

CT Family First Kinship & Foster Care Meeting Notes

Date of Convening: February 14, 2020

Agenda

- Welcome & Introductions
- Reflections & Progress
- Break
- Policy Exploration: Breakout Session
- Group Report-Outs
- Closing

Review of Barriers and Reflection

- The Kinship and Foster Care workgroup's charter is posted on the [Family First Website](#)
- Last week, the group looked at data along a continuum ranging from community supports (before DCF involvement) to post-permanency. The supports identified are summarized below:

In the Community (Non-DCF)	During Careline Engagement & Voluntary Services	In Foster Care	After Achieving Permanency
<ul style="list-style-type: none">• Probate court• 211 referral & information• Department of aging• Local Human Services Department• Support Groups• Office of Early Childhood (OEC)• Department of Social Services (TANF-Medicaid)• Family Initiated Arrangements	<ul style="list-style-type: none">• Non-DCF Involved• DCF-Involved	<ul style="list-style-type: none">• Caregiver Support Team (CST)• Attachment, Regulation, & Competency (ARC Grow)• DCF Service Array• CPS/Foster Care/Therapeutic Foster Care/Family Community Ties• Connecticut Alliance of Foster & Adoptive Families (CAFAP)• State Department of Education• Quality Parent Initiative (QPI) - On the horizon	<ul style="list-style-type: none">• Subsidy (PTOG-STOG-Adoption)• Adoption Assistance Program (APP)• All services listed in "Non-DCF"

- As mentioned in the charter, the focus of this meeting is policy exploration. The continuum concept will carry throughout the meeting, where we will discuss possible policy changes at each stop in the continuum above.

- The workgroup reviewed the barriers that were identified at each point in the continuum using a presentation, which is available on the [DCF website](#) and titled "Kinship and Foster Care Workgroup Policy Exploration." The group then reflected on these barriers. These discussions are summarized below.
- In the Community (Non-DCF)
 - One person was surprised by the statistic that only 20% of families involved with probate cases are also involved with DCF. This raised the question of how we access the 80% that are not CPS-involved. This point was clarified by a representative from probate court. Almost all probate cases do involve a home study that is done by DCF; this is used to determine whether a home is suitable and then there is an initial decision on whether to approve and end DCF involvement or if the family would need further DCF involvement; however, 80% of families served through probate court do not have an open case with DCF. In cases of temporary custody, the home study process typically involves DCF looking at the guardian, birth parents, history of the family, and basic information initially. When it is for the removal of guardianship, there is a longer additional assessment involved.
 - Another reflection was that although probate court may be involved due to family issues, there are not many supports in the probate system to help connect these families with resources.
 - A sentiment that many families have is that it is easier to go through probate court than through DCF. This may not necessarily be true, but even though probate court can be a long process, the way families look at and approach child protective services (CPS) involvement makes them wary of reaching out to DCF.
 - One provider explained that a major gap is present in the mental health system. Often parents, caregivers, and children all need support, but Medicare does not reimburse family-based treatment as well as it does individual therapy. When providers have to choose which option, they often opt for the individual therapy because it is reimbursed better, even though family-based treatment may be better for the family's needs. If it were possible to make the reimbursement more equal, then more providers would take that option. JoShonda reframed the issue and suggested that perhaps destigmatizing and encouraging family therapy would be another way to approach a solution. The provider wondered whether Family First could provide any funds that would reduce the financial barrier to family-based therapy. Family First is the payer of last resort and

cannot supplant funding; while it can be used to expand capacity for certain programs, this is only for services referenced in our plan (and then, only for the specific populations we have identified as candidates). There would be money for kinship supports, but this is different funding that occurs outside of the primary focus of the Family First legislation. The goal of this meeting is to focus on policy areas where we can make changes.

