CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES

We All Need Somebody:
Supporting Children, Families and the Workforce in Connecticut's Family Foster Care System

A REPORT IN THE "FOSTERING THE FUTURE" SERIES

September 30, 2011

Table of Contents

Prologue*

Sometimes in our lives we all have pain
We all have sorrow
But if we are wise
We know that there's always tomorrow

Lean on me, when you're not strong
And I'll be your friend
I'll help you carry on
For it won't be long
'Til I'm gonna need
Somebody to lean on

Please swallow your pride
If I have things you need to borrow
For no one can fill those of your needs
That you don't let show

Lean on me, when you're not strong
And I'll be your friend
I'll help you carry on
For it won't be long
'Til I'm gonna need
Somebody to lean on

If there is a load you have to bear
That you can't carry
I'm right up the road
I'll share your load
If you just call me.

So just call on me brother, when you need a hand
We all need somebody to lean on
I just might have a problem that you'd understand
We all need somebody to lean on…

"Lean on Me," by American songwriter and musician Bill Withers, topped the billboards in 1972.
NOTE: DCF foster youth have created an amazing music DC called "We all need somebody: A compilation of songs…really good gongs."

Message from the Commissioner

The opportunity to grow up as a member of a healthy family, to succeed in school and participate in one's community in a positive and character-building way are my goals for each youngster in the care and custody of the Connecticut Department of Children and Families. Each of them also must have the opportunity to have and keep a solid relationship with important adults in their lives. Experience leads me to believe that this is also what *most* families want for their children. Science has taught me that this is also what is best for most children.

When a child's birth family cannot provide the care, nurturing and protection that a child needs and deserves, it makes sense to turn to relatives, friends and other families for help. It also makes sense not to irrevocably break the bonds between the child and his or her birth family, even when that child is removed as part of Connecticut's child protection system. At the same time, all children need and deserve to have stability and permanency in their lives. Multiple placements, even in foster family, can imperil successful child development.

In addition to supporting birth families to protect and care for their children at home, Connecticut must expand and better support its foster families as a resource when birth families are not able or willing to do so. Distressingly, we have not done this very well over the past decade. While some improvements have occurred over the recent past, many challenges remain if we are to advance Connecticut's system of foster family care *and* improve the life outcomes of youngsters served by this system. Various forms of input from foster families provide very clear information about what we need to do differently and better.

Foster parents need more respect from our regional office staff. They need to become full members of a child's care and treatment team. And they need access to specialized resources that will meet the needs of the children and youth in their care. Foster families do not report that money is an issue for them, yet we do not compensate families for their work and time, and the funding we do provide for the direct care of children is very low compared with our payments to congregate care providers. Additionally, we know from national studies that many relative foster families already live in difficult economic circumstances *before* taking on a foster child.

This report describes the work we must do to better utilize and support our existing foster families. It proposes a much more focused recruiting effort, with a special emphasis on recruiting kinship and treatment foster families for specific children in our care and custody.

The department’s work and partnerships will be guided by the following principles:

- First, the department’s transformed family foster care system must be built upon what is in the best interest of children and youth. This means we must become better at defining and tracking children’s outcomes over time. In addition to health, safety and learning, we need to focus on reducing multiple placements for children, as each of these represents the introduction of yet more trauma in the lives of vulnerable youngsters.

- Second, we must rebuild a culture of respect and shared responsibility among all members of the team of adults who protect children, support their development and well-being, and assure them a set of “always-there” adult relationships. This work must begin with our own staff

through the re-invention of a culture of respect. It will be anchored in the expansion of our Strengthening Families Practice Model to foster families as well as to families on our caseload. The Practice model rests on four core components: respectful family engagement, purposeful family visits, the use of family assessments, and a family teaming model of case planning and decision making.

- Third, family-based care and treatment will become the Department's primary service delivery system. We will need to expand the use of relative care and implement a broader array of treatment foster care for children who cannot remain with their birth families. This will also require improved case practice connecting foster families with birth families and with congregate care providers throughout the life of a case.

- Fourth, the department must continuously and effectively recruit a sufficient pool of foster care families so that an appropriate match can be made for each child in the care and custody of the department who can benefit from living with a foster family. This will require a more strategic approach to recruitment and training in general as well as attention to child-specific recruiting and matching strategies.

- Fifth, *all* foster families must be better supported in their efforts to provide stable, nurturing environments that advance children's health, safety and learning, and their success in and out of school. This will require enhancements to the child-specific and family-supportive services we currently make available and will also require some adjustment in the agency's current rate structure. Recent national studies of young adults who have lived in the foster family system reveal that mental health services, supplemental educational services including mentors, tutors or educational advocates along with independent living skills development are critical to success after foster care.

With this report, I am launching the next phase of the department's work to advance Connecticut's foster family system. Between September and the end of December, we will explore a range of foster family care models that can provide higher levels of support and resources for children and families. I will then identify those policy and resource changes that will need to be considered as part of the next legislative session.

We will also develop a broader set of steps to guide our reform work between January 2012 and June 2013. Over this period, I expect the Department to secure family foster homes for younger children now in congregate placement, increase the number of family foster homes in actual use, increase the number of placements into kinship care, and decrease the number of foster families who leave the system due to lack of respect, support and resources.

I know that, working together, we can better support foster families ***and*** the children they serve. I commit to a process of renewed partnership, conducted with openness and respect.

Joette Katz, Commissioner
Connecticut Department of Children and Families
September 2011

Executive Summary

The Executive *Summary of We All Need Somebody: Supporting Children, Families and the Workforce in Connecticut's Family Foster Care System* is intended to be read as part of the entire report but also as a stand-alone section. While readers are urged to review the entire report, attention to the Executive Summary will provide a solid summary of the whole.

Summary of Findings

This report presents information drawn from many sources and reveals a series of major findings with regard to how Connecticut's family foster care systems functions today. These findings are briefly summarized below, by section.

Part I: Development of the Report

We All Need Somebody is part of an evolving series called *Fostering the Future*. Reports in this series began with a focus on the Department's most intensive care settings and then examined parts of Connecticut's congregate care system. This report brings the Fostering the Future Series to the family foster system.

As part of the transformation that underlies these evolving reports, the Department of Children and Families has reframed its mission, launched four major organizational changes, and identified six cross-cutting themes that serve as the foundation for change. The mission redirects the agency to work much more closely with families and communities to assure children's health, safety and learning, their success in and out of school, the advancement of their special talents, and that they have opportunities to give back to their communities.

Organizational changes now underway involve implementing a collaborative team structure in the Central Office, refocusing the six regions on comprehensive child and family services, the consolidation our own behavioral health institutions, and launching the DCF Academy for Family and Workforce Development and Knowledge. The six cross-cutting themes are:

- Family-centered policy and practice
- Trauma-informed practice for children, families and this agency's workforce
- The application of the neuroscience of child and adolescent development
- Developing stronger state and community partnerships
- Improving agency leadership, management, supervision and accountability, and
- Advancing the department as a learning organization.

Why does this matter? Because all of these organizational changes will enable the Department to better support child outcomes and foster families who are partners in this work.

Part II: Children's Development, Behaviors and Outcomes

The exploding field of neuroscience provides an important base of knowledge about young children's brain development and also about "executive functioning," which does not fully develop until later adolescence. Because extraordinary development occurs in the first three to five years and is dependent

upon a positive, interactive relationship with consistent caregivers, decisions about how to make the best family foster care placements during this period are critical. Young children are highly vulnerable emotionally to the negative impact of family violence and parental mental health problems. Children who experience multiples risks such as these in their early years are more likely to experience developmental delays, behavior disorders and conduct problems as they age.

Executive functioning involves working memory, the ability to self-regulate attention and behaviors, and mental flexibility. Children who have experienced adversity in their early years, including abuse or neglect, prenatal alcohol exposure and prematurity or perinatal conditions, are more likely to have deficits in executive functioning as they grow up.

There are behavioral correlates of experiencing trauma in childhood. Young children (ages birth through five) who have experienced trauma may reject contact, avoid being touched or be clingy and resist separation. Children in middle childhood (ages six through 12) may have behavior swings ranging from shyness to aggression, may revert back to younger behaviors, demand attention and have problems in school. Adolescents (ages 13 and older) may engage in reckless behaviors, including substance abuse and unprotected sex, have problems imagining a future, lack school success, and act out aggressively or withdraw into anxiety and depression.

Studies reveal that foster care alumni have higher rates of mental health problems and lower levels of educational achievement than the general population. While in foster care they may have access to mental health, substance abuse and educational services but may not utilize them. Foster care alumni are largely employed in the service sector, but fewer than half report having received employment and other independent living skills while in placement.

Despite the often traumatic separation from family and after becoming young adults, 60% of foster family care alumni had reconnected with their birth siblings, 41% were in contact with their birth mothers, and just 21% had contact with their birth fathers. Six in ten (62%) remained in contact with their foster parents. Children and youth who lived in foster family care and then were adopted appear to have a generally warm and caring relationship with their adoptive parents. The younger the child was when the adoption was made, the better these relationships develop over time.

Why does this matter? The ways in which children develop and grow, and the types of behaviors they exhibit over time, are highly related to their early childhood experiences as well as to traumatic events in their lives. The science of brain development and the impact of trauma strongly suggest that significant improvements are needed in agency placement policies, case practice and training for our workers and our foster families. Children's success in later life is very dependent on how *we* manage the placement process, how we ensure their continued connections with extended family members and other caring adults, and how we support a positive educational experience and help them prepare for youth adulthood.

Part III: Some Basic Data on Foster Care

The Department currently utilizes five kinds of family foster care:

- Relative families
- Core foster families
- Special Study families

- Independent families, and
- Therapeutic foster care.

All but homes in the Therapeutic Foster Care Program are recruited, licensed and supported by staff from the Department. Private provider agencies manage the Therapeutic Foster Care Program.

Although the number of children placed out of their homes continues to decline in Connecticut, the Department continues to overuse congregate care and under-use family foster care. Also, the likelihood that children will be placed in congregate care as opposed to family foster care rises dramatically with the age of the child.

In each of the last two years, the Department received slightly over 2,000 inquires about becoming a foster or adoptive parent, but only about 19% of these potential applicants completed the recruitment and licensure process. Including these new families and others recruited for specific children, 1059 new homes were licensed from January through December of 2010. During the same period, 1201 homes left the foster family system, however.

While some foster families exit the system on a positive note because permanency has been achieved for the children in their care, a substantial number of departing families report dissatisfaction with the department, especially with regard to the lack of a respectful, fully participative relationship with agency staff in the area offices.

The Department does not fully utilize all of the homes and beds that it has at its disposal. Reasons for this are being explored, but it is hypothesized that poor real time data and information about the families, their wishes and availability contribute to the problem. In 2010, 541 children were successfully placed in adoptive homes.

In December of 2010, the Department has 3,328 children and youth in family foster placements. Of these, 699 were in relative care. In mid-September of 2011, the Department had 3,163 children and youth in family foster care, of which 832 were in relative care.

Why is this important? Any changes to the current system of family foster care in Connecticut must be anchored in a set of quantitative as well as qualitative performance outcomes that can be measured, tracked, evaluated for effectiveness and reported on for public accountability. We cannot know what we do not measure.

Part IV: Challenges in Connecticut's Family Foster Care System

External and internal reports on Connecticut's family foster care system reveal five areas of major challenge that must be addressed. First, in a recent survey, 30% of foster families reported not feeling respected and valued by the Department. This includes not having their phone calls returned, not receiving essential information and being treated "like the enemy" by area office staff.

Second, policies, practice and paperwork frustrate foster parents and inhibit their ability to accomplish the job they signed up to do. Examples include feeling trapped between child welfare staff and foster care staff with no ability to get case issues resolved, paperwork that is lost with no notification to foster parents, long wait times between licensure and having a child placed in their homes, and the fear that if they advocate for their children they will lose them. Specific departmental policies are also cited as

problematic, including those having to do with sleepovers, texting birth parents, the care of medically complex children, and "unrealistic" timeframes related to reunification.

Third, foster families are not included as partners in the case process, and they report that workers view them as a commodity and tend not to involve them in the case process, whether in the assessment phase, case planning, placement or transition steps in the process. Foster parents also report experiencing challenging relationships with birth parents and birth grandparents. Three in ten foster parents indicate that the child's social worker does not discuss the child's treatment plan with them.

Fourth, they experience limited access to agency and community supports and child-specific services. They report needing more mental health supports for children and themselves, especially for the child when he or she is in crisis and for themselves after a child leaves following a lengthy placement. Nearly four in ten parents report feeling inadequately supported during times of unusual stress within their foster families. One quarter do not feel supported during times of birth family visitation. Families also want help to enroll in such services as day care, WIC and other child nutrition programs. They need more help to deal with the behavioral problems of teenagers in their care. They also would like their high school foster children to have access to computers and community-based teen activities.

Finally, while parents do not regularly complain about the rates they are paid to cover the expenses of taking in a foster child, they do say that they need more help with food and clothing costs. A review of the national literature on the economic well-being of foster parents reveals that many foster parents, especially relative caregivers, live in low-income households. A review of Connecticut's foster family rates as compared with daily rates paid to congregate settings shows that foster families receive between $28 and $55 per day, while the rate paid to congregate caregivers is generally ten times that much.

Why does this matter? Because a system that continues to behave in the same way while expecting different outcomes cannot succeed. The culture change required of the Department is enormous but achievable. Policy and practice changes are already underway, but greater attention to assuring that family and child supports are available remains a substantial area of work. If we cannot address the concerns of foster families in a real and timely manner, the Department will continue the cycle of recruiting and then losing its valuable foster family resources. And as more children and youth require access to foster families, these problems will grow.

Part V: Exploring Models of Family Foster Care

Family foster care is understood to have six core functions:

- Emergency protection for children
- Crisis intervention
- Assessment and case planning
- Reunification support
- Preparation of children for adoption, and
- Preparation of youth for independent living.

National research on kinship/relative foster care shows that these placements are as safe for children as traditional foster care; they also provide more stable placements than those in unrelated foster families.

Siblings are less likely to be separated in kinship care, and children are more likely to maintain community connections. Finally, relatives are frequently willing to adopt or become permanent guardians when reunification with birth parents is not possible.
Kinship families do have special needs, however. They tend to be older, less financially secure and in poorer health. They often are also unmarried as compared with traditional foster families. Nonetheless, children in kinship care have been shown to have significantly higher well-being than children in non-relative placements. The Department has identified relative families as the placement of choice when children are removed from their birth families. From January through September of 2011, the number of children placed in relative families has increased from 699 to 846.

There are many models for the delivery of treatment foster family care, also called therapeutic foster care. Connecticut's Therapeutic Foster Care Program requires more training for families and offers more supports than are required of or provided for relative or traditional foster families. The reimbursement rate for families in the Therapeutic Foster Care Program is significantly higher than that paid to most other families in Connecticut's foster care system.

Two other models of treatment family foster care are available on a very limited basis in Connecticut but are more widely used in other states. Multidimensional Treatment Foster Care has been shown to be very effective with youth with significant behavioral problems and those with involvement with the juvenile justice system. It also costs significantly less than congregate care placements. This model includes specialized training and support for foster parents, family therapy for birth parents, skills training and supportive therapy for youth, and psychiatric consultation and medication management. In a randomized research study in California, this model of family foster care was found to be more effective than "case work services as usual," with fewer placement disruptions, more frequent reunification with birth parents, and lower rates of child behavior problems.

Professional Parent Foster Care is yet another promising model in operation in several states as a cost-effective alternative to congregate care placement. In this model, the foster parent is an employee and is trained to function as a treatment professional who works closely with the child's team to implement all aspects of the child's individualized case plan. A small number of children, many of whom carry a significant mental health diagnosis, live in the home of the Professional Parent. The Professional Parent model provides access to support personnel, requires regular meetings with team members, and assures 24-hour access to emergency on-call support as needed.

Finally, although not a foster care "model," the department's work to implement the W.R. Settlement has shown that child-specific services can be provided successfully in family settings to prevent congregate care placements or return children from them. These wraparound services include assessment and evaluation, in-home therapy, and after-school programs. The cost to deliver these services is dramatically less than congregate placement would be, and they are as applicable to foster families as to birth families.

Why does this matter? Because with the department's policies emphasizing the use of family-based care and treatment settings over the use of congregate care, many more children will need relative and treatment-trained foster families for both short-term stabilization and longer-term treatment and permanency. The Department will explore new foster family models, the modification and enhancement of current models, and will work with young people, foster families and private providers to assure expanded access to foster family supports, child-specific services and fair cost models.

Part VI: Ongoing Work to Advance Connecticut's Foster Family System

Since the new administration took office eight months ago, major changes in agency policy have been undertaken. These include a policy of announced visits, the use of relative family foster as the preferred placement for children and youth, the prohibition of congregate care placements for children ages six or younger and a dramatic reduction in the use of congregate care for children ages seven through 12 years of age. When congregate placements *are* utilized, foster families who will receive the child after placement will be increasingly involved in the case planning and transition process.

