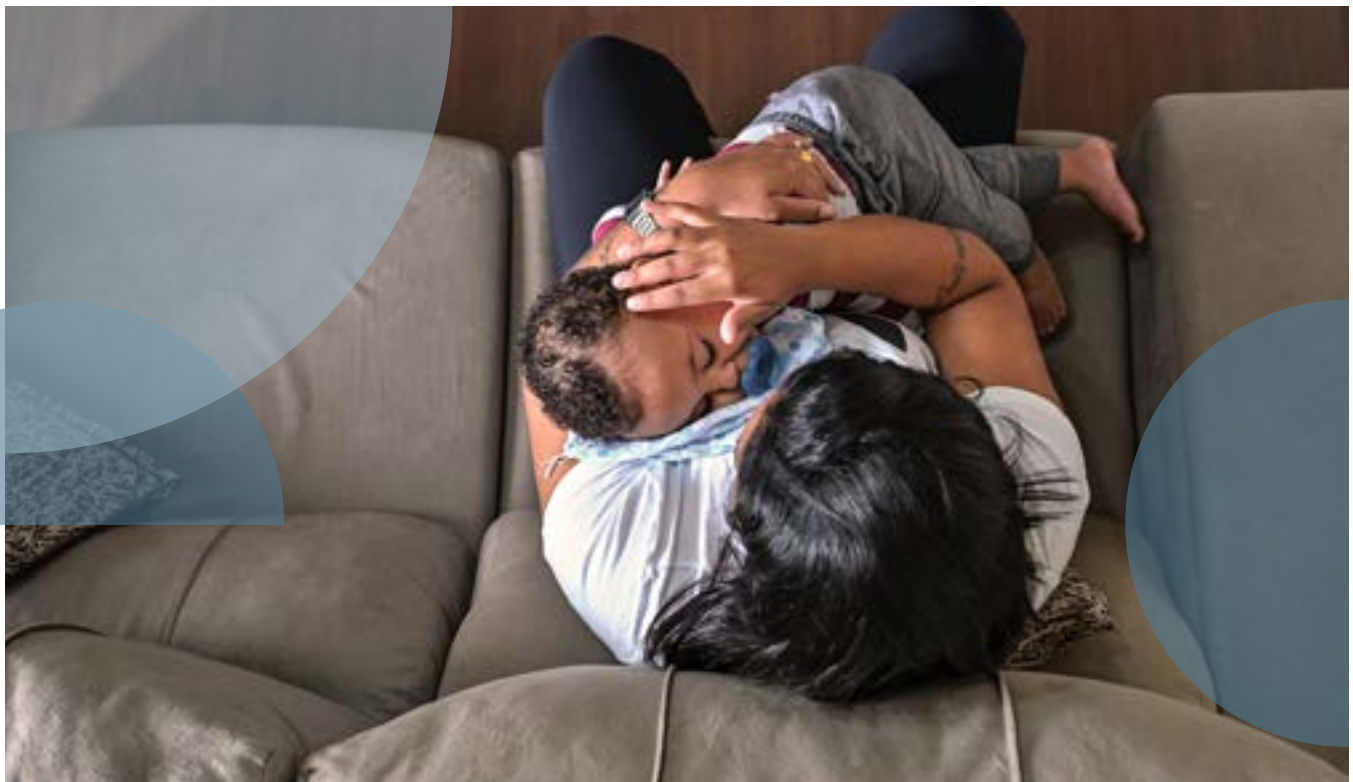
recent or current substance use. Risks can also come from their living environment, employment or familiar or intimate relationships. We recognize some families are also impacted by violence or political divisiveness within their home countries and that there is often trauma associated with immigration into the United States. These are all important factors to hold in mind when supporting families, particularly those who may be experiencing intimate partner violence (IPV).

This **Healthier Pregnancy Provider Fact Sheet on Intimate Partner Violence Screening** from the Agency for Healthcare Research and Quality contains more information on best screening and intervention practices

ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/healthier-pregnancy/documents/intimate-partner-violence-provider-fact-sheet.pdf

Participants may experience IPV in many forms. We understand IPV as a continuum of risk and harm, ranging from verbal abuse, such as shaming or threats, to physical abuse. **Coercive control**⁶ may include behaviors that seek to control aspects of participants’ lives, such as finances or access to education or employment; social, emotional and recovery supports; medical care or medication; reproductive care and choice; transportation; safe housing, ability to see or care for their children, etc. We encourage our sites to screen for these issues and to revisit concerns as needed. (For more information and resources on IPV, please visit chapter 2 on [page 156](#).)

