ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HUMAN SERVICES POLICY

BRIEF
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Coordinating Integrated Prevention Approaches to Serve the Whole Person

Findings from Case Studies in Supporting Prevention Through Human Services Program Integration

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The U.S Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been working with researchers, leaders of human services agencies, and people with lived experience to visualize, describe, and document models of prevention of human services needs, including approaches for the prevention of child maltreatment, the promotion of housing stability and prevention of homelessness for families and youth, and increasing the use of economic supports such as Temporary Assistance for Needy Families (TANF) to promote economic stability. To support this goal, ASPE contracted with Mathematica and the Center for the Study of Social Policy (CSSP) to conduct case studies of innovative prevention approaches that integrate human services.

KEY POINTS

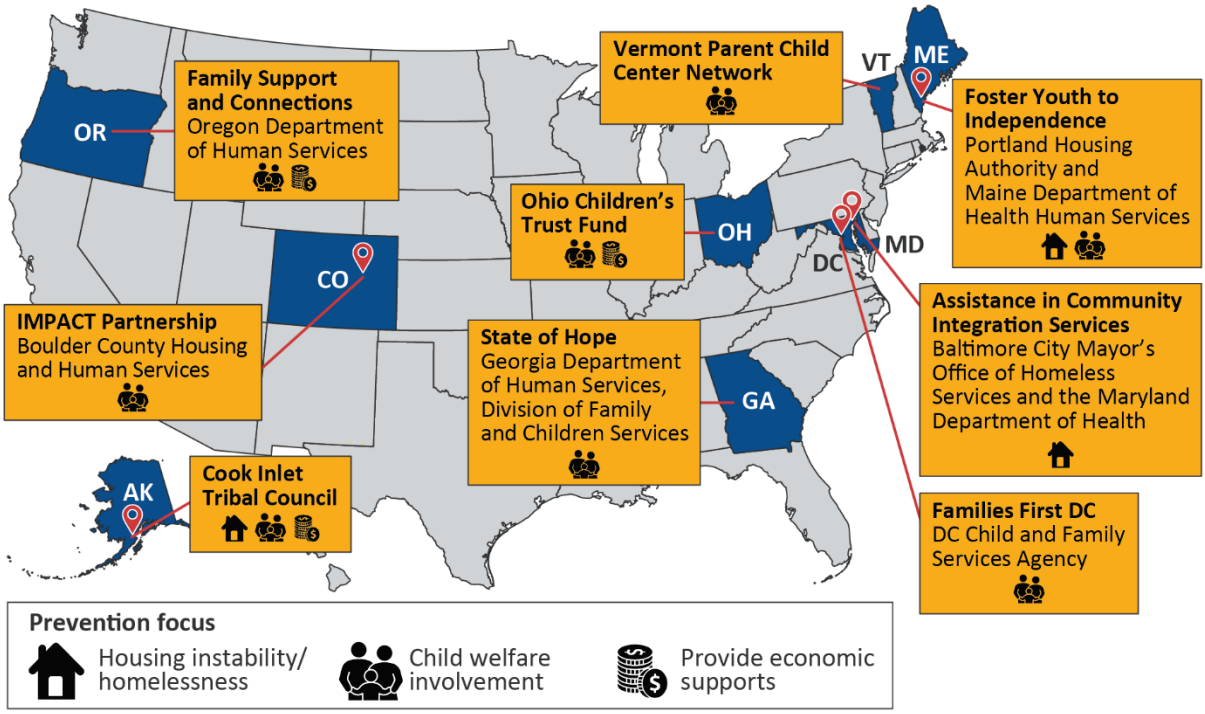
- Case study sites interwove services by developing relationships and building trust with program participants; conducting assessments that incorporate multiple aspects of participants' well-being such as economic security, health, and spiritual and cultural values; and delivering services based on participants' goals and interests.
- Sites were able to be responsive to the full needs of those they serve by partnering with community members and organizations to develop a shared vision grounded in community strengths and values; locating services in the community; and providing flexible resources, including cash supports, outside of intervening systems like child welfare.