Practice changes now being implemented will also result in a more respectful and effective relationship with foster families. As the department's Strengthening Families Practice Model is implemented statewide over the next 12-15 months, it will also be applied to foster families. Core elements of this Practice Model include respectful family engagement, purposeful family visits, the use of family assessments, and a family teaming model for case planning and placement decision-making. In addition, the department's Academy for Family and Workforce Knowledge and Development has begun to work with the Connecticut Association for Foster and Adoptive Parents to include significant training for foster parents on the effects of trauma on children's development.

The Department has implemented a modified organizational structure in the regions and central office that will increase support for foster families and hold regional administrators responsible for a cultural shift in how foster families are treated by area office staff. Regional administrators now have supervisory authority for foster care recruitment and support staff as well as for intake, continuous treatment, and systems development staff. This will enable the regional administration to identify and correct schisms that currently arise between child protective services and foster support services staff. It also makes regional administrators responsible for improving recruitment, utilization and retention of foster families.

Three key statutory changes were made in the 2011 Connecticut General Assembly's spring session. First, *An Act Concerning Kinship Care* gave the Commissioner of the Department the authority to waive certain aspects of the licensure requirements to facilitate the expansion of relative foster care. Second, *An Act Concerning Placement of Children with Special Study Foster Parents* eliminates the minimum age requirement for the Department to temporarily place a child with a special study foster family. Third, *An Act Concerning Access to Records of the Department of Children and Families* expands the list of parties to whom the Department may disclose records, including foster and adoptive parents.

A public-private effort has been launched, called the Continuum of Care Partnership, to secure the assistance of the private provider, advocacy and philanthropic sectors in assessing the impact of new policy and practice changes on the private sector, identifying service gaps and creating joint training opportunities. This working paper, along with other reports in the Fostering the Future Series, will serve as the basis for the Partnership's deliberative process. A first report is due to the Commissioner in later December 2011.

A strategic outreach and communications process has been underway to improve and expand the department's recruitment of family foster care. An electronic tabloid and other recruitment tools are nearing completion. In addition, the Department will continue its relationship with the Child Welfare Strategy Group to identify barriers to utilization and retention and develop solutions specific to each area office.

Part VII. The Way Forward: Building a Better Family Foster System

The report proposes a set of six strategies, which if implemented, will dramatically improve Connecticut's family foster care system and increase the likelihood that the developmental outcomes of foster children will be better.

1. Strategies to retain current and newly recruited foster families

a. Culture: Rebuild a culture of respect among foster families and department staff by including foster families as true partners in the Strengthening Families Practice Model's core elements (family engagement, purposeful visits, family assessment, and family teaming in the case process). With the Child Welfare Strategy Group and the DCF Academy for Family and Workforce Knowledge and Develop, design and implement a "culture of change" campaign for supervisory and managerial staff at the Department

b. Communications and Engagement: Improve the communications process between area office staff and foster families, including prompt, welcoming and informative email, phone and in-person contacts, and respond rapidly to requests for help. Conduct automatic reviews of all foster homes that have not been used in the first 45 days, to inform and counsel them if there are agency reservations about their future use or, if the agency intends to place children, to engage them in ongoing reviews of children needing placements.

c. Feedback: Strengthen the feedback process between foster families, the CT Association of Foster and Adoptive Parents and the Department through regular review of foster parent satisfaction information. Work quarterly with the DCF Ombudsman's Office to review complaints and problems reported by foster families. Contact all foster families at the point at which children in their care are moved to support them through this transition. This is especially important if the placement has been of long duration.

d. Community Supports: Assist families to access community supports, including such programs as the Earned Income Tax Credit, Food Stamps (now called SNAP), WIC nutrition programs, 211 Information and Referral services, 211 Child Development Infoline, adult education and workforce development programs.

e. Family Supports: Improve access to family supports, including formal and informal mentoring, faith-based support networks, fatherhood programs, grandparent support groups, preschool and afterschool programs and educational advocates for children in their care, Connecticut's Help Me Grow Program and address issues related to the use of respite care

f. Crisis Intervention: Assure that foster families can get access to 24-hour emergency assistance and support when behavioral problems emerge with the children and youth in their care.

g. Training: Provide or link families with training and learning opportunities that match the care and treatment needs of children and youth living with them, including education on child and adolescent development, the special needs of infants, and how to recognize and deal with trauma-induced behaviors. Assure that training offered both before and after licensure reflects

the department's six cross-cutting themes. Assure agency policy requires comparable training (including both time and content) across all types of foster families.

h. Cost Projections for Service/Support Expansion: Develop cost estimates for expanded wrap around services (child-specific) and family supports needed to retain families in the foster care system. Request authority to utilize a variety of fiscal strategies to ensure that sufficient funds are available for both child-specific services and family-supports in the current fiscal year,

i. Cost Projections for Expanded and New Family Foster Care Models: Research and develop alternative service delivery models and companion performance outcomes for resourcing and compensating foster families. Develop new fiscal policies, as needed, to implement expanded and new family foster care models, including such policies as "money follows the child," one-time transfers of funds *from* the board and care account for residential and other forms of congregate care *to* the foster family care and community services accounts, and transfers across accounts using the existing governmental Finance Advisory Committee (FAC) process.

2. Strategies to improve outcomes for children and youth in foster family care

a. Developmental Assessments: Develop agency policy requiring foster families with young children to participate in Connecticut's free Help Me Grow program, including the use of the Ages and Stages Questionnaire to track growth and development in children ages birth to six. As required by federal law and internal department policy, assure that all children under the age of three years placed in family foster care are referred to the Department of Developmental Services for mandated B-3 Program assessment and services

b. Youth Involvement: Modify the case planning process to include youth and foster parents in team meetings to improve placement matches and reduce placement disruptions and multiple placements.

c. Sibling and Family Contact: Implement procedures to make it easier for children and youth in foster family placements to maintain contact with birth parents (as appropriate), siblings and extended family members.

d. Child-Specific Services: Develop and implement procedures for foster families to access child-specific services based on individual development needs and trauma histories of the youngsters in their care. These services may include developmental assessments, clinical assessment, in-home and/or community therapeutic services, special education services and supplementary academic supports such as tutoring, independent living, work and learn programs. Note: This work involves both assuring that services are available (access) but also that foster youth participate in them (utilization).

e. Educational Supports: Assure that foster families, departmental staff and youth have access to educational records in order to support the academic progress of youngsters in foster family care. Engage with volunteer educational advocates to assure that students receive IDEA and other services for which they are eligible. Encourage youth to aim for a high school degree rather than a GED.

f. Health Services: Examine the feasibility of creating a "health passport" for foster children and youth that captures information about the health status and needs of individual children and moves with them throughout their engagement with the Department of Children and Families.

g. Special Talents and Community Service: Develop a process, as part of foster children's plan of care, to identify and promote their special talents, skills and interests and to link them with volunteer and civic opportunities to give back to their communities.

h. Transitions: With youth and representatives of the foster family and congregate care sectors, develop and implement a "tool kit" to guide and support children and youth during transitions in and out of placement. Because studies show that youth transitioning out of the foster care system seek to re-establish or maintain contacts with birth family members, siblings and foster parents, transition planning must support and foster these ongoing connections.

3. Strategies to Improve case planning, matching and transitions

a. Family Teaming: Implement a "family teaming model" including the involvement of foster families as the 4th component of the Strengthening Families Practice Model. The use of family teaming means that youth (as appropriate) and family members participate in person at various points in the case process.

b. Trauma-Informed Policy and Practice: Assure that children's trauma history is included as part of information provided during the case planning and matching process. Assure that this information is linked to training in the provision of child-specific behavior management and support strategies for foster families.

c. Transfer Policy and Practice: Ensure that departmental policy requires congregate care providers to include foster families in the treatment and transition process related to children and youth who will enter their care. Evaluate models for possible implementation that compensate congregate care providers to provide follow-up contact and treatment (for up to 90 days) in the homes of foster families who receive children from congregate care placements.

4. Strategies to improve outreach and foster family recruitment

a. Outreach: Utilize electronic, social media and personal contact to reach the general population in Connecticut as well as specific audiences targeted for recruitment. This would include use of the new Electronic Tabloid, forums with the faith community representing African American and Latino families, and other activities specified in the department's emerging Strategic Communications Plan.

b. Improved Recruitment Materials and Tools: Develop a Frequently Asked Questions document for prospective foster and adoptive families that presents current data on children in foster family care in Connecticut. Explore development of a web-based "chat room" for prospective families to support them during the recruitment, licensure and pre-placement period.

c. Recruitment Barriers Analysis: With the Connecticut Association for Foster and Adoptive Families, evaluate the entire recruitment process to identify at what points prospective foster families "drop out" and then devise strategies to remove these barriers to the greatest extent possible.

d. Child-Specific Recruitment: Develop, implement and assess the effectiveness of child-specific recruitment of foster families, beginning with foster family homes for younger children to prevent congregate placements and to return young children now in those placements. Address youth permanency needs by focusing agency attention on creating foster family homes and adult connections for older youth now in congregate care.

e. Cohort-Specific Recruitment: Develop, implement and assess the effectiveness of targeted recruitment strategies for identified cohorts of youngsters served by the Department, including infants and toddlers, sibling groups, medically complicated children and youth, children and youth with complex mental health problems, and gay/lesbian/bi-sexual and transgender youth.

5. Strategies to expand kinship and treatment family foster care

a. Kinship Care: With the Child Welfare Strategy Group and the Connecticut Association of Foster and Adoptive Parents, devise and implement a two-year work plan to increase the recruitment of and support for kinships families, including relatives and special study homes. Continue to modify agency policy and improve practice as necessary to remove barriers to kinship placements. Support kinship families to develop their own support networks to promote self-help, mutual support, leadership, shared resources and advocacy. Develop performance measures including recruitment target, placement and outcomes by region, track performance and report outcomes over time.

b. Treatment Foster Family Care: Explore the development and/or expansion of Multidimensional Treatment Foster Care and Professional Parent Foster Care for implementation by the Department of Children and Families. Develop cost models, need and utilization projections, and an implementation plan for the period between July 2012 and June 2013.

6. Strategies to improve results accountability and data use and to secure legislative approvals (as needed)

a. Performance Measures: In consultation with the Juan F Court Monitor, Child Welfare Strategy Group, Continuum of Care Partnership and the Connecticut Association of Foster and Adoptive Parents, propose a set of Results Based Accountability (RBA) performance measures for implementation beginning no later than July 1, 2012. The measures should address: how much service is provided (with detail); how well the service is provided (with detail); and the degree to which both foster children and youth and foster families are "better off" as the result of this work and investment.

b. Data Infrastructure, Development, Use and Reporting: In consultation with Casey Family Programs, the Child Welfare Strategy Group and senior departmental leadership, develop a short- and medium-term set of proposals to improve all aspects of data use and support related to the delivery and effectiveness of foster family services in Connecticut. This should include any

changes needed to affect data exchange and sharing across state agencies related to case coordination and the provision of services to foster children and foster families by other state agencies.

c. Legislative Action: Develop and submit such legislative proposals as needed to secure clarification of existing policy or law, or new statutory authorizations related to changes in Connecticut's family foster care system.

Next Steps

Following release of both the Executive Summary and the complete report, the Department will engage in the following next steps. First, the internal process of analysis and cost modeling will continue over the next 90 days in order for the agency to describe its needs for the current year (SFY 11-12) to appropriate executive agencies and to the legislative branch. This analytic process will draw upon the expertise and knowledge of outside groups and organizations, including the Connecticut Association of Foster and Adoptive Parents, the Continuum of Care Partnership, the network of providers associated with the Connecticut Therapeutic Foster Care Program, and both national and regional technical assistance and consultation resources.

Second, department staff will work with interested stakeholders, including the Connecticut Association of Foster and Adoptive Parents and the new Continuum of Care Partnership, to review and prioritize proposed action items within each of six strategy areas for modification or implementation over the period January – June 2012, and July to June 2013.

This collaborative work will result in a strategic work plan for advancing and expanding a vibrant, effective family foster care system for the State of Connecticut. The work plan is expected to be completed as soon as possible, but in no case later than January 30, 2012.

The Report in Detail

Part I: Development of the Report

This report is part of the Connecticut Department of Children and Families' *Fostering the Future* Series. The first report in the series, *The Future of Riverview*, was released in April, 2011. It described a process to consolidate the department's two behavioral health institutions.[1] This consolidation has resulted in the operation of a single institution, the Albert J. Solnit Children's Psychiatric Center. The Solnit Center provides psychiatric hospitalization for children and youth as well as six brief treatment residential units for adolescent boys and girls with significant psychiatric and behavioral challenges.

The second report, *Congregate Care Rightsizing and Redesign*, was released in August 2011. It outlines a series of dramatic policy changes that will result in the reduction of congregate placements for younger children, shorter length of stay in placement over time, and the more significant involvement of families and foster families with children in the congregate care system in Connecticut. Additional reports in the *Fostering the* Future Series will address the use of restraints and other emergency safety interventions, the educational needs and progress of children in its care and custody, and will help us to apply the neuroscience of children's development to our policy and daily practice.

In *this* report – *We All Need Somebody; Supporting Children, Families and the Workforce in Connecticut's Family Foster Care System* -- we describe both challenges and opportunities to better serve vulnerable youngsters who must be removed (for at least some period of time) from their birth families. Building more respectful relationships with foster families, including them as full partners throughout the case process, providing them with essential information about the children they are serving, and better meeting their resource needs (in terms of type, amount and timeliness), will result in a more robust and effective system of family foster care.

The Department's Reframed Mission and Cross-Cutting Themes

Since the appointment of Justice Joette Katz as Commissioner of the Connecticut Department of Children and Families (DCF) in January 2011, the agency has been engaged in a period of dramatic change and realignment. These changes are all built around a revised vision for children and youth served by the Department. This expanded view moves the Department from a dominant focus on "safety and placement" to one that also embraces children's health and learning within the context of a family-centered framework:

> *In partnership with families and the community, children and youth served by the department will grow up healthy, safe and learning, and will experience success in and out of school. The department will advance the special talents of the children it serves and will make opportunities for them to give back to the community.*

The Department has also identified six cross-cutting themes that will be applied to all agency operations, including the changes to the foster family system to be proposed later in this working paper:

[1] A second Interim Report was released in July and the Final Implementation Report will be published early in October 2011. These reports are all available online at – www.ct.gov/dcf

- A family-centered approach to all service delivery, reflected in development and implementation of a Strengthening Families Practice Model and the Differential Response System
- Trauma-informed practice as related to children and families but also to the workforce that serves them
- Application of the neuroscience of child and adolescent development to agency policy, practice and programs
- Development of stronger state and community partnerships
- Improvements in leadership, management, supervision and accountability, and
- Advancing the Department as a learning organization.

Finally, the Department has launched four types of major structural change. First, the central office organization has been flattened and collaborative teams have been substituted for siloed bureau structures. Second, the work of the department's regions has been re-conceptualized as comprehensive service systems. Third, the department's two behavioral health institutions have been consolidated and are being refocused on briefer treatment, even for the most challenging children and youth, with a return to home and the community as the desired outcome. Fourth, the department has committed itself to become a learning organization through the creation of the DCF Academy of Family and Workforce Knowledge and Development. The Academy is dedicated to creating and promoting learning opportunities for all who work on behalf of Connecticut's most vulnerable children and youth.

Creating this Working Paper

In this working paper, the Connecticut Department of Children and Families tackles the family side of foster care. Work on the paper began in May 2011, in partnership with the Connecticut Association of Foster and Adoptive Parents[2] and the Annie E. Casey Foundation's Child Welfare Strategy Group.[3] The Strategy Group has involved a total of six national consultants in continuous consultation and review of this work. The Department gratefully acknowledges their work.

In addition, we would like to thank the following individuals who analyzed data and helped to craft this working paper:

- Linda Dixon, DCF Academy for Family and Workforce Knowledge and Development
- Jean Fiorito, Connecticut Association of Foster and Adoptive Parents
- Jacqueline Ford, DCF Foster and Adoption Services Unit
- Elizabeth Graham, DCF Deputy Commissioner for Administration
- Dr. Janice Gruendel, DCF Deputy Commissioner for Operations
- Nancy DiMauro, DCF Child Welfare, Early and Middle Childhood Unit
- Anne McIntyre-Lahner, DCF Academy for Family and Workforce Knowledge and Development
- Robert McKeagney, DCF Clinical and Community Consultation Team
- Ken Mysogland, DCF Foster and Adoption Services Unit
- Dr. Brett Rayford, DCF Child and Adolescent Development, and Prevention Team
- Felix Rodriquez, Executive Secretary to the DCF Deputy Commissioner for Operations

[2] Online at -- www.cafap.com
[3] Online at -- www.aecf.org/MajorInitiatives/ChildWelfareStrategyGroup.aspx

- Dr. Michael Schultz, DCF Academy for Family and Workforce Knowledge and Development
- Susan Smith, DCF Office of Research and Evaluation.

Earlier drafts of the working paper were reviewed and revised from July through September 2011, including review of first draft challenges and recommendations by the Commissioner's Transition Team in July. In August, a preliminary discussion of the working paper was held with private organizations that provide treatment foster care as part of the Department of Children and Families' Therapeutic Foster Care Program. In early September, a working draft was presented to the *Juan F* Consent Degree Court Monitor and plaintiffs' attorneys.