Coercive control is a strategic form of ongoing oppression and terrorism used to instill fear. The abuser will use tactics, such as limiting access to money or monitoring communications, to exert control.



Tobacco Cessation

Continued tobacco use can impact not only the health of a participant and their family members but may also affect their ability to sustain their recovery.

“Recovery rates are enhanced by not smoking and the continued use of nicotine may be a factor in alcohol relapse and other drug use.”⁷ Janet Smeltz, M.Ed., LADC-I, former Director of Tobacco Education and Treatment Programs, Institute for Health and Recovery describes tobacco use as a “pilot light” that can keep the pathways for addiction primed.

Additional recommended smoking cessation resources include:

A Practical Guide to Help Your Patients Quit Using Tobacco from the CDC:

cdc.gov/tobacco/patient-care/pdfs/hcp-conversation-guide.pdf

Getting Started with Tobacco Awareness Groups from the Massachusetts Department of Public Health:

massclearinghouse.ehs.state.ma.us/PROG-BSAS-YTH/SA5824.html

We regularly assess participants’ tobacco use as part of their overall health and wellness. Screening includes evaluating a parent’s tobacco use and their desire and readiness for change. If they are interested, we offer educational materials to encourage harm reduction or abstinence. If a participant is eager and motivated to change their smoking habits, we provide direct smoking cessation services or education or refer them to an outside intervention program.



I didn’t know quitting smoking could help my recovery. **My FRSS provided resources and supported me when I decided it was time to quit.** It felt nice having her cheer me on. Quitting was hard but I’m now smoke-free, I want to set a good example for my children.”

- PARTICIPANT



Ongoing Engagement

Once the program participant has engaged with our services, the intake and initial data collection has been completed, and relevant screeners have been conducted, we shift into ongoing service provision.

For all families, ongoing engagement includes weekly home, community, or virtual visits with a Family Recovery Support Specialist. For parents who want additional support, they can access individual clinical counseling, as well as groups. Our program offers care coordination, which includes collaborating with other service providers, to advocate for the family’s wellbeing and to make sure there are no duplicative services, and that families’ service needs are being met. We also help with concrete resources to ensure parents’ and children’s basic needs are met.

Thinking about a participant’s flow through services in goal setting provides mile markers to guide the work with families. This practice also supports the parent’s progress and builds their skills and confidence. Having smaller action steps as guides towards longer-term goals gives both staff and participants a structure for the work and a sense of accomplishment.

In the ongoing engagement period, our program’s service delivery model shifts to more routinely planned visits. The following chapters will explore each aspect of these services, including conducting home visits, planning and running groups, and building and sustaining community connections.



I was overwhelmed by all the different services we had in the beginning. **My FRSS worked with my other providers to make sure our needs were met, and we had the right supports. Knowing she’ll be with us every week as long as we need her has helped relieve my stress.”**

- PARTICIPANT

2.1

Key Takeaways

ENGAGEMENT IS A PROCESS: Engaging new participants often requires time, multiple forms of outreach and persistent follow up.

COMMUNICATE EXPECTATIONS: During intake, staff should review the services offered by the program, the mandated reporting requirements, and the commitment required by participants, while explaining the unique services we provide.

CONDUCT SCREENINGS: A variety of screenings and assessments conducted over the first few months of engagement, and then repeated as needed, provide useful information on which to base family services and participant's goals.

2.1

Tools





FIRST Steps Together Service Agreement



What is FIRST Steps Together?

FIRST Steps Together is a home visiting program that provides peer coaching and parenting support to parents on their recovery journey. Each family is matched with a Family Recovery Support Specialist who is a person in recovery with specialized training. They will walk alongside you on both your recovery and parenting journey.

Services provided to you and your family

- **Home, Community, or Virtual Visits:** regular meetings with a Family Recovery Support Specialist as well as clinical services if needed to support you on your parenting and recovery journeys.
- **Group Connections:** opportunities to connect with other parents in recovery to share experiences, offer each other support and build your recovery community.
- **Resource Support:** connections to day-to-day parenting items (diapers, wipes, etc.) and other resources in the community to help meet and maintain your family's specific needs.
- **Advocacy:** guidance and support working with care systems and building relationships with other service providers.

What can you expect?