OVERVIEW

Supporting families and individuals means understanding that their needs are complex, interrelated, and affected by the particular opportunities available in their environments. Integrated service approaches to prevent homelessness or involvement in systems like child welfare may be best positioned to succeed when they center families' strengths, needs, and identities and when they coordinate access to resources and services—such as housing, physical and mental health care, food and nutrition, workforce development, and cash support.

This brief highlights the efforts made by select programs to coordinate services and supports for program participants, including how sites identified participants' strengths and needs and how sites integrated services to be responsive to those needs. The findings are based on interviews with staff and partners from nine different programs across the country and with people who have been served by these programs (Figure 1).

Figure 1. Map of case study sites



HOW SITES IDENTIFIED PROGRAM PARTICIPANTS' STRENGTHS AND NEEDS

Sites emphasized that engaging with participants in collaboration and coordination of eligible services was a critical foundation for developing trusting relationships with participants and identifying their strengths and needs. Building trust is especially important when systems have caused past harm to program participants and their communities. Six sites worked in partnership with families to set goals and identify services that met family- and individual-identified needs. Case managers and navigators in these sites not only helped to determine program participants' eligibility for various internal and external services, but also administered assessments, provided referrals, and followed up with program participants to help them engage in services. Staff stressed the importance of approaching case management in a collaborative and supportive, rather than paternalistic, way. Boulder County IMPACT Partnership, for example, coordinated early intervention for children, youth, and their families across a range of services and providers in the areas of housing, health and mental health, education, and justice. Boulder County IMPACT Partnership staff used a care coordination model both to prevent families from becoming involved in multiple systems, such as child welfare and juvenile justice, and to work with

Boulder County IMPACT Partnership staff

"We think about [prevention] in terms of… preventing harm from being involved in systems that can themselves cause harm."

families to address challenges that contribute to system involvement. The partnership's model brought teams from different areas together to align services for specific families and adopted a common family assessment. Having this common assessment meant that families only needed to provide information once, avoiding the potential frustration and re-traumatization of having to share painful and humiliating information with multiple providers.

Assessments that centered on strengths and protective factors helped sites focus on families' overall well-being, rather than narrow compliance-related requirements of specific programs or funding streams. To assess the well-being of their program participants, four sites used established frameworks such as the Cantril Ladder (Families First DC), the Protective Factors Survey (Oregon Family Support and Connections and Ohio Children's Trust Fund), and the Strengthening Families Protective Factors Framework (Vermont Parent Child Center Network). These frameworks asked families about aspects of their well-being, such as family functioning, availability of social and concrete supports, and child development, that could protect against child abuse and neglect. In Ohio, for example, participants in the Triple P+ online parenting program completed an intake form and the Protective Factors Survey, which allowed program staff to determine a wide range of needs related to family well-being, including their eligibility for cash supports.

Sites' definitions of well-being included connection to culture, family, or community; financial stability; healthy relationships; and engagement in meaningful activities. Sites' assessment of aspects of individuals' and families' well-being focused on strengths and protective factors instead of weaknesses and deficits. It allowed service providers to build a stronger foundation of trust with program participants, which sites saw as a critical link to families engaging in initial and continued services. For example, Cook Inlet Tribal Council (CITC), which served indigenous people in and around Anchorage, Alaska, intentionally integrated cultural values into its work (Box 1). As a part of its approach, the organization framed services in terms of "wellness" instead of prevention because organizational leaders believed language around prevention may not be welcoming. According to CITC staff, "wellness" was more aligned with participants' cultural definition of well-being than "prevention." CITC also employed navigators who greeted individuals when they entered the building, administered its common assessment, provided warm handoffs to CITC services, and continued to check in with program participants throughout their involvement in services. CITC developed its navigation approach to help participants feel comfortable sharing their needs and to model values of connection, support, empathy, and compassion. This helped ensure families received the services they most needed and reinforced families' continued engagement and partnership.