Next Steps

Following release of both the Executive Summary and the complete report, the Department will engage in the following next steps. First, the internal process of analysis and cost modeling will continue over the next 90 days in order for the agency to describe its current year (SFY 11-12) needs to appropriate executive agencies and to the legislative branch. This analytic process will be draw upon the expertise and knowledge of outside groups and organizations, including the Connecticut Association of Foster and Adoptive Parents, the Continuum of Care Partnership, the network of providers associated with the Connecticut Therapeutic Foster Care Program, and both national and regional technical assistance and consultation resources.

Second, department staff will work interested stakeholders, including the Connecticut Association of Foster and Adoptive Parents and the new Continuum of Care Partnership, to review and prioritize proposed action items within each of six strategy areas for modification or implementation over the period from January through June 2012, and July 2012 through June 2013.

This collaborative work will result in a strategic work plan for advancing and expanding a vibrant, effective family foster care system for the State of Connecticut. The work plan is expected to be completed as soon as possible, but in no case later than January 30, 2012.

Part II: Children's Development, Behaviors and Outcomes

The Neuroscience of Development

By definition, all children removed from their homes for safety reasons are impacted by trauma. If we are to better support foster families in their vital role of nurturing children who have experienced trauma, it is also essential to understand how children's brains develop and mature and how experience – both positive and negative – impacts that development. It is also important to understand that when we talk about "brain development," we are talking about both children's cognitive and emotional development, for in terms of neuroscience they are inextricably joined.

Much recent research on early brain develop has been translated into easily understood language for both the general public and policy makers by researchers and faculty associated with the National Scientific Council on the Developing Child, the National Forum on Early Childhood Policy and Programs, and the Harvard Center on the Developing Child. A series of 11 working papers published between 2004 and 2011 describe early brain development, its dependence on positive interactive experiences between young children and their caregivers, the impact of stress, fear and anxiety on the chemistry of the brain and on children's learning and development, and the role of early experience on the brain's "air traffic control system," also called "executive function."[4]

Key findings related to foster family care are summarized below.

The critical role of early experiences

In its first working paper – *Young Children Develop in an Environment of Relationships*[5] – the National Scientific Council on the Developing Child presents key findings on the critical role of experience in early (and later) brain development:

- "Nurturing and stable relationships with caring adults are essential to healthy human development beginning from birth."[6]
- "Young children are highly vulnerable emotionally to the adverse influences of parental mental health problems and family violence."[7]
- "Young children who grow up in seriously troubled families, especially those who are vulnerable temperamentally, are prone to the development of behavioral disorders and conduct problems."[8]

---

[4] *Building the Brain's Air Traffic Control" System: How Early Experiences Shape Development of Executive Function*: Working Paper #11. National Scientific Council on the Developing Child and the National Forum on Early Childhood Policy and Programs (2011).

[5] *Young Children Develop in an Environment of Relationships: Working Paper No. 1*. Online at --//developingchild.harvard.edu/index.php/resources/reports_and_working_papers/working_papers/wp1/

[6] Ibid, p. 1

[7] Ibid, p. 3

[8] Ibid, p. 3

- "Although young children certainly can establish healthy relationships with more than one or two adults, prolonged separations from familiar caregivers and repeated 'detaching' and 're-attaching' to people who matter are emotionally distressing and can lead to enduring problems."[9]

The implications of these findings for Connecticut's foster family system are clear. First, when children are separated from their birth families, placement in stable, nurturing foster families who understand child development is critical. Second, these placements should – if at all possible and appropriate – enable a continued relationship with the birth family with mental health supports for all of the adults involved with the child. Third, repeated moves in and out of placement are damaging to children's long-term emotional and behavioral development.

The impact of stress, fear and anxiety on brain development

Two other papers in this series explain how excess stress, fear and anxiety disrupt the architecture of the developing brain.[10] [11] "Stressful events can be harmful, tolerable, or beneficial, depending on how much of a bodily stress response they provoke and how long the response lasts…Toxic stress refers to strong, frequent or prolonged activation of the body's stress management system. Stressful events that are chronic, uncontrollable, and/or experienced without the child having access to support from caring adults tend to provoke these types of toxic stress responses."[12] Key findings include:

- The release of two brain hormones – adrenaline and cortisol – occurs when a child, or an adult, experiences adverse situations and acute stress. Both of these brain hormones are normal components of a well-functioning nervous system and they enable the body to respond to dangerous or stressful circumstances.

- Sustained or frequent activation of the hormonal systems that respond to stress can have serious developmental consequences, some of which may last well past the time of the stress exposure.

- "When children experience toxic stress, their cortisol levels remain elevated for prolonged period of time….can alter the function of a number of neural systems, and even change the architecture of regions in the brain that are essential for learning and memory."[13]

- Research has also shown that children who are neglected or abused, or grow up in families with maternal depression or facing economic hardship, have "abnormal patterns of cortisol production that can last even after the child has been moved to a safe and loving home."[14]

---

[9] Ibid, p. 3
[10] *Excessive Stress Disrupts the Architecture of the Developing Brain*: Working Paper #3 (2005), online at -- //developingchild.harvard.edu/index.php/resources/reports_and_working_papers/working_papers/wp3/
[11] *Children's Emotional Development is Built into the Architecture of their Brains*: Working Paper #2 (2004). Online at -- //developingchild.harvard.edu/index.php/resources/reports_and_working_papers/working_papers/wp2/
[12] Excessive Stress Disrupts the Architecture of the Developing Brain, op cit. p. 1
[13] Ibid, p. 1
[14] Ibid, p. 4

The implications for development of a foster family system capable of mediating these negative effects of toxic stress on the brain and on children's emotional and behavioral health are clear. Child assessments prior to placement must properly identify likely behavioral challenges that foster families will face, and this information must be made available to the foster parents. Additionally, expert assistance and both formal and informal supports should be readily available to foster parents so that they are sufficiently prepared to address the needs of the foster child and, at the same time, buffer the impact of the foster child's likely behaviors on the rest of the foster family. Finally, the economic and community circumstances of the foster family must be addressed in order that children experiencing toxic stress are not moved from one volatile situation to another.

Executive function in vulnerable children and youth

The most recent paper in this series – *Building the Brain's "Air Traffic Control" System* – describes three types of components of executive function and the role of adversity in their development.[15] *Working memory* is "the capacity to hold and manipulate information in our heads over short period of time." *Inhibitory control* is "the skill we use to master and filter our thoughts and impulses so we can resist temptations, distractions, and habits and to pause and think before we act. This capacity keeps us from acting as completely impulsive creatures who do whatever comes to our minds." *Cognitive or mental flexibility* is "the capacity to nimbly switch gears and adjust to changed demands, priorities, or perspectives. It is what enables us to apply different rules in different settings."[16] Key findings include:

- "The building blocks of children's capabilities to retain and use new information, focus attention, control impulses, and make plans are acquired during early childhood, but the full range of executive function skills continues to develop into the adolescent years."[17]

- "Adverse environments resulting from neglect, abuse, and/or exposure to violence can impair the development of executive function skills as a result of the disruptive effects of toxic stress on the developing architecture of the brain. Chaotic (and thus, from the child's standpoint, unpredictable) environments can also lead to poor self-regulatory behaviors and impulse control."[18]

- "Children who experience adversity at an early age are more likely to exhibit deficits in executive functioning, suggesting that these capacities are vulnerable to disruption early in the developmental process. Among the conditions that have been studied and found to affect the development of executive function are early abuse and neglect, orphanage rearing, prematurity and/or perinatal complications, and prenatal alcohol exposure…"[19]

- Despite subsequent adoption, maltreated children who experienced foster care placements have been found to perform poorly on tests of executive functioning, as well to display oppositional behavior towards their adoptive parents. Furthermore, large numbers of unique

[15] *Building the Brain's Air Traffic Control" System: How Early Experiences Shape Development of Executive Function*: Working Paper #11. National Scientific Council on the Developing Child and the National Forum on Early Childhood Policy and Programs (2011)
[16] Ibid, p. 2
[17] Ibid, p. 4
[18] Ibid, p. 7
[19] Ibid. p. 7

foster placements have been found to predict lower scores on a wide range of neuropsychological executive functioning tests, suggesting that frequent changes in a child's primary caregiver may disrupt the development of these important skills."[20]

Serving Vulnerable Children Who Experience Trauma

As defined by the National Child Traumatic Stress Network,[21] "a traumatic experience threatens the life or physical integrity of a child or of someone important to that child (parent, grandparent, sibling), causes an overwhelming sense of terror, helplessness, and horror [and] produces intense physical effects such as pounding heart, rapid breathing, trembling, dizziness, or loss of bladder or bowel control." Long term exposure to trauma "can interfere with healthy development and affect a child's ability to trust others, sense of personal safety, ability to manage emotions, ability to navigate and adjust to life's changes, [and] physical and emotional responses to stress."[22]

Understanding the impact of trauma on the lives and behaviors of children in the foster care system is essential for foster parents, private providers and department staff as well as organizations that comprise a foster family's informal community network. As part of its *Resource Parent Workshop*, the National Child Traumatic Stress Network puts this knowledge into context as it describes the impact of trauma on children at three developmental periods.[23]

- Early Childhood (ages birth through five years): "Children who have experienced trauma during early childhood may be particularly sensitive to loud noises; reject contact and avoid being touched; have a heightened startle response; be confused about what's dangerous and whom to go to for protection particularly if trauma was at the hands of a caregiver; be clingy and resist being separated from familiar adults or places where they feel safe."[24]

- Middle Childhood (ages six through 12 years): "School-aged children who have experienced trauma may: experience mood swings, for example, shifting from being shy and withdrawn to being aggressive; have difficulties in school and other learning situations; have specific anxieties and fears, such as fear of the dark; demand lots of attention; revert to 'younger' behaviors, such as baby talk or wanting adults to feed or dress them."[25]

- Adolescence (ages 13 through 21): "Adolescents who have experienced trauma may: have difficulty imagining or planning for any kind of future, instead 'living in the moment' without regard to consequences; have trouble accurately assessing risk--either over- or underestimating the danger of a situation or activity; engage in aggressive or disruptive behaviors; engage in reckless or self-destructive behaviors, such as drug or alcohol abuse, cutting themselves, or having unprotected sex. Adolescents who are re-experiencing their trauma or are troubled by trauma reminders may feel that they are weak, strange, or childish, or 'going crazy' because of

[20] Ibid, p. 7-8
[21] Online at -- www.nctsn.org
[22] Trauma 101 (Module 2). The National Child Traumatic Stress Network.
[23] Understanding Trauma's Effects: Resource Parent Workshop (Module 3). National Child Traumatic Stress Network, online at --
[24] Ibid, p. 9
[25] Ibid, p. 10

their bouts of fear or exaggerated physical responses. This may lead them to even further isolation, anxiety, and depression."[26]

Looking Back: The Northwest Foster (Family) Care Alumni Study

A landmark study of nearly 500 young adults who lived for some period of time in foster family care was recently published.[27] The purpose of the study was to "address the lack of objective data available about adolescents who were placed in foster care… to understand how youth formerly in foster care were faring as adults and what experiences in care related to long-term success."[28]

These young adults were between the ages of 20 and 33 when interviewed over the period 2000 through 2002. More women (61%) than men (39%) participated, and slightly more than half (54%) were of African American, Hispanic, American Indian or Alaskan Native descent. They had all been served by one of the following organizations: Casey Family Programs, the Oregon Department of Human Services, Division of Children, Adults and Families or the Washington Department of Social and Health Services, Children's Administration.

Prior to placement, over half of the young people who participated in the study had experienced sexual abuse (54%), physical abuse (65%), physical neglect (67%) and/or emotional maltreatment (85%). One quarter of these young people had experienced all four forms of maltreatment. About a third had experienced three or fewer placements, but another third experienced eight or more placements. Nearly all (95%) lived in a foster family with a mother present, but only seven in ten lived in a foster family with a father present.

Study Findings

The report summarizes the results of earlier studies showing mixed outcomes for young adults who lived with foster families, although it does not distinguish the type of foster family involved. Several studies found that children in foster care "were at greater risk of being arrested or incarcerated, of having lower high school graduation rates, of experiencing lower employment rates, of suffering from depression more frequently, and of being overrepresented among

Young People Speak

"I wish I would have been given the tools to manage my adult life effectively. I could have been taught that my actions and choices create my present and future rather than merely being a victim of circumstances."

"I was not into it. I wouldn't let anyone help me. If I would have, [the foster parents] may have been there. I don't know. It took a couple of tries to get to a home that was decent. By that time, I was spoiled—I was negative and closed up."

"As my case moved from one work unit to the next, or from one agency to the next, so did I…new people, new schools, new neighborhoods, new rules and all that. In retrospect, this system that was striving so hard and so quickly for permanence would have been better off taking more time. Would I have had two failed adoptions if more front-end work had been done? I'll never know."

Source: *What Works in Foster Care* (2010)

[26] Ibid, p. 11
[27] *What Works in Foster Care? Key Components of Success from the Northwest Foster Care Alumni Study.* Oxford University Press, 2010.
[28] Ibid, p. 217

the homeless when compared to the general population."[29] Studies have also found that "in some areas, such as post-secondary educational achievement and employment earnings, the results are unacceptably poor…In contrast, however, other studies have found that certain alumni outcomes were reasonably positive: Youth in care exhibited improvements in physical health, emotional adjustment, school performance, and behavioral functioning."[30]

The Northwest Alumni Study found both negative and positive outcomes for young adults who had been served in the family foster care system:

- Mental Health and Substance Use Challenges: Alumni of foster family care had higher rates of mental health disorders, including Post Traumatic Stress Disorder, depression, social phobia and drug dependence than the general population. Just over half (54%) experienced "symptoms of mental health disorder within the past 12 months"[31] but 68% reported no longer abusing alcohol and 51% reported having overcome depression.

- Homelessness: One in five (22%) was homeless for one or more nights within a year after leaving foster care.[32]

- Access and Utilization of Services: While nearly all of the young people (89%) had access to tutoring and other supplemental education services while in foster family care, only about half (48%) utilized these services. Similarly, many (84%) had access to mental health, drug and alcohol counseling, but "a significantly lower proportion actually utilized these services."[33]

- Educational Achievement: Slightly more than eight in ten (85%) completed high school, although many received a GED rather than high school degree. Only 2% completed a college degree or higher.

- Life Skills and Employment Preparation: Three in four were working or in school at the time of the study, but "fewer than half reported receiving employment, job location, and other independent living-skills preparation."[34] The "three most common job categories (among the alumni group) were financial records processing (14%), service occupations (18%), and sales occupations (16%)."[35]

- Birth Family Contact: Six in ten of the young adults (59%) participating in this study were in contact with their birth siblings, four in ten (41%) remained in contact with their birth mothers, but just two in ten (21%) were in contact with their birth fathers.

- Overall Satisfaction with Foster Families: "Of their foster parents overall, 64% of the alumni rated them as somewhat or very helpful. Just under six in ten (58%) reported that their foster parents (including kinship caregivers) were "the people most helpful to them while they were in

[29] Ibid, p. 10
[30] Ibid, p. 10
[31] Ibid, p. 219
[32] Ibid, p. 219
[33] Ibid, p. 225
[34] Ibid, p. 219
[35] Ibid, p. 227

care."[36] Six in ten (62%) also reported that they remain in contact with their former foster parents. Four in ten (41%) reported being strongly satisfied with their overall foster care experience.

- Overall Satisfaction with Caseworkers: More than half (53%) thought that their caseworkers did not see them enough and just three in ten (30%) felt that "their caseworkers were helpful."[37]

Recommendations from the Study

The authors of the Northwest Alumni Study offer a broad set of recommendations for supporting both young people in foster family care *and* foster parents.

1. Placement Stability: Maintain placement stability by improving initial placement decision-making, enabling youth in foster family care to maintain contact with siblings and birth parents, and working to stabilize the current placement rather than operating on "a presumptive move policy wherein a child is automatically moved when there are problems in the placement setting."[38]

2. Access to Mental Health Treatment: Because of the disproportionate levels of PTSD, depression and other mental health disorders, increase access to evidence-based mental health treatment for youth placed in foster families. "Improve foster parent orientation and training with respect to youth mental health. Agencies should provide foster parents with more comprehensive information about how to identify and address mental health difficulties that children in foster care experience."[39]

3. Education: Encourage young people "not to settle for a GED credential [because those] who complete a GED generally attain less education and earn less than individuals who have a high school diploma."[40] "Maintain enrollment in the same school, even if the foster placement changes... Maintain an educational profile or 'passport' for all children in foster care that moves with them." Identify an adult who can "guide youths' choices and decisions in a meaningful way. This person can be a foster parent, relative, paid educational advocate, or other adult but must be someone who is knowledgeable and consistent."[41]

4. Independent Living Skills: Help foster youth to improve independent living skills and access to vocational and employment opportunities early in the high school years. "For every youth, develop a comprehensive transition development plan that includes planning for supportive relationships, community connections, education, life-skills assessment and development, identity formation, housing, employment experiences, physical health, and mental health."[42]

---

[36] Ibid, p. 224
[37] Ibid, p. 224
[38] Ibid, p. 234
[39] Ibid, p 236
[40] Ibid, p 237
[41] Ibid, p. 240
[42] Ibid, p. 240

> "Provide foster parents and alumni of foster care with resources for maintaining their relationship after emancipation."[43]

Parental Satisfaction Following Adoption of a Foster Child

The May 2011 research brief cited earlier, *Children Adopted from Foster Care*, reports on how parents who adopted children from the family foster system felt about "the parent-child relationship, the child's effect on the family, and the satisfaction of children and parents with the adoption."[44] Three-quarters of children in this survey had a parent-child relationship described as "very warm and close." More than 90% of parents believe that the child has positive or mostly positive feelings about the adoption, and 95% of parents would probably or definitely make the same decision to adopt the child.