First, we will meet with you to learn about your family's needs and how best to support you. Your goals for recovery, parenting, and for your family as a whole will guide our work together. You will help set a visit schedule for us to meet at your home, in the community, or virtually, at a day and time that works for your schedule.

- **Your involvement and participation** with our program are voluntary.
- **You will work with your FIRST Steps Together team** to plan for what you need to meet your goals.
- **You will have the opportunity to create a Recovery Portfolio**, including a Family Care Plan (Plan of Safe Care).
- **You can participate in groups** to connect with other parents in recovery, to share experiences, explore learning topics, and build community.
- **We will explore other services and resources** available to you to support your parenting and recovery journeys.
- **You will have the opportunity to meet with a therapist** who works in our program or receive referrals to outside mental health supports.
- **We will support you to better understand** your child's development and any needs they may have.

What will we ask of you?

- **Be present** for and participate actively in all scheduled visits.
- **Not be under the influence** of any substances during our visits.
- **If you need to cancel or reschedule a visit, give at least 24 hours notice** when possible and we will do our best to accommodate rescheduling in a timely manner. In the event that we need to cancel or reschedule, we also will try to give at least 24 hours of notice when possible.



FIRST Steps Together Service Agreement *continued*

- **Be open to sharing your experience** as a parent and reflecting on your relationship with your child.
- **Share your thoughts, challenges, and successes** with recovery.

Record keeping

- **During your participation in FIRST Steps Together, routine information will be collected, kept confidential and stored in a secure location.** This includes family background information, health related information, referrals, client notes, information shared from other services providers with your permission, and information about the services we provide to you and your family. Collecting this information helps us better serve all families and ensures we receive funding for the program.

Confidentiality

FIRST Steps Together will not release confidential information outside of the program without your written permission, with the following exceptions as required by law:

- To protect you or others from serious harm. For example, we are mandated to report if a family member plans to harm him or herself, if a family member plans to harm another person, or if there are concerns about abuse or neglect of a child or other vulnerable person.
- If we receive a court order telling us to do so.

When possible, we will work collaboratively with you when responding to these situations. You will always be informed about what information has been released.

The Limits of Our Services

Family Recovery Support Specialists are not psychologists or medical professionals. We cannot diagnose any health or medical condition, but we do have therapists who can provide you with additional support if needed. We can also complete referrals to help connect you to qualified professionals for mental and physical health care for yourself or your child.

If you have any questions, you can contact your Family Recovery Support Specialist or the Program Supervisor.

I have read and understand the above. I agree to participate in FIRST Steps Together services. By signing this form, I understand that at any time, I can let my Family Recovery Support Specialist, or the Program Supervisor know verbally or in writing that I no longer want to participate in the program.

Printed name of enrolled participant

Signature of enrolled participant

Date

Printed name of FIRST Steps Together staff member

Signature of FIRST Steps Together staff member

Date



2.1

Endnotes

- 1 The California Evidence-Based Clearinghouse for Child Welfare. (2015). *CEBC » Assessment Tool » Ages And Stages Questionnaire*. cebc4cw.org/assessment-tool/ages-and-stages-questionnaire/#:%7E:text=ASQ%2D3%20screens%20and%20assesses,depth%20evaluation%20for%20developmental%20delays
- 2 Massachusetts Early Childhood Comprehensive Systems State Impact Team. (2018). *MECCS Racial Equity Planning Highlights from the Literature*. Early Childhood Comprehensive Systems Project.
- 3 Massachusetts Early Childhood Comprehensive Systems State Impact Team. (2018). *MECCS Racial Equity Planning Highlights from the Literature*. Early Childhood Comprehensive Systems Project.
- 4 Massachusetts Early Childhood Comprehensive Systems State Impact Team. (2018). *MECCS Racial Equity Planning Highlights from the Literature*. Early Childhood Comprehensive Systems Project.
- 5 Design Options for Home Visiting Evaluation. (2011, October). *LIFE SKILLS PROGRESSION BRIEF: Information and Guidelines for Use in Meeting MIECHV Benchmarks*. mdrc.org/sites/default/files/img/LSP_Brief.pdf
- 6 Lamothe, C. (2019, October 10). *How to Recognize Coercive Control*. Healthline. healthline.com/health/coercive-control#getting-out
- 7 MA Department of Public Health Bureau of Substance Addiction Services. (2020, August). *Getting Started with Tobacco Awareness Groups* (No. SA5824). files.hria.org/files/SA5824.pdf