- Another provider expressed their belief that part of the issue is overreliance on younger, newer workers who do not have the experience to provide good quality services. Older, seasoned workers who can provide better service can't afford to provide these services.
- Additionally, there are many parts of Connecticut where no services are available. Services are often clustered in certain parts of the state, and not everyone can access those areas. There need to be more hubs and more therapists.
- It was also discussed that more therapists are needed at Planning and Placement Team (PPT) meetings and more in-home services are necessary to better serve families. Again, reimbursement becomes an issue here as the reimbursement for in-home services is lower. We need to match kids to services, not match providers to reimbursement; unfortunately, the reimbursement continues to be an issue.
- One member explained that some of this conversation is problematic. Age should not be used to disqualify people's opinions and value. The folks in the room need to understand that some young folks may not have that experience that is needed, but some do. Allyship and lived experience make younger folks more prepared to deal with these kinds of issues. Of course it is important to deliver high-quality care, but it is not fair to assume that younger providers are less capable of delivering that.
- Along with that, another provider explained that there are five universities in the state that license family therapists--there is not a lack of qualified people. Perhaps we just need better partnership with these universities. Furthermore, we are talking about a major public health shift, and these do not just happen overnight. There are many large, great systems in Connecticut that just do not talk enough to each other. They would suggest pulling these universities in and examining some of the requirements (as certain licenses are not sufficient for certain reimbursements from Medicare).

- Careline Engagement and Voluntary Services
 - One person explained that a big issue is disrupted adoptions. How do we put "bumpers" around this?
- Post-Permanency
 - A member discussed how there is a gap with the siblings of adopted children.
 - Family systems dissolve or weaken due to trauma.
 - In cases of transfer of guardianship or adoption, there are caregivers who don't necessarily want to be involved or even do visits with birth parents. These relationships are very strained. Who can help navigate these relationships? How does that connection stay once DCF's involvement ends?
 - One workgroup member who works with college youth who have experienced foster care or adoption discussed the ways a college stipend affected them and their students. A college subsidy/stipend was a safety net that helped them after their adoption dissolved. It is hard to track these situations, but youth who experience kinship transfers of guardianship have some of the highest need. They are very vulnerable, and issues that occur later like homelessness and incarceration are far more expensive in the long run. The subsidy/stipend system is therefore one of the biggest ways we can support these youth.
 - The group agreed with this, but the point was also made that it is important to also provide supports for those who are not on the college path. These youth "fall off the face of the earth" and are often forgotten about.
 - One point of discussion was the difficulty in terminology. "Adoption" vs "transfer of guardianship" are two different situations that result in different benefits, but for many families, they appear to be the same thing. This is something that needs to be clarified for families. Adoption is difficult to pursue because there needs to be a big reason for it to happen. Also, many families do not want to adopt due to cultural or familial reasons, and they simply won't regardless of the benefits that might be added if they were to do so.
 - It was suggested that perhaps the subsidy system be reexamined. Perhaps the subsidy should go past eighteen (to age twenty-one) for kids with IEP or stop at age eighteen, and then give the child the adoption subsidy. The two tracks could both be considered when the child is at age sixteen and the decision could be made based on the child, not the family.
 - Age limits was identified as a barrier for youth who want to go to college. Some youth could have gone to college if their trauma had been addressed. They

needed time to catch up emotionally, but by the time they are ready, they are too old to receive the supports available to younger folks. One member explained that this very thing happened to her son. He was not ready to go to college after he graduated, but he now does not qualify for the subsidy because he is too old.