The study did uncover several other aspects of the adoption relationship worthy of mention. First, there is an association between age at placement and problems with the parent-child relationship. Specifically, the younger the children at adoption, the more likely it is that the child is perceived to have a positive effect on the family. Second, children with special health care needs had less positive parent-child relationships and there was less satisfaction with the adoption by the parent. Importantly, the quality of the parent-child relationship does not appear to vary "based on the race and Hispanic origin of children, household income, whether or not parents had adopted children's siblings, transracial/transcultural/transethnic placement…"[45]

[43] Ibid, p. 245.
[44] *Children Adopted from Foster Care*, op cit. p. 14. Note that, as the report cautions, "…this brief focuses only on children with legally finalized adoptions from foster care as of 2007. For some children, placements disrupt before finalization or dissolve following finalization, and these children were not part of the NASP sample." (p. 15)
[45] Ibid, p. 17

Part III: Some Basic Data on Foster Care

The field of child welfare has long struggled with how best to serve vulnerable children and youth whose safety and well-being are compromised by family circumstances including abuse and neglect.[46] Children who are removed from their families by the child welfare system are generally placed in foster care, a term that includes family-based settings, congregate care and independent living settings.

"While a child is in foster care, he or she attends school and should receive medical care and other services as needed. The child's family also receives services to support their efforts to reduce the risk of future maltreatment and to help them, in most cases, be reunited with their child. Visits between parents and their children and siblings are encouraged and supported, following a visitation plan. Every child in foster care should have a permanency plan that includes the person with whom the child will live after leaving foster care and who will serve as the child's primary emotional and family connection."[47] This description is useful for it signals a broad array of data needed to fully describe the delivery and effectiveness of foster care.

In Connecticut, the Department of Children and Families manages a continuum of foster family services. The five types of family foster care available in Connecticut are:

- Relative foster families[48]
- Core foster families
- Special study families[49]
- Independent foster homes,[50] and
- The Therapeutic Foster Care Program.[51]

National and Connecticut Comparative Data

In May 2011, the Annie E. Casey Foundation's Kids Count Initiative published a *Data Snapshot on Foster Care Placement* based on 2009 data provided by each state to the federal Adoption and Foster Care

---

[46] *How the child welfare system works* (2011). Child Welfare Information Gateway. U.S. Department of Health and Human Services, Children's Bureau. This fact sheet includes an extraordinarily useful flow chart on decision-making in the child welfare system. Online at -- www.childwelfare.gov/pubs/factsheets/cpswork.cfm

[47] *Rightsizing Congregate Care* by The Annie E. Casey Foundation (2010) explains its focus on assisting states to reduce their reliance on this type of foster care. "No research proves that children fare better in congregate facilities than family care and some studies have shown the outcomes are worse. What's more, institutional placements are three to five times the cost of family-based placements. Thus, savings from congregate care reduction could be diverted to community-based services (including evidence-based interventions) to improve permanence and other long-term outcomes for children." Online at -- www.aecf.org/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Foster%20Care/RightsizingCongregateCare

[48] See Part III of this working paper for more detail.

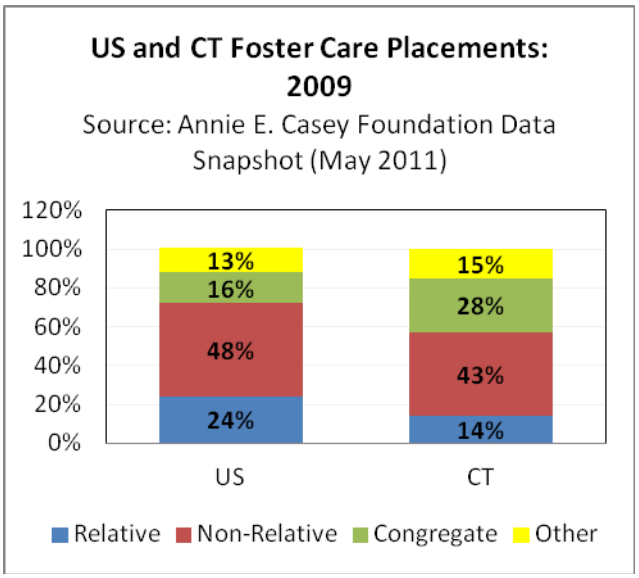
[49] A Special Study home is one that is licensed by the Department to provide foster care for a specific, unrelated child. It is not a general use foster family home.

[50] An Independent Foster Home is a child-specific home licensed by the Department to provide care for a child in the custody of another state.

[51] See Part III of this working paper for more detail.

Analysis and Reporting System (AFCARS). [52] In 2009, slightly fewer than 425,000 youngsters were placed by state child welfare agencies into formal foster care. Nearly three quarters of these youngsters were placed with a foster family in either relative care (24%) or non-relative care (48%). Fewer than one in twenty (16%) were placed in a group home or institution.[53]

Connecticut-specific data reported in the *Data Snapshot* present a somewhat different picture. In 2009, 72% of all foster care placements nationally were in family-based settings. In Connecticut, just 57% were in family-based settings. In contrast, while 16% of placements nationally were in congregate care, Connecticut placed 28% of its foster care youngsters in congregate care.



Comparing Connecticut's foster family and congregate care data with that of the United States as a whole reveals an over-reliance on congregate care and a lower use of family foster care. These data are shown in the chart to the right.

Besides Connecticut, seven other states placed one quarter or more of their foster children in congregate care settings in 2009, while eight states placed fewer than 10% of their foster children in congregate care.

States with 25% or More in Congregate Care (2009)	States with 10% or Fewer in Congregate Care (2009)
Colorado (36%)	Alaska (8%
Wyoming (36%)	Hawaii (9%)
Rhode Island (34%)	Idaho (9%)
Delaware (28%)	Kansas (8%)
West Virginia (28%)	Nevada (7%)
Minnesota (25%)	New York (5%)
North Dakota (25%)	Oregon (5%)
	Washington (5%)

[52] *KIDS COUNT Data Snapshot* on Foster Care Placement (May 2011). Annie E. Casey Foundation. Online at -- http://www.aecf.org/~/media/Pubs/Initiatives/KIDS%20COUNT/D/DataSnapshotFosterCarePlcmnt/DataSnapshot_FinalWeb.pdf

[53] The *Data Snapshot* provides congregate care definitions based on Adoption and Foster Care Reporting System . A group home is "a licensed or approved home providing 24-hour care for children in a small group setting that generally has from 7 to twelve children." An institution is is "a facility operated by a public or private agency providing 24-hour care and/or treatment for children who require separation from their own homes and group living experiences. These facilities may include child care institutions, residential treatment facilities or maternity homes." There is a final category for foster care placement types, called "other." This includes "supervised independent living, runaways, pre-adoptive homes, and trial home visits."

Placement Data and Trends for Family Foster Care in Connecticut

Analysis of departmental data on all children in placement from December 2000 through June 2011 reveals a slow decline, over time, in the proportion of placements into the foster family system as compared with placements into the congregate care system.[54] In December of 2000, 71% of all placements were made to the foster family system (including core foster families, relative placements and special study families). In June of 2011, 68% of all placements were made into family foster care. Another way to view these trends over time is to look at the total number of children in placement over the same period. In January of 2000, 7059 youngsters were in placement through the Connecticut Department of Children and Families. In June of 2011, 4854 youngsters were in placement. In September, there were 4,585 youngsters in placement.

The chart below shows the trend for family foster care placements over the same period.

The Placement of DCF Children and Youth in Foster Family Homes: 2000 through 2011				
	Total Foster Family Placements	**Core Foster Families (including Therapeutic)**	**Relative Foster Families**	**Special Study Homes**
December 2000	4921	3339	1329	253
December 2005	4382	2919	1186	277
December 2010	3238	2358	699	181
June 2011	3302	2298	819	185
September 2011	3,163	2,143	832	188

Types of Placement by Age

Based on agency data for November of 2010, an analysis by the Child Welfare Strategy Group reveals a disturbing (but not uncommon) increase in the use of congregate care as children enter adolescence and a concomitant decline in family foster placements. These data are significant for they suggest that many young people (perhaps six in ten) may enter young adulthood without a connection to their birth family (and siblings) ***or*** to a foster family. That such connections are hugely important is clearly shown by the Northwest Alumni Study of young adults who lived in family foster care, summarized later in this working paper.

Likelihood of Placement in Congregate Care by Age	**Likelihood of Placement in Family Foster Care by Age**
• Children under age two: About 1% • Children two through five years: 3% • Children six through 12: 19% • Youth 13 through 17: 53% • Youth 18 and older: 58%	• Children under age two: 99% • Children two through five: 97% • Children six through 12: 81% • Children 11 through 17 years: 47% • Youth ages 18 and older: 42%.

[54] Utilizing data based on the proportional use of foster family allows us to take into account the decline over time in the department's out-of-home placement numbers, from a total of 6929 in December of 2000 to a total of 4,854 in June 2011.

Length of Placement

The November 2010 Child Welfare Strategy Group study also provided an analysis of the length of time children were in foster family placements. Of 3263 children in this analysis:

- 801 (24%) had been in their current placement for 36 months or longer
- 371 (11%) had been in placement for 24 to 36 months
- 773 (24%) for 12 to 24 months; and
- 1318 (40%) for less than 12 months.

There were no significant differences by race or ethnicity for length of placement.

These data are important because they point out a recurrent tension between permanency and placement stability goals. If the goal is for youngsters to be reunified with their birth families, it is likely that the longer they remain in foster care the less likely that reunification will occur. On the other hand, placement stability is very important to children, so the longer they remain in a single placement, the more likely it is that their development will not be negatively impacted.

Recruitment, Licensure and Retention

To become a foster or adoptive parent, an individual or family typically contacts the department's 1-888 KIDHERO number managed by the Connecticut Association of Foster and Adoptive Parents. Basic information about foster care and adoption is provided to the potential applicant at that time, including information about next steps. The applicant then attends an Open House.

Following the Open House, a personal interview is conducted at which time additional information about the licensing process is provided, and background information is gathered from the applicant. The background check process then begins. This includes both state- and federally-mandated checks. The applicant (a person or a family) then attends the 30-hour PRIDE training.[55] At the same time, concurrent home visits are made as part of the home study process.[56]

State law requires that licensing be completed within 120 days from the date that the entire foster family care application is received by the Department of Children and Families. Since the application includes such documents as a physician's statement, income verification, and releases of information for background checks, the time from an individual's first expression of interest to submittal of the completed application may vary significantly.

[55] The PRIDE (Parent Resources for Information, Development and Education) training has been developed by the Child Welfare League of America and consists of a 14-step, competency based program. The PRIDE program utilizes a child welfare social worker or educator and an experienced foster or adoptive parent as co-instructors.

[56] Occasionally, staff members from the Department of Children and Families seek to become foster parents. To manage any potential conflicts of interest, the Department has developed contracts with five private foster care agencies to aid in the licensing of persons who are employed by the Department. Currently, 53 employees of the Department are licensed as foster families.

Recruitment

Over the past two fiscal years (2009-2010 and 2010-2011), the Connecticut Association of Foster and Adoptive Parents reported a 4% increase in contacts related to foster care and adoption, from 5516 in SFY 2010 to 5741 in the fiscal year ending in June of 2011. However, the number of inquiries related to providing foster or adoptive care actually decreased, from 2335 to 2040. The balance of inquires were seeking information only.[57] Of the 2,040 inquiries, 390 families were licensed. This represents a licensure rate of just 19%.

Among the 2040 inquiries related directly to becoming a foster or adoptive parent, 42% were from white families, 29% were from African American families, 16% were from Hispanic families, and 13% were listed as "other." Most of these inquiries (82%) were related to becoming a foster family.

The largest source of these 2040 inquiries to the Connecticut Association of Foster and Adoptive Parents was the Internet (25%). Fifteen percent (15%) came at the urging of current foster families. In another 15%, the caller indicated calling based on his/her own personal interest, and just 10% came from the recruitment activities of community collaboratives funded by the Department to recruit and support foster families.[58] The fact that just 10% of inquiries are generated by the five community collaboratives, at an annual cost in excess of $300,000 suggests that this service may need to be modified the upcoming state fiscal year (2012-2013).

Over the past several months, the Department has engaged the services of a Connecticut strategic communications expert to begin development of a strategic outreach and communications plan for the period beginning January 2012. Several products have already results from this collaborative effort:

- An Electronic Tabloid about foster family care in Connecticut has been developed that can be used online and also customized for print production specific to various outreach targets
- A Foster Care *Myths and Misconceptions* document has been prepared that, in two pages, asks and answers a series of key questions frequently raised by potential foster and adoptive families. That document is included as Appendix B of this working paper.
- A draft Strategic Communications plan to aid both outreach and recruitment is under consideration. It will include more detailed assessment of when and why families "drop out" of the recruitment process.

Senior agency leaders have met with the Connecticut Latino and Puerto Rican Affairs Commission to seek assistance in outreach to potential relative families. The Commissioner will host five community forums this fall with community leaders, elected officials and other key stakeholders to answer questions about the Department and solicit foster and adoptive parents. Similar activities are in the planning stage for targeted outreach to the African American community.

---

[57] Data provided by the Connecticut Association of Foster and Adoptive Parents, June 15, 2011

[58] The Department of Children and Families awards contracts to four "community collaboratives" plus the Queen Ester Project to recruit and support neighborhood-based, culturally-competent foster and adoptive families. Activities of these contractors include special family events, appreciation dinners, media and materials development, promotional items and training. Total funding for the collaboratives is approximately $300,000.

In addition, the Department has identified the following groups of children for specialized recruitment of foster families: babies; adolescents; sibling groups; children with complex medical circumstances; children and youth with complex mental health needs; and lesbian, gay, bi-sexual and transgender youth. And, to advance the recruitment of relative families, the Department has purchased Lexis-Nexis software that creates lists of adults and their connections with particular children.

Licensure and Retention

At the beginning of June 2011, Connecticut family foster system had 3269 licensed homes with a total bed capacity of 4275. The number of homes by type is shown below, along with data on new homes licensed in calendar year 2010 as well as homes that left the foster care system in the same time period.

Status of the Department's Family Foster Care System			
	Licensed Capacity September 2011	**New Homes Licensed January-December 2010**	**Homes Exiting January-December 2010**
Relative Homes	518	324	417
Core Foster Homes	1184	210	251
Special Study Homes	177	109	145
Independent Homes	59	46	41
Therapeutic Homes	845	190	247
Adoptive Homes	400	180	100
Totals	**3,183**	**1059**	**1,201**

Department staff analyzed data from 2005 to 2010 to identify points at which potential applicants in the foster and adoptive process "dropped out" prior to licensure. The Connecticut Association of Foster and Adoptive Parents reports that just one in three callers to the 1-888 KIDHERO completes a formal inquiry to become a foster parent, resulting in a capture rate of 33% at this first critical point in the recruitment process.

It appears that some families drop out of the process based on two types of issues: those related to the process of recruitment and licensure and those related to applicant-specific problems. On the systems side, it appears that unanswered phone calls, lack of timely training opportunities, and poor information exchange across the DCF system contribute to the loss of potential foster and adoptive resources. Issues specific to applicants include:

- The determination that a family has inadequate financial resources to become a foster parent,
- Housing issues
- A prior criminal history
- A history of prior abuse or neglect that cannot be waived, and
- Lack of follow up for core information such as references and medical forms.

Department staff are reviewing all of these barriers with area offices to identify where modifications in the recruitment process is required.

Department staff also reviewed reasons that families leave the state's family foster care system. As will be described in some detail in Part IV of this report, one key reason for exiting Connecticut's foster care system involves a feeling among foster parents that they are not valued or respected by staff in the department's area offices. To add further clarity to this issue, the Office of Foster and Adoption Services reviewed all of the 925 cases in which foster families left the system over the period January through December 2010. (Note: This review did not include a review of the 247 families that exited the Therapeutic Foster Care Program). Importantly, this review revealed that 52% of these departures resulted from positive outcomes related to a child. The table below shows all reasons for the closure of foster family homes in calendar year 2010.