Box 1. Cook Inlet Tribal Council's approach to promoting well-being

The Cook Inlet Tribal Council (CITC), a nonprofit organization with tribal authority serving American Indian and Alaska Native (AI/AN) people residing in the Cook Inlet region of south-central Alaska, developed a five-factors assessment that included cultural connection as a protective factor. CITC employed a single-access point ("no wrong door" approach) by using this common assessment during intake to improve program participants' access to services and minimize the burden of providing the same information multiple times to determine eligibility. With the five-factors assessment and intake process, CITC participants could gain access to any of the organization's offerings regardless of their initial reason for seeking help.

HOW SITES INTEGRATED SERVICES TO BE RESPONSIVE TO FAMILIES' NEEDS

Integrating programs and services enabled sites to focus on early identification and anticipation of needs for individuals and families so they could receive support before they were in crisis. For example, each of the 15 Vermont Parent Child Centers within the state network functioned as a service hub, providing a range of wrap-around services for families tailored to family and community need. These services included child care, early

intervention for infants and toddlers with developmental delays or health conditions, home visiting, connections to TANF, and women's and pediatric health services. At some centers, a multidisciplinary care coordination team, including representatives from the local health department, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), child welfare office, and other local partners, met regularly to coordinate care for families involved in multiple systems.

A shared vision and open communication were essential to successful partnerships in implementing integrated prevention approaches. Staff from five sites highlighted how developing a shared vision or goal with partners was critical to strong partnerships and implementation. For example, for Georgia's State of Hope, staff from the Georgia Division of Children and Family Services conducted a series of interactive workshops and human-centered design activities with community members and organizations to co-create a vision for an initiative focused on funding and building the capacity of local service providers. The initiative focused on four pillars that contributed to a vision of "safety and success for every child, family, and individual": (1) improving educational attainment; (2) increasing trauma-awareness; (3) improving quality caregiving; and (4) strengthening economic self-sufficiency. Staff from seven sites said they scheduled weekly, monthly, or quarterly calls to facilitate communication between partner organizations. They reported that an open line of communication facilitated program participants' timely access to services and removal of systemic barriers because they could provide updates, share information, refer program participants, and address issues.

Vermont Parent Child Center Network staff

"One of the great things about [Parent Child Centers] is the way in which we approach the work…. What it breaks down to is relationships… [both] working with community partners [and] how we provide the services to the individuals accessing them…. Our ongoing outreach within the community is what helps us be successful."

Community and family partnerships allowed programs to better incorporate community and cultural values into their practices, including administration, service delivery and assessment, and program evaluation. Staff from seven sites specifically described their approach as community-driven or grassroots. These sites engaged with community partners and community members to better understand what values were most important to community members and what services and supports community members needed most. Three sites established community advisory boards to serve as a channel for direct input from the parents, families, and other community members who benefitted from the programs. If they are established in ways that ensure meaningful and consistent engagement, community boards provide a model of engagement that, because of their ongoing nature, can contribute to strong partnerships, co-designed services, and program accountability. The iterative co-design that can be developed through community boards can also help remove systemic barriers that organizational partners, such as service providers, may have missed or overlooked in the development of the program or service. For example, in Georgia's State of Hope, the state saw itself as the convener of the approach but not its owner. The state trained and partnered with community members and regional partners to review applications and

Program Participant

"[The program staff] have asked the community a lot, like, 'What would you like to see here?' They even ask the youth, 'What else would you like to see? What activities would you like?' and they make that happen."

recommend organizations for funding from their regions to the state. Partnering with community members and regional partners helped State of Hope make sure that grantees—and the services they provided—were grounded in the values and needs of the communities they served.