- Another person explained that there are also lots of students who are unsuccessful in college. These students use subsidies but never complete their studies. If there was a way to identify who would be successful in college and focus subsidies on those students, this could be a way to reduce waste.
- One member pointed out that the group had just spent twenty minutes talking about college policy. College is great, but not everyone needs to go to college. If we want to create a truly inclusive plan, we need to understand that there are other pathways for youth to be successful. Students who do not go to college for whatever reason need to be included.
- The workgroup agreed that the SUN Scholars was a good model. It provides mentors and supports throughout college. How do youth without support make it through college? How could we expand the SUN Scholars program?
- An important note is that college prep does not begin senior year. It needs to be discussed much earlier because if it is not seen as an option, students may not strive for it.
- Another issue is that some children do want to go to college, but the final decision lies with Central Office (C.O.), who does not know the youth as well as those who have worked directly with them. Along those same lines, sometimes C.O. will not pay for driver's ed for students, which is often very expensive.
- One workgroup member emphasized that the important thing is not where you start, it is where you end up. They personally began their college career at community college and is now a graduate student at Harvard. Quantitatively, about 3% of foster care youth graduate college nationally. In Connecticut, it is around 7%. Yet around 30% enroll in college--where do they go? Why do we not better support these youth? The first year of college is challenging for everyone, but couple those struggles with trauma and it is even more difficult for foster care youth. Wraparound services are key here, as is trauma-informed pedagogy. They also shared the story of one of their mentees: this student almost failed out twice but was ultimately able to pull themselves up to a 3.5 GPA and is doing a policy internship. These programs and funding are beneficial because they

help students in these difficult situations and provide support when it is most needed.

- Another important point is that this is not a zero-sum game. Talking about college support does not mean that we will not also support foster care youth who do not go to college. We can do both.

Break

Policy Exploration: Breakout Session

Group members were randomly assigned to 1 of 4 groups and were asked, "Based upon what we know about the identified policy limitations, what are some strategies/opportunities for improvement? Where are strengths? What limitations exist?"

Group Report-Outs

The groups then shared the results of their discussions:

- **Group 1: Community Supports**

- Strengths & Opportunities to Enhance
 - Current probate funding → expand funding
 - Increase funding to Adoption Assistance program, provide social workers to increase services (make available to any family)
 - Increase access to programs (and knowledge on how to access)
 - Use probate and 211 to direct all families to trauma-focused trainings (bio, kin, foster, adoption)
 - Use (FC)-FFT available to all families (in-home service)
- Policy Limitations
 - Age barriers to access services
 - Not enough experienced, quality, family-focused therapy
 - Make sure higher education trains students to work with kinship families + foster families
 - Have in-home or office family therapy to ALL families to assist in family preservation
 - Fiscal limitations in probate court, reimbursement rates
 - Need to level the playing field: fiscal, wraparound support systems
 - Have state study to look at outcomes, focus @ on programs that are working (and get data)

- **Group 2: During Careline/Voluntary Services**

- Strengths and Opportunities to Enhance

- FAR workers help navigate systems
- Great services available
- Opportunity to expand services to all kinship care situations w/o need
- FAR, CST, CAFAF, Probate Court already exist
- Beacon taking over Voluntary Services
- Policy Recommendations: 1) Entry points for assistance need to be changed; 2) Criteria definitions need to be changed/expanded; 3) Coordinated handoff when worker changes.

- Policy Limitations

- Length of time to respond to Voluntary Services
- Different phone number for Voluntary Services
- Hard for families to call for Voluntary Services due to stigma
- Training for 211 personnel
- Kinship Navigator for everyone
- Some services end post-transition when needed
- Lack of knowledge of services
- Need an accepted case/Careline call for assistance
- Does 211 ask enough questions? (e.g. are you in foster care?)
- How well-trained are providers on using the 211 services? Does 211 do enough training around the state?
- Policy Recommendations: 1) Make an in-person kinship navigator system; 2) Voluntary service packet is daunting--make shorter/more streamlined; 3) Some services require DM5 serious diagnoses--reexamine these requirements.