2010 Annual Reasons Homes Closed	
1. Finalized an adoption	190
2. Transfer of Guardianship	154
3. Retired In Good Standing	64
4. Transferred to TFC Agency	24
5. Family Relocated - Out Of State	27
6. Personal Issues (including health issues, change family demographics, death in family)	68
7. Retiring (disinterest in providing care to children/no negative implication to DCF)	45
8. Child reunified	141
9. Child transitioned to CHAPS/independent living/college	43
10. No longer able to meet DCF Requirements	25
11. Licensing Concerns Voluntary Closure	28
12. Unwilling to meet child's needs	6
13. Child left the home (disrupted / run away)	71
14. Foster home reports negative impact to family due to DCF child	5
15. Closed after an investigation	10
16. Revocation of License	24

Utilization

The Child Welfare Strategy Group working jointly with the DCF Office of Foster and Adoption Services conducted a series of "utilization reviews" of Connecticut's current foster family system. One study focused on the numbers of homes and beds in January of 2011 (excluding foster families recruited and managed as part of the agency's separate Therapeutic Foster Care Program).

On January 24, 2011, the department had 2777 licensed foster family **homes,** of which 1668 (60%) were licensed to provide general foster family care. Of these homes, 15% were "on hold" and not available for placement. Among the remaining homes, 429 of the 1109 were approved for adoption, and 680 were

licensed to provide child-specific placements as relative, special study or independent foster family homes. Independent homes are "child specific" and thus not available for general use.

Across all 1668 homes, there were 2906 **beds**. Of these, 47% of the beds were empty in January of 2011. Additionally, in just over 900 homes there was at least one empty bed.

Child Welfare Strategy Group consultants have suggested possible explanations for this high number of empty beds. These hypotheses include:

- Ineffective use of current resources based on poor real time data
- Ineffective recruitment practices that do not assess families willing to take children with complex needs
- Inaccurate representation of families' placement preferences in the department's data system, and
- Families being unwilling to accept placements.

Additional data review has now taken place, by area office, of the numbers of vacant foster family beds, the predominant reasons why children were not placed into these homes, and the total number (and age) of all children removed from foster family care in the region. Results of these data analyses were presented to foster care staff by Strategy Group consultants during the first two weeks of September. During each of these two-hour meetings, strategies were developed to increase placement for underutilized beds. Data will be reviewed on an annual basis.

Adoption and Subsidized Guardianship

Over time, more than of half of adoptions through the public child welfare system have been by foster parents. The most recent federal data, from the Adoption and Foster Care Analysis and Reporting System (AFCARS), show that 54% of all adoptions that occurred in 2009 were by foster families and an additional 32% were by relative families.[59] In May 2011, the federal Department of Health and Human Services provided new information about adoptive families derived from data collected as part of the 2007 National Survey of Children's Health.[60] It is important to note that AFCARS data is based on the 53,000 adoptions that occurred in 2009, while the National Survey data represents all children adopted from foster at the time of the interview, approximately 660,000 who had ever been adopted from foster care.

Data shown below indicate that, among all former foster care children in adoptive families in 2007, 77% were adopted by non-relatives – more than half of whom did not know the child ahead of time. Of those who knew the child ahead of time, 80% had been the child's foster parent.

[59] See the 2009 AFCARS Report at -- www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.htm

[60] Children Adopted from Foster Care: Child and Family Characteristics, Adoption Motivation, and Well-Being. ASPE Research Brief, U.S. Department of Health and Human Services. (May 2011). Online at -- aspe.hhs.gov/hsp/09/NSAP/Brief1/rb.pdf

Data from the 2007 National Survey of Children's Health			
Children Adopted by Non Relatives 77%			Adopted by Relatives 23%
Knew the Child Prior 22%		Did Not Know the Child Prior to Adoption: 55%	
Was the Child's Foster Parent: 80%			

As to why these adoptive parents chose to adopt from the public child welfare system rather than through a private agency, several key findings emerge. Adoptive parents reported that it was less expensive and faster, that they wanted a child with special needs, or they had adopted from the public sector before. The National Survey also reveals that families that adopted from the foster care system were more often married and had one parent who did not work full-time. Despite the fact that many children are adopted into two-parent families, "…almost half of children adopted live in households with incomes at or below 200 percent of the poverty threshold."[61] As a point of reference, 200% of the Federal Poverty Level for a family of four in 2011 is approximately $44,000.

In Connecticut in 2009, the Department completed 687 adoptions. In calendar year 2010, 541 adoptions were finalized. The Department's adoption completion performance was high enough in 2009 to result in the receipt of $550,000 in federal Adoption Incent Grant funding from the federal government. This was the second year the Department received this grant.

In addition, staff members from the department's Office of Foster and Adoption Services manage the payment of subsidies for over 8,000 children annually. A subsidy is approved for children who present with current or potentially long-term physical, emotional or psychological needs and who are determined to be eligible for a financial stipend and medical coverage that is provided to their caregiver on their behalf. Finally, the department's Interstate Compact Office manages some 1,500 inquiries from state and private agencies, and parents regarding the placement of children both in and outside of Connecticut.

Implications for Family Foster Care from the Congregate Report

In the *Congregate Care Rightsizing and Redesign Report* released in July of 2011,[62] the Connecticut Department of Children and Families examined several aspects of congregate care use:

- The placement of children ages 12 and younger in congregate care, with a special emphasis on those ages six and younger
- Use of the state's Voluntary Services Placement Program, and
- Characteristics of the state's therapeutic group homes.

[61] Ibid. p. 18

[62] *Congregate Care Rightsizing and Redesign* (August 2011). CT Department of Children and Families. Online at -- www.ct.gov/dcf/lib/dcf/latestnews/pdf/cc_right_sizing_report__young_children_and_voluntary_placements_8_4_11.pdf

The report presents the Department's goal to prohibit the placement of children ages six or younger into congregate care and dramatically reduce (or eliminate) congregate care placements for children ages 12 and younger. In early September, a listing of all children ages 12 and younger in congregate care was created by the department's Office of Research and Evaluation. This analysis revealed that 130 young children are currently placed in congregate care. The permanency goals for these children are shown below. It is anticipated that some of these children will return from congregate care to foster families prior to being adopted or reunified with their birth families.

Permanency Goals for 130 Children (Ages 12 and Younger) in the Care and Custody of the Department of Children and Families Placed in Congregate Care in September 2011					
Adoption	Reunification	Long Term Relative Foster Family	APPLA: Another Planned Permanent Living Arrangement	Transfer of Guardianship with Subsidy	No Goal Indicated
39	68	1	10	3	9

Part IV: Challenges in Connecticut's Family Foster Care System

There has been substantial attention over the past 20 years to challenges within Connecticut's foster family system, beginning with the federal *Juan F* foster care lawsuit against the Department of Children and Families. More recently, there have been a series of highly useful external reports as well as a period of very recent analysis led by the new administration, all of which point to challenges within the department's family foster system. This section of the working paper summarizes these external and internal reviews and presents the views of the state's foster families themselves.

External Reviews

A December 2010 policy report to the Governor's Transition Team from the Children's Services Working Group calls for family group conferencing prior to removal of children from their homes, in-person engagement by DCF workers with relatives, the elimination of regulations that hinder the delivery of kinship care, an audit of relative foster application denials, and a family-to-family support program to support biological and foster parent collaboration. In addition, the report calls for targeted recruitment of kinship foster families for infants and toddlers who must be removed from their birth homes.[63]

A May 2011 report, entitled *Increasing Retention of Connecticut's Foster Families*[64] and published by Connecticut Voices for Children, identifies a number of barriers to the retention of foster families, based on an analysis of exit interviews conducted over the period 2007-2009. These barriers include a "disconnect between some former foster parents and DCF social workers," confidentiality laws that hinder the sharing of child-specific information with foster families, the view of foster families that they are not treated as team members and full partners, the need for improved communication with foster families and improved responsiveness to foster parents' requests for services to the children and youth in their care.

A May 2011 presentation by the Annie E. Casey Foundation's Child Welfare Strategy Group outlined the results of a lengthy data collection and analysis process focused on foster family care in Connecticut. Data was drawn from four sources: the department's current data system; data submitted by the department to the federal government; data provided as part of an ongoing project with Chapin Hall of the University of Chicago; and data from a study of foster family utilization across a number of the department's area offices. The major finding from the 2010 study is a lack of engagement of youth, birth and foster families in case planning and decision-making. Other challenges identified in the May 2011 presentation include an over-reliance on congregate care, the underutilization of existing foster family beds, and an under-emphasis on recruiting and using relatives as core foster family resources.

Internal Review

Our internal review of Connecticut's foster family system, undertaken over the period May through July, 2011 reveals a glaring problem: despite recruiting and licensing hundreds of new homes each year, the department routinely loses more foster families each year than it gains. This has been repeatedly noted

---

[63] *Children's Services Working Group Policy Proposals*, December 2011. pp. 33 and 35. Online at -- www.earlychildhoodalliance.com/node/5446

[64] *Increasing Retention of Connecticut's Foster Families*, Connecticut Voices for Children. May 2011. Online at -- www.ctkidslink.org/publications/cw11increasingretention.pdf

in reports of the *Juan F* Court Monitor."[65] Using information from state and national reports coupled with feedback directly from foster families, we have identified five major challenges that contribute to the problem of recruitment, utilization and retention:

1. In a very recent survey of foster families, 30% indicated that they did not feel respected and valued by the Department.
2. Policies, practice and paperwork frustrate foster parents and inhibit their ability to accomplish the job they signed up to do.
3. Foster families are not sufficiently included in the assessment, case planning and matching process.
4. Limited access to community supports and child-specific services can jeopardize children's success and the success of the foster family experience.
5. Current rates and resources are limiting factors for families *and* the department in crafting a fair way of compensating families for real work that they do on behalf of the children they serve.

While these are serious concerns, they are not insolvable and there is much to build upon within Connecticut's foster family system. In the recent annual satisfaction survey conducted by the Connecticut Association of Foster and Adoptive Parents:

- 84% said that they work as a team with their children's social worker
- 70% said the child's social worker regularly discusses the foster child's treatment plan with them
- 76% reported that they are adequately supported in terms of birth family visitation
- 64% indicate that they are adequately supported during time of unusual stress within their foster families. [66]

Foster Families Speak: Frequently Mentioned Challenges

In 2009, department staff conducted a series of Appreciative Inquiry sessions with about 80 foster families across the state. These families came together with foster care support staff to identify strengths and weakness in the current foster family system.[67] In March 2011, the Commissioner's Transition Team sent out a request through the Connecticut Association of Foster and Adoptive Parents for feedback on this state's foster family system. Fourteen foster parents replied, several writing lengthy observations. Across all of the sources of foster parent feedback, a series of common themes emerge.

Inadequate follow-up by department staff: Examples cited include phone calls and emails not being answered by child protective services staff, paperwork that is lost with no notice to foster families, no follow-up when a family has indicated an interest in becoming a foster family and long wait times between licensure and placement. One parent reported being licensed in 2008 and receiving a first child in 2010. Families report that while foster social workers are supportive, they cannot resolve case issues

[65] *Juan F*. v. *Malloy Exit Plan Quarterly Report*. January 1, 2011 –March 31, 2010, p. Online at -- www.ctmirror.org/sites/default/files/documents/1st Qtr report 2011 final.pdf

[66] 169 foster families replied to this survey: 80% of the respondents were foster/adoptive parents, 8% were relative or special study families, and 14% were licensed by a private foster care agency.

[67] This report of the listening tour is available from Jacqueline Ford, Department of Children and Families -- jacqueline.ford@ct.gov

related to specific children, as these are the responsibility of child protective services staff and supervisors.

The need for a much more respectful and reciprocal relationship with departmental social workers: This includes the provision of essential information when a child is placed, better communication between child protective services workers, foster family support workers and foster families, improved social worker punctuality.

Foster families also expressed fear that if they speak their minds they risk removal of children in their care. "The attitude of the majority of DCF workers at all levels toward foster parents is "Don't pay attention to them. They're just the foster parents…I definitely feel like the enemy when I advocate for my foster children with their caseworker's supervisor."

Improved delivery of services for children in care: This includes such services as day care, WIC nutrition services, programs to address mental health and behavioral issues of children and especially teenagers between 13 and 18 years of age, and access to computers for high school aged foster students and other teen activities. One parent reported, "It took me seven months, with the support of the surrogate parent and ultimately the Ombudsman's Office, to get desperately needed one hour per week of tutoring for my foster daughter."

Improved in-home supports for foster families: This includes more help with food and clothing costs, mental health supports when a child is removed after a lengthy placement in the family, visits by support workers when a child is in crisis in the foster home, and more post-adoption services for those foster families who adopt a child in their care.

"To a social worker, these kids are just one kid on their caseload. To us, these kids are the center of our world." **Foster parent, 2009**

"Change the climate of the social work staff and everything will fall into place." Foster parent, 2009

"Our (foster care) social worker is a real go-getter and a pure joy to work with. Our kids' social worker is a wonderful, compassionate person. We can tell she is genuinely concerned about our children. It's beyond our comprehension how each of these amazing individuals manage to make us feel as our case is the only one they are working on." Foster parent, 2011

"There seems to be so many people involved in one case, yet no communication between all of these people." Foster parent, 2011

Challenging relationships with birth parents and grandparents: This includes disruptions for children related to return to birth parents, repeated custody moves, and sometimes acrimonious relationships with birth grandparents.

Court and custody delays that do not accord with "child time": This includes lengthy time frames for custody and termination hearings. For very young children, they can spend 2/3's of their lives in limbo. "I am currently fostering an infant…This is the second infant I have fostered. This one I took home from the hospital at one week old and she is still with me. She is now 9 and ½ months old. I'm not sure she really needed to be in DCF custody. Now the reunification process has started, and she'll probably be a year old. So first she was ripped away from her biological mother at birth, and now she is going to be ripped away from her foster mother and the only home she has ever known."

Recommendations from foster parents

Foster families attending the Appreciative Inquiry sessions in 2009 and those who responded to the Transition Team's request for feedback had some recommendations for the Department of Children and Families. To improve recruitment, they recommend including the real voices of children in foster care. To improve retention they recommend fixing the overall relationship between department staff and foster families. Addressing these relationship problems also encourage current foster families to become "great recruiters" themselves. "Many foster parents noted that *their* friends and families were aware of their issues with the department and would never come forward to present themselves as a resource because of this."[68] Other more specific recommendations are summarized below.

Improving Communication

- DCF should offer a conference time with foster parents statewide to learn what is and is not working.
- Foster families waiting for a child should have access to a DCF-hosted email or online "chat room" so parents could discuss the waiting process. The same kind of online "space" could help parents support one another.
- At 1-888 Kid HERO open houses, prospective foster parents should receive FAQ-type handouts along with some general statistics on children in care.
- DCF should support grassroots efforts by foster families such as Unite4Foster Kids.

Practice and Policy Changes

- DCF should set real timelines for birth parents and relatives to seek and achieve return of children in foster care. The timeframe should be shorter the younger the child is.
- Foster parents should be invited to participate as partners in a transition team in order to reduce the stress and disruption that comes with returning a child from a foster home to a birth parent or relative. Concurrent planning needs to be begun sooner.
- Policies related to medically complex children should be reviewed. They may be too restrictive for those children who have less severe needs.
- The department needs clear policies on sleepovers and rides. Families get conflicting guidance from different workers and different offices.
- The current guidance on foster children not being allowed to text their birth parents is unrealistic. Children text all of the time.
- DCF should ask foster families who may already have one child if they would be willing to take additional children. Failure to do this results in underutilized bed, and thus homes.

Training and Shared Knowledge Development

Post-licensure training is provided by the Connecticut Association of Foster and Adoptive Parents through a broad arrange of courses organized around 21 learning "modules. Each licensed foster family is required to complete six training modules annually. A module consists of a three-hour session, offered at various times and location across the state. Relative foster families are invited to attend these trainings but are not required to do so at this time. Families recruited as part of the department's Therapeutic Foster Family Program are not required to participate in Association training, but higher levels of training are required of them than of relative and core foster families.

[68] Appreciate Inquiry Listening Tour, op cit. p. 3

CT Association of Foster and Adoptive Parents Post-Licensure Training Offered in 2011[69]
Module 1: Meeting the developmental needs of children at risk
Module 2: Using discipline to protect, nurture and meet developmental challenges
Module 3: Developmental issues related to sexuality
Module 4: Responding to the signs and symptoms of sexual abuse
Module 5: Supporting relationships between children and their families
Module 6: Working as a professional team member
Module 7: Promoting children's personal and cultural identify
Module 8: Promoting permanency outcomes
Module 9: Managing the foster experience (including change in the foster family)
Module 10: Understanding the effects of chemical dependence on children and families
Module 11: Medically complex pediatric health
Module 12: Knowing who you are: The adoptees perspective
Module 13 & 14: Cardiopulmonary resuscitation and first aid
Module 15: My brother, my sister: Sibling relations in adoption and foster care
Module 16: Crisis intervention
Module 17: The oppositional defiant child
Module 18: Ethnic hair care
Module 19: Applied behavior analysis: Understanding changing behaviors
Module 20: Autism
Module 21: Kinship care

Importantly, there is no training in the current set of modules that addresses core knowledge and strategies associated with trauma-informed practice, or that presents the richly evolving base of knowledge from the neuroscience of early childhood or adolescent development.