Flexible and responsive implementation models, including a no-wrong-door approach, allowed programs to serve and support multiple and diverse populations in their communities. Staff from seven sites highlighted a flexible approach to service provision that allowed them to adjust their services to the needs of the community. One example of how this approach was operationalized was to allow program participants to access multiple services in one location. Staff at six sites said that being a one-stop shop for all needs was important to reduce barriers to services. Staff from a Family Success Center that is part of Families First DC, for example, helped participants apply for Supplemental Nutrition Assistance Program (SNAP) benefits on-site instead of referring people to a different office. Parent Child Centers in Vermont functioned as service hubs for early childhood and family services in sparsely populated, rural communities. Where needed, they operated vans to bring families to the centers.

> **Families First DC staff**
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> *"[Community advisory board members] live in the community, they work in the community, they will tell us what they want and how they want it to go…. We meet with them every month to give them our data to know what impact we are making each month. And we are asking questions to see what they know, so we can have an informed discussion to see what the best approach is to move forward."*

Community partners enabled programs to meet participants where they were and respond to their needs in ways in which government offices were sometimes unable. In Baltimore, the Mayor's Office partnered with a community organization that had expertise in providing healthcare services for people experiencing homelessness. The organization provided therapy and case management that the Mayor's Office could not provide. Maine Foster Youth to Independence worked with shelters and housing partners outside the child welfare system to engage youth leaving foster care who were choosing not to interact with the Maine Department of Health and Human Services (Box 2).

> **Maine FYI staff**
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> *"To meet people where they are at, you need to literally go to them instead of having them come to you. I don't know when the model became that people come to me or I don't do anything for you. If you're really interested in helping, that's not going to work."*

Box 2. Maine Foster Youth to Independence's approach to working with young adults at risk of homelessness who were exiting foster care

Maine Foster Youth to Independence—a joint initiative of the Maine Department of Health and Human Services, the Portland Housing Authority (PHA), and the Quality Housing Coalition—supported young adults between ages 18 and 25 who had experienced foster care and needed housing support. The initiative helped participants find and keep housing through direct housing vouchers and by connecting them to services that promote education, employment, economic mobility, and self-sufficiency. PHA partnered with a trusted homeless shelter for teenagers to identify youth aging out of foster care who were eligible for a housing voucher. During intake, the homeless shelter asked youth whether they were exiting foster care. Maine Foster Youth to Independence then matched those young adults with a navigator (employed by a community partner) who helped them access community-based resources such as furniture donations and community dental care. Staff also could use cash supports to help participants cover emergency needs.

Sites provided direct cash assistance and other concrete supports, such as food, to address participants' immediate barriers and crises. Programs expressed that these direct supports to meet families' highest priority needs were a critical example of treating participants with dignity and respect. Staff from two sites also noted that concrete supports enabled them to serve participants quickly, which addressed their immediate stressors before engaging them in more comprehensive case management and other important assessments. A staff member at a Georgia State of Hope grantee that served Hispanic/Latino, primarily immigrant families, described how it was important to stock its food bank with culturally appropriate food that families were comfortable cooking and to provide services in Spanish, without first "expecting them to learn English in five to seven years." A staff member with Families First DC noted that if a person was going hungry, they needed food first, not "a case manager to talk to [them] about why [they] don't have groceries." By providing cash assistance to families to take care of pressing needs like food, clothing, or transportation, staff in two sites believed families experienced reduced stress associated with these needs and a reduced likelihood of future challenges or system involvement. Staff from the Ohio Children's Trust Fund, for example, reported that providing direct cash to eligible families to address immediate and pressing needs also enabled participants to focus more fully on participating in program services and meeting other priority needs that were less immediate (see Box 3).

Program Participant

"Instead of being stressed out and not having the time because I had to work more trying to afford [my son's camp, the $500] took a load off because I could focus on [participating in the program] instead of focusing on trying to come up with more funds."