- **Group 3: In Foster Care**

- Strengths & Opportunities to Enhance

- MDE-need to extend hours so kin can attend
- MDE also need to include assessment of strengths + needs of kin/FH to better recommend services to support success
- After-school summer programs (12+ up)
- 48 hours: prudent parenting policies
- Multidisciplinary work

- Policy Limitations
 - Training caregivers--child-specific, trauma-informed, whether in congregate care, JJ, or in-home.
 - Navigators who know policy process and can attend PPTs, ACRs, and court
 - Kinship-specific training provided in home
 - MDE hours extended-clinical component occur in FH
 - Assessing family/kin during MDE as component
 - Mandatory training on cultural competence. Sensitive--onus on provider to be humble and learning
 - Time-sensitive limits extended (currently restrictions on services such as ICAPs)
 - Training for providers that prepares staff for in-home/family work
 - Policy Recommendation: Extend timeline for services
 - Following the family--DCF, SW, providers all integrated and eliminating regional boundaries
 - Summers and after-school (12+ up) and summer employment
 - Availability of service hours
- **Group 4: After Permanency**
 - Strengths & Opportunities to Enhance
 - Review age requirements for post-secondary education (college, vocational, trade schools)
 - Bring in more therapists--especially adoption-competent therapists. Strategies include developing lists of therapists who are vetted, house the list with AAP, emphasize competent and culturally competent therapists, pay higher rates, emphasize good training and understanding of trauma.
 - Case coordinators and other services that help navigate relationships with bio family following TOG/adoption
 - Make AAP more widely available
 - Communication--clinicians don't engage enough in the supportive parts of therapy (need someone to facilitate collaboration and wraparound meetings)
 - Challenge Medicare reimbursement rates
 - Schools

- Insurance
- Collaboration
- Co-parent councilor
- Psychiatrists
- Services to help build skills in families so they can negotiate and navigate the systems
- High-fidelity wraparound services (mass model + intensive coordination of care)
- Make sure families understand trauma and how it will keep resurfacing
- Better prepare adults and children for permanency, including working with the bio family
- Supports and services are in place prior to finalization and then many disappear--need them to continue because trauma keeps coming up (e.g. developmental triggers)
- Need to have housing options for older relatives (esp. grandparents) to be able to accommodate children)
- Hubs across state so families can get good services no matter where they live
- Active support groups with childcare (Casey used to have these for post-adoption families)
- Need to review services before, during, and after permanency
- Ongoing trainings
- Policy Limitations
 - Insurance
 - Psychiatrist (child)
 - Communication
 - Psy. Hospital emergency/crisis management
 - School knowledge of our kids

Next Steps

- The workgroup will meet again in two weeks on **Friday, February 28 from 9 am-12 pm at Beacon.**
- The group agreed they felt so far, they have made several solid recommendations.
- JoShonda summarized the narrow candidacy population that has been finalized by the Candidacy workgroup:

- 1) All accepted Careline calls. This includes both Investigation (INV) and Family Assessment Response (FAR) tracks. It also includes all calls for voluntary services.
 - 2) Pregnant and parenting youth in foster care.
 - 3) Siblings of children in foster care.
 - 4) Youth exiting to permanency. This includes reunification, adoption, etc.
 - 5) Youth who have aged out of the system.
 - 6) Community pathways
 - a. Caregivers with a disability, mental health, or substance use issue that impairs their parenting
 - b. Families with a child with a disability, mental health, or substance use issue
 - c. Substance-exposed infants
 - d. Homeless or unstably housed youth or families
 - e. Trafficked youth
 - f. Children and youth who are truant or chronically absent from school/preschool
 - g. Families experiencing intimate partner violence (IPV)
 - h. Youth with incarcerated parents
 - i. Youth involved with juvenile justice (either involved with the Juvenile Review Board or arrested)
- One person asked whether there was an age limit to receive services. JoShonda explained that to be in the candidacy pool, a child/youth has to be under the age of 18, unless qualifying under the age-out population portion of the definition, then under age 21.
 - One member asked whether autism would be covered under that definition. JoShonda responded that the workgroup did not list out specific diagnoses, but it would likely fall under 6a and/or 6b.
 - Another person wanted to know if medically complex youth/caregivers were included in 6a and 6b. JoShonda felt this was something the Candidacy workgroup would need to review, but also felt it unlikely that they would disagree with including this population.