Fiscal Challenges

While issues of respect and relationships were often mentioned by foster families and in the reports of outside organizations, a preliminary analysis of financial payments across the family and congregate care placement continuum suggests that resource issues are also at play here.

The Connecticut rate for foster families and subsidized guardians is based on the age of the child in the home and whether the child is experiencing complex medical problems or requires service in a therapeutic context. Of note, these payments are not intended to represent compensation to foster families. Rather these funds reflect the normal "cost of care" associated with the children themselves, based on federal guidelines.

Annual adjustments for inflation were required by the Juan F Consent Decree and were awarded through State Fiscal Year 2007. When the *Juan F* Exit Plan was adopted in 2008, annual increases to account for inflation were no longer required. Rates for relative and core foster families and subsidized guardians have not been adjusted since 2007. Over this period, the national Consumer Price Index indicates that the cost of living has risen just over 8%.

[69] Further detail for each module is available online at --//cafap.com/cgi/site/training.pdf

2008 Department of Children and Family Rates for Foster Care and Subsidized Guardianship		
Age Group/Service Type	**Per Diem Rate**	**Annual Payment for 365 Days of Service**
Child Ages 0-5	$25.73	$9,391.45
Child Ages 6-11	$26.03	$9,500.95
Child Ages 12 and older	$28.24	$10,307.60
Child w/Medically Complex Needs	$46.63	$17,019.95
Minor Parent with Child	$53.97	$19,699.05

The Department's Therapeutic Foster Care Program pays 18 private providers an all inclusive rate of $133 per child per day for family foster services to children with serious emotional disturbance. This daily rate includes $68 for the provider agency to administer the program, $55 to the foster family to care for the child, and $10 towards the purchase of special resources for the child as needed. If a therapeutic foster family cared for one child for an entire year, the family would receive $18,250.

In contrast, daily rates paid to the department's therapeutic group home providers ranges from a low of $336.48 to a high of $631.88 for each youngster in care. For each youngster served in a therapeutic group home for one entire year, the annual cost could range from $122,815 to $230,636. A sample of other current rates for congregate care placements in Connecticut are shown below:

- Residential Treatment In-State: $375 per day (Juvenile Justice) and $275 (Behavioral Health)
- Residential Treatment Out-of-State: $235 per day (Juvenile Justice) and $332 (Behavioral Health)
- Safe Homes: $281 per day[70]
- Pass Group Homes: $264 per day.[71]

Taken together, this fiscal data suggests that the Department of Children and Families needs to review cost models for family foster care as it is now provided and what might be required if the agency were to develop and implement new types of family foster care programs or increase access to child-specific and family supports across the family foster care system. Despite some possible increases in the cost to provide alternative family foster care models, the comparative cost of family foster care in relation to all congregate settings will remain significantly lower.

[70] Safe Homes and Permanency Diagnostic Centers (PDC's) are intended for children requiring stabilization and assessment after removal from home. These programs are intended for children in need of short-term out-of-home care due to abuse or neglect. Currently, there are 17 Safe Homes (run by 13 providers) with a total bed capacity of 178.

[71] A PASS group home (Level 1.5 home) is a moderately-sized home, with six to ten beds. In contrast to therapeutic group homes, PASS homes are not intended to be utilized as clinical programs. These homes are located in neighborhood settings and are staffed with non-clinical paraprofessionals who provided services 24 hours a day, seven days a week. The homes are designed to serve adolescents ages 14-21 years old with mild to moderate behavioral health needs who are either too young or lack the necessary skills to move into an independent living situation.

Part V: Exploring Models of Family Foster Care

A concise description of foster family care goals, objectives and key outcomes is presented in a recent book entitled *What Works in Foster Care: Key Components of Success from the Northwest Foster Care Alumni Study.*[72] Six major functions are expected to be provided by family foster care, regardless of the particular model:

- Emergency protection
- Crisis intervention
- Assessment and case planning
- Reunification
- Preparation for adoption, and
- Preparation for independent living.

"To implement such functions, diverse forms of [family] foster care are required, including emergency foster care, kinship foster care, placement with unrelated foster families, treatment foster care, foster care for medically fragile children, shared family foster care, and small-family group home care. Also, long-term family foster care is an option for a small number of youth for whom family reunification, kinship care, or adoption are not viable permanency planning options."[73]

In describing trends in the provision of family foster care, the authors note "…indications [are] that family foster care is responding to the substantial behavioral health needs of children in care and becoming more treatment oriented. Specialized family foster care programs -- particularly treatment foster care -- for children and youth with special needs in such areas as emotional disturbance, behavioral problems, and educational underachievement are gaining significant use."[74]

At the same time, the Child Welfare League of America writes that, "One of the most recent stunning changes in the child welfare system has been the major growth in the number of children in state custody who are living with their relatives." Factors that may account for these increases include:

- Increased reporting of abuse and neglect
- A change in drug usage related to the spread of crack cocaine addiction and other drugs
- Increased levels of poverty
- More children affected by HIV/AIDS
- Parents who struggle with physical and mental health problems
- Family violence and parental incarceration, and
- A decline in the availability of traditional foster homes.

In the balance of this section of the working paper, we will review several specific models of family foster care, including kinship care, treatment foster care, and professional parent programs.

---

[72] Pecora, P.J., Kessler, R.C., Williams, J., Downs, C.A., English, D.J., White, J. & O'Brien, K (2010). What Works in Foster Care: Key Components of Success from the Northwest Foster Care Alumni Study. Oxford University Press, New York: New York. See Part I.

[73] Ibid, pp. 6-7

[74] Ibid, p. 7

Kinship/Relative Family Foster Care

Kinship care as described by the federal Children's Bureau "refers to placements of children with relatives or, in some jurisdictions, close family friends (often referred to as fictive kin). Relatives are the preferred placement for children who must be removed from their birth parents, as this kind of placement maintains the children's connections with their families. Kinship care is often considered a type of family preservation service."[75] The Children's Bureau also notes that kinship care "…may be formal and involve a training and licensure process for the caregivers, monthly payments to help defray the costs of caring for the child, and support services. Kinship care also may be informal and involve only an assessment process to ensure the safety and suitability of the home along with supportive services for the child and caregivers."[76]

Myths Debunked

In a March 2007 report entitled *Is Kinship Care Good for Kids?,* the Center for Law and Social Policy addresses two "myths" related to kinship care. The first myth is that "the apple doesn't fall far from the tree." This belief is used, explicitly or implicitly to justify ***not*** placing children with relatives. "In fact, research shows that children living with relatives are no more likely…than children living with non-kin foster parents to experience abuse and neglect after being removed from their homes."

The second belief is that extended families should take on responsibility for vulnerable children because it is "their moral responsibility." Whether a myth or not, kinship caregivers agree. "They take the responsibility of raising their grandchildren, nieces, and nephews when the children's parents, for a variety of reasons, cannot. These caregivers lack neither morals nor a sense of responsibility; they do, however, lack resources. They may be living on a fixed income or be retired; whatever the reason, it is highly unlikely that they planned financially for raising a relative's child."[77]

Research summarized by The Pew Charitable Trusts and Generations United in a 2007 publication[78] reveals that:

- ***Children in relative foster care tend to be just as safe as or safer than children placed with non-relative foster families.*** Data indicate that foster children living with relatives experience abuse or neglect at lower rates than children with unrelated foster families.

---

[75] The Child Welfare League of America defines kinship care as "…the full time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It allows a child to grow to adulthood in a family environment." This definition appears on the website of the Child Welfare League of America . Online at -- www.cwla.org/programs/kinship/factsheet.htm

[76] Child Welfare Information Gateway (2011). Kinship Care. Online at -- www.childwelfare.gov/outofhome/types/kinship.cfm

[77] *Is Kinship Care Good for Kids*, op cit., p. 2. This report also noted that the "vast majority of children living with relative caregivers are eligible for the Temporary Assistance for Needs Families (TANF) child-only grant. However, 70% of relative caregivers do not access TANF or any other public assistance."

[78] *Time for Reform: Support Relatives in Providing Foster Care and Permanent Families for Children* (2007). The Pew Charitable Trusts and Generations United. Online at -- www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Foster_care_reform/SupportingRelatives.pdf. See also, *Is Kinship Care Good for Kids?* (2007). Center for Law and Social Policy. Online at -- www.clasp.org/admin/site/publications/files/0347.pdf

- ***Relative foster placements tend to be more stable than placements with unrelated foster families.*** Children placed with relatives generally have fewer moves while in foster care.

- ***Siblings are less likely to be separated when placed in relative foster care.*** Siblings are more likely to remain together while in foster care when placed with relatives than children placed with non-relatives.

- ***Children in relative foster care maintain community connections.*** Children placed with relatives are more likely to remain within their own neighborhoods and continue in their original schools than children who are placed with unrelated foster families.

- ***Relatives are frequently willing to adopt or become permanent guardians when reunification is not possible.*** Experience across the country has demonstrated that many relatives are, in fact, willing to adopt or become permanent guardians to their kin when not forced to give up critical financial assistance in order to do so. [79]

Identifying and Meeting the Special Needs of Kinship Caregivers

In June of 2000, the Urban Institute prepared a major report for the U.S. Department of Health and Human Services. The *Report to the Congress on Kinship Foster Care* describes the role of extended families in child rearing, the evolution of kinship care in state and federal policy, how kinship families differ from other foster families, and the experiences of kinship care families involved with the public sector.[80] Research summarized in the 2000 report revealed that kinship caregivers were "older than non-kin foster parents, with a dramatic difference in the number of caregivers over age 60," disproportionately African American, more likely to be single," and had achieved lower educational levels than non-kinship families.[81] Finally, kinship caregivers were more likely to have lower incomes, and fewer were employed on a full-time basis.

Importantly, studies cited in this 2000 report "show that the well-being of kinship caregivers is generally lower than that of non-kin foster parents. Kinship caregivers experience a variety of economic, health, and emotional difficulties and often have difficulty making ends meet... Kinship caregivers are also more likely than non-kin foster parents to report being in poor health… [and] are significantly more likely to report feeling "downhearted and blue" and "unable to be cheered up."[82] Despite these challenges, the *Report to the Congress* also finds that "children in kinship care appear to have significantly higher well-being than children in non-kin foster care."[83]

Of concern is another set of research findings presented in this landmark (if decade-old) report to the U.S. Congress: kinships families generally receive less child welfare staff attention and fewer services than afforded to non-kinship foster families. Specifically, caseworkers were less likely to have offered

---

[79] For a useful summary of kinship care policies across the states, see State Kinship Care Policies for Children that Come to the Attention of Child Welfare Agencies: Findings from the 2007 Casey Kinship Foster Care Policy Survey (2007), published by Child Trends. Online at -- www.childtrends.org/Files/Child_Trends-2009_02_24_FR_KinshipCare.pdf

[80] Online at -- //aspe.hhs.gov/hsp/kinr2c00/full.pdf

[81] Ibid, pp. 34-38

[82] Ibid, p. 38

[83] Ibid, p. 38

kinship caregivers health screenings, psychological assessments, substance abuse treatment, tutoring for children in their care, and the children in their care were less likely to have seen a dentist or a mental health professional within the last year.[84] These behaviors on the part of some child welfare workers may stem from their view that it's the moral responsibility of extended families to care for their children, and they don't need and may not require extra help to do so.

Recognizing both the benefits of expanding of kinship care and the challenges facing kinship families, Casey Family Programs published a report in 2007 outlining a concrete series of actions that, if taken, would result in an effective system of kinship foster care.[85] The *Supporting Kinship Care* report was the result of a 12-month effort across states, including the Connecticut Department of Children and Families. Four overarching themes emerged from this work as did eight categories of action. Further detail on specific action steps is provided in the report.

Supporting Kinship Care: Promising Practices and Lessons Learned

Overarching Themes:

1. To engage kin, it is imperative to serve them in the context of their culture
2. Inclusion and relationship-building are critical.
3. Ensuring that kin and youth voices are represented during all facets of case planning and organizational planning contributes to changes in policy and agency culture.
4. Effective use of materials can expand the knowledge of kinship caregivers and give staff and community partners a better understanding of these individuals' needs.

Strategies that That Support Kinship Care

1. **Placement:** Identify, explore, and pursue birth family relationships with kin at the initial point of contact with the child welfare system and from that point forward as a resource to help meet child and family needs.
2. **Permanency:** Support permanence, broadly defined. This means kinship can be recognized and supported as a permanency option.
3. **Family Relationships:** Maintain, strengthen and support connections between birth parents, children, youth, their siblings, and their kin. This includes frequent interactions and contact.
4. **Services and Supports:** Implement inclusive planning that results in the provision of culturally-relevant, kinship-competent services that birth parents, children, youth and their kin ask for—and are available when they need them, throughout their involvement with the child welfare system. This includes information exchange, family choice of services, meeting the financial needs of kin families, offering "strength-based" services and supports that are community-based, available when needed and assessed regularly.

[84] Ibid, p. 42

[85] *Supporting Kinship Care: Promising Practices and Lessons Learned*. Breakthrough Series #003. Casey Family Programs. November 2007. Online at -- www.casey.org/Resources/Publications/BreakthroughSeries_Kinship.htm

5. **Constituent Engagement:** Actively engage birth parents, children, youth and their kin as true partners in designing the system of kinship care services and supports. This includes sharing information, compensating kinship participation and expertise, providing training and supports (like transportation and child care), and establishing clear expectations for all parties.

6. **Collaboration:** Collaborate with the community, other public agencies, and families to effectively meet the needs of birth parents, children, youth, and their kin by building on community leadership and strengths.

7. **Self-Support:** Facilitate kinship families' connections with one another in ways that promote self-help, mutual support, leadership, shared resources and advocacy.

8. **Training:** Train and support child welfare staff in the specific skills and competencies required to effectively work with birth parents, children, youth and their kin.

Kinship Models in Other States

Allegheny County, Pennsylvania operates a successful kinship placement program that is state-administered and county-operated. About 60% of the county's 1600 children in foster care are placed in kinship families through a private provider, A Second Chance. Allegheny County employs a set of specific strategies to encourage kinship care:

- Pennsylvania policy designating kinship care as the agency's practice
- Building "champions" for kinship care among agency staff and external partners
- Training staff on agency policy and waiver provisions related to kinship placements
- Requiring foster care staff to obtain approval to place children with anyone but kin
- Provide agency staff with tools and information to build rapport with kinship families
- Immediately address licensing deficiencies in kinship homes. [86]

The Allegheny County kinship program enlists birth family members to identify "suitable kinship care placements and engage them in developing a family-focused, family-driven reunification plan."[87] Issues of safety and risk are assessed and addressed using "a consistent set of assessment tools applied uniformly to foster and kinship care providers, standardized assessment timeframes, and continually refreshing staff understanding of the difference between safety and risk."[88] To advance reunification and permanency, Allegheny County "certifies all relative caregivers as foster homes. This helps to expedite placement and lends greater credibility to the kinship care provider."

[86] Peer Technical Assistance Match: Increasing Kinship Care Placements in Connecticut. Report from January 2011 session, Hartford, Connecticut. Prepared by Casey Family Programs
[87] Ibid, p. 6
[88] Ibid, p. 6

The county utilizes Family Group Decision Making (FDGM)[89] "to increase buy-in and participation by staff; engage family members in decisions; lay the foundation to develop greater knowledge about the family and their relationships to community; and to understand the services the kinship care provider may need to support a youth's placement. In emergency placement situations, through the use of the FDGM model, Allegheny County invites family members to participate in pre-placement conferences and permanency planning caucuses to identify family networks and supports, relatives, kinship caregivers and inform the work of the Department."

Kinship caregivers in Allegheny County have developed "their own extended network of supports by and through other licensed kinship caregivers. These relationships have resulted in families providing support to one another through substitute care when needed, transportation for children to visit parents, siblings, other family members and incarcerated parents. An additional innovation of support services involves the use of technology to ensure ongoing contact with family who do not reside in the area."[90] Part of this work also includes a male-run support group called Dads Assisting Dads. For Allegheny County, the greatest predictor of kinship success is whether these families are able to access the kinds of services and supports that they need.

In order to support their relative caregivers, the State of Tennessee developed two specific initiatives. First, an orientation program, co-facilitated by a kinship caretaker, was established. During orientation, relative families receive training on their role as partners in permanency with the Department. They also receive concrete supports such as daycare assistance, car seats, immediate financial support and other services which directly benefit the children in their care. Second, a private provider agency in the community runs support groups for all relative caregivers which are different than the support groups run for core foster families. Kinship families receive more specific information about the unique roles that they play and the dynamics that occur within their family system.