Box 3. Ohio Children's Trust Fund's approach to providing economic supports

The Ohio Children's Trust Fund (OCTF) provided a free, online version of the Positive Parenting Program Plus (Triple P+), an evidence-based parent education program. Triple P+ was offered to any interested parent or caregiver across all 88 Ohio counties and in partnership with 15 children's services agencies across the state. Interested families could receive supplemental coaching from accredited parent educators. OCTF also received funding to evaluate the impact of providing $500 on a preloaded debit card to select parents and caregivers who signed up to use Triple P+ online and who demonstrated elevated fiscal need on pre-test surveys. These selected participants were able to choose how to use the $500 cash supplement. In a program evaluation, participants noted that they used the funds to alleviate particular economic stressors, like car repairs and rental deposits. Some noted that being able to pay for items such as groceries reduced stress and conflict in the home and made it possible for them to spend more quality time with their children.

CONCLUSION

Integrated services and supports are crucial to meeting the broad needs that families have and preventing deeper system involvement. To ensure that services are responsive to the needs of families and individuals, the sites in these case studies interwove services by developing relationships and building trust with program participants, conducting assessments that incorporated multiple aspects of well-being—including economic security, health, and spiritual and cultural values, as defined by those receiving services—and delivering services based on individuals' goals and interests. Sites engaged program participants and community members when developing services and held themselves accountable to program participants during implementation through ongoing opportunities for co-development and feedback. Sites located services in the community and provided flexible resources outside of intervening systems. These integrative practices have important implications for ensuring that programs and services respect the dignity of participants—for example, by meeting families' and individuals' needs as they themselves define them—and thus promote families' initial and ongoing engagement in the services they most need.

Case study sites

The *Case Studies in Supporting Prevention Through Program Integration* project included nine sites.

- **Boulder County IMPACT Partnership** supports young people and families engaged with multiple systems, such as the juvenile justice and child welfare systems. Multiple partners work to address the root causes of challenges that bring youth to the attention of these systems.
- **Cook Inlet Tribal Council** is a nonprofit organization with tribal authority serving American Indian and Alaska Native people residing in the Cook Inlet region of south-central Alaska. Their primary areas of focus include child and family services, education, early childhood learning, youth development, addiction and recovery services, career development, and employment and training. They also have a program to coordinate housing services for indigenous Cook Inlet region residents facing housing instability.
- **Families First DC** funds Family Success Centers in three wards in the District of Columbia. Staff at the centers offer service navigation to meet families' broad needs, community-centered programming, and provide emergency materials and supplies for stabilization when needed.
- **State of Hope** is an initiative operated by the Georgia Division of Family and Children Services and funds networks of nonprofit partners, such as community based organizations, government agencies, and philanthropic organizations, to implement projects that can prevent foster care involvement. The projects address education, trauma-informed practices and awareness, caregiving, and economic self-sufficiency for families.
- **Maine Foster Youth to Independence** is a joint initiative of the Maine Department of Health and Human Services and the Portland Housing Authority, supports young adults between ages 18 and 25 who have experienced foster care and need housing support. The initiative helps participants find and keep housing—including through direct housing vouchers and by connecting them to services that promote education, employment, economic mobility, and self-sufficiency.
- **Maryland Assistance in Community Integration Services Pilot** provides tenancy and case management services to help individuals with chronic or emergency health challenges obtain housing and other medical and social services. Maryland conducted the pilot using Medicaid waiver funds in four jurisdictions Baltimore City, Cecil County, Montgomery County, and Prince George's County before authorizing state funds to expand the pilot.
- **Ohio Children's Trust Fund** implements the online version of the Positive Parenting Program+ (Triple P+). The initiative provides free parenting courses, and interested families can receive supplemental coaching from accredited parent educators. Families who receive home-visiting support also receive a gift card for basic needs due to elevated financial risk identified during an assessment.
- **Oregon Department of Human Services Family Support and Connections** helps families with low incomes by connecting them to a Family Advocate. Advocates use home visits to help families address emergent needs and increase protective factors to prevent child abuse and neglect.
- **Vermont Parent Child Center Network** coordinates general prevention services for families with low incomes through 15 Parent Child Centers located throughout the state of Vermont. These centers use a family-centered, multi-generational, strengths-based approach to both treat and prevent adverse childhood experiences in families.

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