In addition, the Tennessee kinship program includes:

- The identification of barriers to placement, including the mindset of agency staff
- Mandatory use of a family teaming model
- Focus groups with staff and kinship providers
- Development of Kinship Protocols requiring "diligent relative searches" and a "rule out" of kinship placement before children could be placed in non-relative homes
- Creation of a Kinship Coordinator position to chair a monthly Kinships Care Improvement meeting with agency staff and providers and also approve for staff to place outside of kinship settings
- Review by the Tennessee Attorney General's Office and judges of kinship cases to ensure "that when petitions for neglect are filed, custody and placement remains with the relative, and the case remains open."[91] [92]

---

[89] Online at -- www.americanhumane.org/children/programs/family-group-decision-making

[90] Ibid, p. 9

[91] Ibid, p. 7

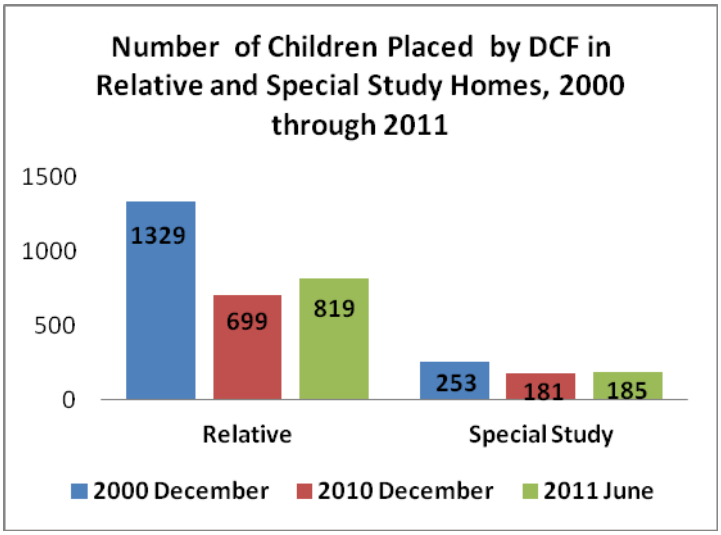
[92] For more information about Tennessee's dramatic move away from congregate care to family settings (of which kinship care is an important element), see *What Works in Child Welfare Reform: Reducing Reliance on Congregate Care in Tennessee*. Children's Rights, July 2011. Online at -- www.childrensrights.org/wp-content/uploads/2011/07/2011-07-25_what_works_reducing_reliance_on_congregate_care_in_tn_final-report.pdf

Kinship Foster Family Care in Connecticut

In Connecticut, a "relative foster family" is identified as a family related by blood, marriage or adoption, descended from a common ancestor not more than three (3) generations removed from a child. A "special study" family is defined as a non-related family identified by the child or parent(s) to care for the child. The Department of Children and Families recognizes the need to identify and assess any and all people who share a connection to a family and/or child, whether or not they are blood related. For the purposes of this report, relative and special study resources will be referred to as "kinship" family care.

Changing Trends in Kinship Care: 2000-2011. Over the period December 2000 through December 2010, the Department's use of relative foster families declined by 47% from 1329 children placed in relative families to 699. Over the same period, the number of children placed in special study families declined by 28%, from 253 in December of 2000 to 181 in December of 2010.

To address this problem, the department's new commissioner issued a directive in February of 2011 that foster families, with a special focus on relatives, be the presumed placement of choice as the department moves forward. By mid-September of this year, the number of children in relative homes had increased to 846. This represents a 22% increase since January when the department's new administration took office. Over the same period, special study placements increased to 188. Waivers issued by the Director of the Office of Foster and Adoptive Services increased from 32 for all calendar year 2010 to 60 for the first eight months of calendar 2011.



Who is in Relative Care Right Now? Among the 846 children and youth in relative foster care, more than half (446) are between the ages of birth and six. Another 236 are ages six through 11 and 158 are ages 12 through 18. Six young adults, age 18 or older, also remain in relative care. The population is quite evenly distributed by gender (409 girls and 437 boys). [93]

Placement Stability. As part of its ongoing federal Child and Family Service Review process, the Department of Children and Families tracks the stability of placements for children in the care and custody of the Department. These data are important because research and experience have shown that the more placements children are in, the more trauma they experience and the more challenging their behaviors.[94] Recently, the department's Office of Research and Evaluation analyzed placement

[93] The Department's current data system does not allow for the clear presentation of these data by race and ethnicity.

[94] See for example, Harden, B.J. Safety and Stability for Foster Children: A Developmental Perspective. Journal of Children, Families, and Foster Care, Winter 2004. Vol. 14, No. 1 Online at --

stability data for children served in 2010. The total data sample included information on over 6,000 cases. The bottom line: Connecticut youngsters in kinship placements experience fewer placement changes than do children served in core foster care, and short or long term congregate care.[95] This finding is consistent with national research.

Business Process Mapping. The Child Welfare Strategy Group conducted a "business process mapping" exercise to better understand the processes for identification, approval and supporting relative families in the Bridgeport, Norwich, Middletown, and Willimantic area offices. Staff members at all levels were interviewed to identify policy, procedural and perception barriers that, if addressed, would facilitate more placements of children into relative care. Results of this work indicate some potential barriers resulting in the historically low number of foster children reported as placed in relative care:

- The department's LINK placement database does not capture relative and special study placements in some placement service types, such as therapeutic foster care and pre-adoptive homes. Data also do not capture relative placements when they occur out of state.

- Staff members do not maximize the opportunities to identify kin options for children beginning at inception of the case and continuing throughout the life of the case. If parent(s) refuse to provide kin resources at the time of a removal, staff members do not regularly search any further.

- In some jurisdictions within Connecticut, judicial Orders of Temporary Custody are made directly with relatives without bringing children into the care and custody of the Department. Because these data are not captured by the Department, it is possible that the current count of relative placements is inaccurate.

- Staff at all levels of the Department are not yet comfortable with the idea that waivers for non-safety licensing standards can be granted at the regional/area office level.

Specific strategies were articulated to increase the use of relatives when a placement is required. A similar process will be conducted with all remaining area offices by June 2012.

Peer Technical Assistance. Peer Technical Assistance is a systems improvement method that brings a team of individuals together and pairs them with peers who have demonstrated success with a similar initiative.[96] In January 2011, Casey Family Programs brought together staff from the Connecticut Department of Children and Families, a peer consulting team from Allegheny County, Pennsylvania and a peer consulting team from Tennessee. The session resulted in a January report that summarizes effective practices in Allegheny County and Tennessee as well as problems facing the Connecticut Department of Children and Families kinship recruitment process, and outlines an action plan for Connecticut to employ in increasing and better supporting kinship placements.

//futureofchildren.org/futureofchildren/publications/journals/article/index.xml?journalid=40&articleid=133&sectionid=875&submit

[95] For further information, contact Susan Smith, Director of the Office of Research and Evaluation, Connecticut Department of Children and Families at – susan.smith@ct.gov

[96] Peer Technical Assistance Match: Increasing Kinships Care Placements in Connecticut. Op cit.

Foster Family Satisfaction. Data is regularly collected by the Connecticut Association of Foster and Adoptive Parent. Analysis of the 4th quarter 2011 Relative Foster Parent Exit Survey revealed that most relative foster families were satisfied with services provided by the Department. However, they did not all utilize support services that were available to them. Several of these findings are noted below:

- Eight in ten (79%) agreed that DCF had informed the family of the relative child's needs at the time of placement, and three-quarters (74%) that the department provided support to the family in times of crisis. Six in ten (64%) felt that the department had provided satisfactory management of their relative child's case.

- More than eight in ten (84%) reported that the department met with the family at a frequency that was appropriate and included the family in decision making.

- Seven in ten (69%) reported that the department helped them access resources for the child after placement, and 95% felt that the stipend received covered costs of providing relative care.

- Only 39 % of the relatives surveyed participated in a support group. However, 58% participated in post-licensing training; and 47% utilized a CAFAP buddy.

These data suggest that many relative foster families find the work of department staff to be helpful and timely. It does not mean that significant improvements cannot be made, however, including the much earlier involvement of extended family members when child welfare services are involved and better means of supporting relative families in general and when crises occur.

Treatment/Therapeutic Family Foster Care

On its Child Welfare Information Gateway online, the federal Children's Bureau provides information about treatment foster care, also called therapeutic foster care.[97] Treatment family foster care"…involves placement of children with foster families who have been specially trained to care for children with certain medical or behavioral needs. Examples include medically fragile children, children with emotional or behavioral disorders, and HIV+ children. Treatment foster care programs generally require more training for foster parents, provide more support for children and caregivers than regular family foster care, and have lower limits on the number of children that can be cared for in the home. Treatment foster care is preferred over residential or group care because it maintains children in a family setting."

A 2006 report entitled T*reatment Family Foster Care: Its History and Current Role in the Foster Care Continuum* provides a highly useful review of treatment family foster care in the United States.[98] The authors note that treatment family foster care results from the confluence of three "discrete traditions": child welfare's traditional foster family care; residential treatment of youngsters through the mental

[97] Child Welfare Information Gateway (2011). Treatment Foster Care. Online at -- www.childwelfare.gov/outofhome/types/treat_foster.cfm

[98] Dore, M. & Mullin, D. Treatment Family Foster Care: Its History and Current Role in the Foster Care Continuum (2006). Families in Society, the Alliance for Children and Families. Online at-- www.familiesinsociety.org/Show.asp?override=true&docid=3562.
See also, *Best Practices in Therapeutic Foster Care: Review of the National Literature and Local Practices in the State of Kansas*, October 2003.

health system, and "as an alternative to incarceration of youngsters in the juvenile justice system.[99] In short, traditional child welfare is expected to protect children. Residential treatment is expected to treat children. Secure congregate care is expected to protect the community.[100]

Treatment family foster care has emerged across these three traditions, offers multiple services and shares a set of common functions:

- Behavior management and problem-solving training
- Special education
- Acquisition of independent-living skills
- Intensive case management, and
- Individual, family and group services for children and biological parents.[101]

"Treatment foster parents are carefully selected and trained to provide specialized care, and they receive additional support and assistance from professionals who carry limited case loads. [Foster] Parents are viewed as members of the professional team and are reimbursed at higher rates than typical foster parents." Because of the effectiveness of treatment foster care in encouraging discharge to less restrictive settings," it is viewed as a "step-down placement for youth from more restrictive settings."[102]

Connecticut's Therapeutic Foster Care Program

The Department of Children and Families has provided treatment foster care for many years. These programs were developed to serve children with complex mental and behavioral health care needs within a trained, supported and nurturing family environment. Over time, however, "model drift" in program population and deviation from agency expectations occurred.

In 2007, the department's Office of Foster Care and Adoption Services embarked on a two and a half year process to comprehensively remodel Connecticut's treatment foster family program consonant with: (a) a coordinated System of Care and wraparound philosophy and (b) current evidence-based approaches to foster care. In April of 2010, following a series of public-private collaborative activities, contracts were awarded with 18 private providers for the new Therapeutic Foster Care Program. At the end of June 2011, the 18 contract agencies had recruited and licensed a total of 850 therapeutic foster family homes. Each family is permitted to serve only one child. See Appendix C for a listing of these provider organizations.

The new program includes a partnership with five foster care agencies contracted to function as Service Area Lead Agencies (SALAs), one for each of the department's five regions.[103] The Lead Agency is responsible for:

- Ensuring the timely matching of submitted referrals

[99] Ibid, p. 475
[100] Ibid, p. 475
[101] Ibid, p. 476
[102] Ibid, p.476
[103] Some adjustment will need to be made to accommodate the department's move to a six-region structure if this service continues over time. Funding for these coordinating entities is provided by the 18 Therapeutic Foster Care Program providers from their own budgets.

- Expeditious but carefully planned placement of children referred to the program, and
- Regional service quality and accountability.

Monthly and quarterly meetings are held to support collaborative oversight of the program. See below for a comparative analysis of the original and re-designed program.

A Comparison of Connecticut's Past and Current Therapeutic Family Foster Care		
Contract Elements	**Original Program**	**Redesigned Program**
Training		
Foster Parent Pre-Licensing Training	30 hours	7 -40 hours
Post Licensing Training Hours	20-24 hours	28-32 hours
Staff Training Required	None	Yes
Annual Training Plan Required	No	Yes
Wraparound Funds for Children	None[104]	At least $3,650 per annum.
Family and Provider Payments		
Foster Family per diem	$42.02	$55.00
Provider per diem	$49.05	$68.00[105]
Administrative Requirements		
Annual Quality Assurance Plan	No	Yes
Annual Recruitment/Retention Plan	No	Yes
Performance Indicators	No	Yes
Case Manager Caseload Size	Up to 12 children	Up to 9 children
Child specific Reporting	No	Yes
Mandatory Recruiter Position	No	Yes (0.5-1.0 FTE)
Required Monthly Walk Through	No	Yes
Service Requirements		
Time Frame for Match to be Made	No	Yes, within 10 business days
Time Frame to Placement	No	Yes, within 45 calendar days
Child Specific Recruitment	No	Yes
Face to Face Contact with Child	2 per month	Weekly (4 per month)
Contact with Foster Parent	2 per month	Weekly (4 per month)[106]
Birth Family Contact	No	Yes
Contact with Collaterals	No	Yes, including data
Minimum Foster Parent Respite	14 days	18 days
Permanency Emphasis	No	Yes
Independent Living Skills (Ansell Casey Life Skills)	No	Yes
Aftercare Services	No	Yes

[104] Only the original professional foster care program provided for wrap-around funds.
[105] A statewide per diem of $73 was allocated to the provider who is contracted for 100 slots to exclusively serve children discharging from Safe Homes and STARS.
[106] Two face to face contacts and either two phone and/or email contacts per month.

The principles listed below serve as the basis for Connecticut's Therapeutic Foster Care Program. They are presented in some detail because it can be argued that many of them should apply as well to both the department's core foster families and kinship foster care.

Step-Down Expectations: The program functions as a step down from higher, restrictive levels of care and to prevent children from requiring such placements. Behavioral, psychological, and psychosocial supports and interventions are included to support mastery of the skills necessary to ensure, to the greatest extent possible, children's growth into happy, self-sufficient and productive adults.

Community Opportunities for Children: Children served are to be placed in foster homes in their community, allowing them to attend their home school and maintain, as clinically appropriate and congruent with protective service requirements and relationships with their familial and social network.

Supports and Services for Placement Stability: Programs are to be developed and administered in a manner that ensures that foster children and their foster parents receive the supports and resources necessary to facilitate placement stability. Foster families are viewed as allies in devising and implementing treatment options that reduce disruption, support foster children's improved functioning and aid with permanency achievement.

Culture and Linguistic Competence: Children are to be cared for in a culturally and linguistically competent manner, supporting, respecting and upholding their cultural identity, religious/spiritual ascription and linguistic needs.

Community and Provider Collaboration: Collaboration with other providers, including DCF Area Offices, Community Collaboratives, local Systems of Care, Managed Service Systems and various formal and informal community-based services is expected, including with faith-based organizations.

Foster Family – Birth/Adoptive Family Relationships: Foster parents serve as role models and coaches to the biological family, or an adoptive family. The therapeutic foster care agency will provide a comprehensive aftercare component that includes foster parents as agents to facilitate transition to reunification through continuity of supports and services, and transfer of skills and strategies to the biological family as a means to successfully maintain children in their homes. Aftercare services are similarly to be used to support children who are transitioning from therapeutic foster care to an adoptive home or independent living.

Training: Staff and foster families are expected to attend specialized pre- and in-service training to support their duties and meet the individualized needs of the children receiving and/or requiring care.

Accountability: Accountability, model fidelity, data and quality management are core components. Child specific and administrative program data are to be submitted at routine intervals and regularly shared to aid with program administration, support for foster families, and ongoing planning for children. Data will further be used to create a performance-based contracting model.

Multidimensional Treatment Foster Care

Another form of treatment foster care, called Multi-dimensional Treatment Foster Care, was established nationally in 1983 to meet the placement needs of juvenile offenders. The goal of this program is to

decrease problem behavior and increase developmentally appropriate normative and pro-social behavior in court-involved children and adolescents who are in need of out-of-home placement. Although the program was developed to treat serious and chronic juvenile offenders, youth enter the program through referrals from the juvenile justice, foster care, and mental health systems.

Goals for participating youth are accomplished by providing close supervision, establishing fair, consistent limits and predictable consequences for rule-breaking, creating a supportive relationship with at least one adult mentor, and reducing exposure to peers with similar problems. The intervention is multifaceted, occurs in multiple settings and includes:

- Behavioral parent training and support for multi-dimensional treatment foster parents
- Family therapy for biological parents (or other aftercare resources)
- Skills training and supportive therapy for youth
- School-based behavioral interventions and academic support, and
- Psychiatric consultation and medication management, when needed.

The treatment team is led by a program supervisor who also provides intensive support and consultation to the foster parents. The treatment team includes a family therapist, an individual therapist, a child skills trainer, and a daily telephone contact person. The team meets weekly to review progress on each case, review the daily behavioral information collected by telephone, and adjust the child's individualized treatment plan.

Evidence of positive outcomes from this unique multi-modal treatment approach is compelling. Research shows that compared with alternative residential treatment models, the cost of this program is substantially lower. In addition, both boys and girls referred from the juvenile justice system show greater benefits than those served in congregate care; youth have half the number of subsequent arrests, fewer episodes of running away, and significantly lower levels of violent criminal activity.

The model, based on social learning parenting-training, can be implemented by any agency or organization providing services to children with serious behavior problems. [107] There are now three versions of the program, each serving a specific age group (children ages three through six years, seven through 11 years, 12 through 17 years). Each has been rigorously evaluated and found to be efficacious.[108]

Of considerable importance relative to the effectiveness of a multidimensional treatment foster care model is a randomized trial study, in progress in California since 2007, in which foster and kinship homes were randomly assigned to either enhanced services or case work services “as usual.” Foster and kinship homes in the MTFC condition had fewer placement disruptions, more frequent reunifications with birth families, and lower rates of child behavior problems.

---

[107] Moore, K. J., & Chamberlain, P. (1994). Treatment Foster Care: Toward development of community based models for adolescents with severe emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*. Vol. 2(1). pp 22-30.

[108] Online at -- www.mtfc.com/journal_articles.html

Connecticut's Multi-dimensional Treatment Foster Program

The North American Family Institute initiated the Multi-dimensional Treatment Foster Program in Connecticut in 2006 with a first site in Hartford. A second site in New Haven followed in 2008. In January 2009, a third site, in Norwalk, was launched. Sites are evaluated ("certified") by the Center for Research to Practice every two years. Results for the Hartford and New Haven sites are positive. In Hartford, 25 youth were being served at the point of the review. Seventeen (17) experienced positive outcomes; 12 of these young people returned to their birth parents, three were placed in a relative home, and two were placed in long term foster care. In New Haven, 12 youth were served by the program at the time of the review. Nine experienced positive outcome; six returned to their birth parents or a relative.

Professional Parent Foster Care

In a 2002 analysis of state actions to support and retain foster parents, the National Conference of State Legislatures examined reasons that states were losing foster families.[109] As part of this review, the Conference described several state initiatives to "professionalize" foster parenting, also called "paid parenting." In this model, professional foster parents "are trained employees of a public or private child welfare agency and receive a salary and benefits in addition to a monthly subsidy. Advocates of this model believe that professional foster parents are more likely to:

- Remain in the foster family system, especially in low-income areas
- Be better prepared to handle children with serious behavioral problems
- Be less likely to be confused about their roles and responsibilities,
- Have more time to work directly with foster children and birth parents, and
- Be given greater respect by caseworkers.

Finally, advocates assert that professionalization removes economic disincentives to fostering and lessens the need to place children away from their communities. Critics of this approach argue that professionalization is fundamentally inconsistent with the idea of family and that professional concerns will interfere with the intimacy and spontaneity of the parent/child relationship. They worry, for example, that a professional foster parent will be less likely than an unpaid foster parent to adopt a foster child because of the resulting loss of salary, benefits and professional status."[110]

In general, this model provides a group of carefully selected parents the opportunity to work as specialized foster parents with a payment for their work plus the dollar amount that a state would have paid for the actual cost of raising a child. In addition, professional foster parents receive intensive training, child care and respite care, and other services. These paid foster parents could be employees of a non-profit organization or of the state. The National Conference of State Legislatures report indicates that, in 2002, professional foster parenting was being piloted in Florida (Neighbor to Family Program), in Chicago (Neighbor to Neighbor) and in Boston. In Florida in 2003, the daily payment for the professional

---

[109] NCSL State Legislative Report: Supporting and Retaining Foster Parents (April 2002). Online at -- www.ncsl.org/default.aspx?tabid=16406

[110] Ibid, p. 4. See also, Testa, M. & Rolock, N. , "Professional Foster Care: A Future Worth Pursuing?," *Child Welfare* LXXVIII, no. 1, 108-124, and Waldock, T. "Professionalizing Foster Care: The Welfare of Children," *The Social Worker* 64, no. 3, online at --//home.ica.net/~sharyn/article2.htm

parent was $55, or just over $20,000 on an annualized basis. In addition, the parent received an additional $360 - $455 per month as reimbursement for the actual costs of caring for a child.

The Florida professional foster parenting program had four goals:

- Provide safe, nurturing foster care for sibling groups in a home setting and in close proximity to the family of origin
- Provide case management and additional services to promote social, emotional, physical and educational development of the children in care
- Promote and strengthen attachment between siblings and family members, and
- Provide services of sufficient quality to ensure that participants and stakeholders are satisfied with services.

An evaluation of the Florida program in 2003[111] revealed that, even in its early phase of implementation, the program "showed exemplary progress" in achieving its 29 objectives and 12 outcomes. During this time 68 children (20 sibling groups), 45 biological parents and 16 paid foster caregivers were involved in the program. A search of the online literature does not reveal any later evaluations of this program. The Chicago program (Neighbor to Neighbor) was evaluated in 1999 and was found to have achieved many of its goals. There is no evaluation of the Boston program online nor is there current information on the continued use of this program.

A search of other exemplars of this model revealed programs in New Jersey, Nebraska, Illinois, New York and in Connecticut. The New Jersey Professional House Parent Program recruits and trains foster parents to live in with a group of four to six teenagers "whose issues require active and sustained support from a therapeutic team."[112] The agency "pays a salary ($40,000 annualized) and benefits to one stay-at-home parent, while the co-parent is not employee of the agency and may work outside of the home." Professional parents must be at least 21 years of age, have at least a high school diploma, a driver's license and a good driving record. Extensive skill development training is provided. While parents are expected to provide a safe and nurturing family environment for foster youth, they are also required to participate in and follow the recommendations of the child's treatment plan.

In Illinois, the Baby Fold Professional Foster Care Program serves children ages birth to 21, regardless of gender or race. Children served must be able to function in a small group family environment of 2-4 children, but many also carry a significant mental health diagnosis. Diagnoses of children served by this program include anxiety disorder, attention deficit disorder, bi-polar disorder, conduct disorder and post traumatic stress disorder. Professional parents are trained and experienced foster parents who function as employees of the Baby Fold agency. They are also full members of the child's treatment team and they are responsible for working with the team to carry out each child's individual plan. All Professional Parents are trained in Cornell University's Therapeutic Crisis Intervention Program. Each crisis situation becomes a learning experience.

The New York program is called the REACH Family-based Treatment Program and it is licensed by the New York State Office of Mental Health. This program recruits, trains and support Professional Parents

[111] Neighbor to Family: An Innovative Approach to Foster Care. Amended Evaluation Report (April 2003). The Ounce of Prevention Fund of Florida. Online at -- www.neighbortofamily.org/Files/neighbor_to_family_evaluation_report_final-as_amended_04-03.pdf

[112]

who work as part of a "service planning team" which includes "everyone involved in the care and treatment" of children and youth placed in these homes. The target population is youngsters between ages of five through 18 who experience serious emotional and/or behavioral problems. A family specialist provides professional support to up to five cases, including case management, service planning, individualize counseling, supportive counseling and casework for the family, and support, supervision and training for Professional Parents. The Professional Parents and Family Specialists meet at least weekly, and 24-hour emergency on-call support is available to the families.[113]

Connecticut's Professional Parent Programs

The North American Family Institute first introduced a Professional Parent Program in Connecticut in 1994. This statewide, therapeutic foster family program serves youngsters who have histories of trauma, abuse, neglect and/or delinquency. These professional parents open their homes to young people, providing a safe and nurturing environment, but they also receive and then provide special training and child-specific services for individual children in the home. The Institute provides comprehensive pre-service training, individual and child-specific training, case management services, educational coordination, clinical assessments, continuing education and 24-hour on-call availability for guidance and support to the foster parents.

Learning from Connecticut's W.R. Settlement

The W.R. lawsuit was filed March 2002 seeking to improve services for children and youth with mental illness. The settlement agreement, reached in May 2007, became effective July 1, 2007 and was completed in July 2011. The department has used this work "to focus greater attention on the potential to divert younger children from residential placements and to provide targeted support to older youth who need special assistance in leaving long-term congregate placements."[114] The *Final Evaluation Report* of the W.R. Settlement Agreement, published in July 2011, provides substantial insights in the types and costs of in-home and community services needed to avert congregate placement and support families – including relative foster families -- in the care of their children and youth.

Overall, the WR program developed individualized plans for 356 children and youth through the end of May 2011. To date, half of the youngsters served with these wrap-around services were functioning at a higher level or maintaining appropriate stability in their lives, 69% remained in the same community-based placement for the duration of the WR plan, and 88% continued to live in community-based settings.

A review of services provided through the WR program to 74 WR children ages 12 and younger and living with families reveals that the most frequent services were therapeutic support staff (provided in 52% of the cases) and behavior management (42%). Other frequently utilized services include in-home therapy, after school programs, and assessment/evaluation. Annualized costs for the WR program ranged from $528 to $316,342. The median annualized cost of these plans is $21,998, or $60.22 per day. The actual average cost of active WR plans is $28,585 for an average of 9.2 months of service.

[113] Online at – www.pathwaysforyou.org

[114] *Final Evaluation Report. Individualized Community Based Options*. W.R. Settlement Agreement, July 2011.p. 1

Part VI: Ongoing Work to Advance Connecticut's Foster Family System

Changes in Agency Policy and Practice

Over the past six months, Commissioner Joette Katz has issued several directives and reports that bear on Connecticut's present and family foster family care system. These include:

- A directive to agency staff to make announced, rather than unannounced visits, with parents and families (February 2011)
- A directive that relative foster family care will be the preferred placement for children rather than the exception (April 2011)
- Policy guidance clarifying Connecticut's statutes on the continuation of services to youth who reach the age of majority (July 2011/September 2011).
- Policy guidance that children ages six years or younger will not be placed in congregate care, except with a very few exceptions authorized directly by the commissioner (Congregate Care Rightsizing and Redesign report, August 2011). This will require the development of additional foster family homes for those young children who cannot return to their birth parents.
- Policy guidance that over the next 12-18 months most children under the age of 13 years will not be placed in congregate settings (Congregate Care Rightsizing and Redesign report, August 2011). This will require the development of additional foster family homes for those children who cannot return to their birth parents.

The department's *Strengthening Families Practice Model*, in development for the past two years with support from Casey Family Programs and Casey Family Services, has been launched in two of the agency's regions with training provided by Partners in Change. Over the coming 18 months, training and implementation will occur in the department's remaining four regions. The Strengthening Families Practice Model incorporates a focus on family strengths and protective factors and draws on the Strengthening Families framework being implemented across the nation.[115] Core elements of the Connecticut Practice Model include family-centered practice, purposeful visits, family assessment and a family teaming model of engagement.

The department's Differential Response System will be launched in January of 2012. This new system will support families who have been referred for child welfare services but whose child safety risk level is low. In development for several years, the Differential Response System has received specific state funding for implementation in the current State Fiscal Year (2011-2012). Effective implementation requires a new level of partnership with local agencies and natural supports in the community. Other states that have already implemented a Differential Response System have found improved service delivery for vulnerable families. As one example, Ohio reports improved child safety, a reduction in court caseloads and a 42% reduction in the need for out-of-home placements over a five-year period when child welfare referrals actually rose.[116]

---

[115] This work is led and supported nationally by the Center for the Study of Social Policy. Information and materials are accessible online at -- www.cssp.org/reform/strengthening-families.

[116] *Morning Musings: Strengthening Families and Differential Response*, May 10, 2011. Online at -- www.ct.gov/dcf/cwp/view.asp?A=3623&Q=482766

Organizational Changes to Support Foster Family Care

Over the six month period between January and June 2011, the new departmental senior leadership team has worked closely with the governor's office and the Department of Administrative Services to implement a series of organizational changes designed to improve the effectiveness of agency operations, including the expansion and support of the Connecticut foster family system. These changes have been described in various publications[117] and are summarized below.

Creation of a 6th Region and New High Level Regional Administrator Positions

Effective September 1, 2011, the Department of Children and Families will operate with six rather than five regions. There will be no change in the number of Area Offices, but several will be administratively located within a different region. The six regions and the newly appointed regional administrators[118] are identified below along with area offices included in each region.

SFY 12 DCF Regions, Leadership and Area Offices		
Region: Administrator	**Area Offices**	**Change from SFY 11**
Region 1: Maria Brereton	Bridgeport Norwalk Stamford	The Danbury Area Office is transferred from Region 1 to Region 5.
Region 2: Michael Steers	New Haven Milford	The Meriden Area Office is transferred to Region 6.
Region 3: Allon Kallisher	Middletown Norwich Willimantic	No change in area offices.
Region 4: Michael Williams	Hartford Manchester	No change in area offices.
Region 5: Kenneth Cabral	Danbury Waterbury Torrington	Danbury is added to this region and New Britain is transferred to Region 6.
Region 6: Terry Nowakowski	New Britain Meriden	This is the new region.

[117] See *Congregate Care Rightsizing and Redesign* (August 2011), online at -- www.ct.gov/dcf/lib/dcf/latestnews/pdf/cc_right_sizing_report__young_children_and_voluntary_placements_8_4_11.pdf

[118] In order to obtain permission to create and hire for these six new unclassified positions, the Department of Children and Families vacated and turned in 11 other senior central office positions. These actions will result in an annual savings of about $400,000 in personnel cost. Legislation was passed by the 2011 Connecticut General Assembly creating the unclassified positions. The Department worked with the Department of Administrative Services to create job descriptions and the position classification.

Building Systems Capacity in the Regions

The Department is taking two actions designed to strengthen the capacity of the six regional offices to better manage and support community-based resources for children and families in their care and custody. The first of these actions has been to create a new position description within the regional administration for "systems development." This function will support the area offices to better know resources and providers – along the entire continuum of services (including foster families) in the catchment area that comprises each region. Early in September 2011, six senior people from the department's central office were transferred to the regions to assume this responsibility.

The second action involves return of responsibility and authority for foster family workers[119] (now sited in area offices) to the six regional administrators. This means that these new regional leadership appointees will be responsible not only for the work of the child welfare intake and treatment staff assigned to area offices but for the work of foster family staff as well, and – importantly – for the development of stronger, more positive and effective relationships between the two. Continued standardization of policy and practice will be guided by the Central Office Foster and Adoption Services.

Taking these two actions squarely places both authority and responsibility for assuring that the kinds of improvements called for by foster families in the hands of the agency's new regional leaders, supported by the new Systems Managers described above. As noted earlier in this report, among the problems identified by foster families are the disconnection between foster family workers and child protection workers, and the existence of non-respectful relationships between some child protection workers and foster families.

Central Office Organizational Changes

Prior to the spring of 2011, the department's Office Foster and Adoption Services was administratively located within the Bureau of Child Welfare, located in the Central Office. When the Child Welfare Bureau and other siloed units were eliminated by the new administration, two new collaborative teams were established: the Clinical and Community Consultation and Support Team, and the Child and Adolescent Development, and Prevention Team. The DCF Office of Foster and Adoption Services is a member of the Clinical and Community Consultation and Support Team. The major units that comprise these teams are shown below.

[119] The department's Foster and Adoption Service Units were established to recruit, license and support temporary and permanent family-based placement resources for children. Prior to 2006, these units were assigned to the area offices to strengthen the connection between the families available to provide a foster home and the child protective staff in each of the 14 area offices. Foster care and adoption workers reported to the area office director. In 2006, administration of these units was centralized in the department's Bureau of Child Welfare. Five program managers were hired to oversee all responsibilities of foster care and adoption, one per region. This change in management was undertaken to achieve greater standardization of policy and practice statewide, while retaining the work location of foster care workers in each of the area offices.

New Collaborative Team Management in the Department of Children and Families	
Clinical and Community Consultation and Support Team[120]	**Child and Adolescent Development, and Prevention Team**[121]
• Foster and Adoption Services • Community Clinical Services • Regional Psychiatric Services • CT Behavioral Health Partnership • Interagency/Transition Services	• Health and Nursing • Educational Services • Child Welfare, Early and Middle Childhood • Adolescent Services • Juvenile Justice

In addition to the elimination of bureaus within central office, the Department has dramatically expanded the scope of and support for agency training functions. In the spring of 2011, the DCF Academy for Family and Workforce Knowledge and Development was launched, according to a higher education model with full time faculty as well as adjunct faculty partnerships across the department and with the private sector. Staff members from other areas of the department have been reassigned to the Academy which is co-led by a senior leader from the child welfare field and a senior leader from the field of mental health.[122] The Academy also operates a "Provider Academy" for the private sector and will more formally partner with the Connecticut Association for Foster and Adoptive Parents.

Statutory Changes to Advance Family Foster Care[123]

In the 2011 legislative session, the Connecticut Department of Children and Families requested and advocated for three specific legislative changes to address problems raised by foster families. Both bills were passed by the Connecticut General Assembly in the spring of 2011.

An Act Concerning Kinship Care (Public Act 11-116)[124]

This act gives the Department of Children and Families Commissioner authority to waive any standard for separate bedrooms and room-sharing arrangements when placing a child in foster care with an unlicensed relative. Under current law and the act, the Commissioner is barred from waiving any standard or procedure related to safety. Any such placement must otherwise be in the child's best interest.

It also requires the Department to (1) report to the Superior Court, rather than simply make a determination on the appropriateness of a placement, when the court has identified a relative who

[120] For more information, contact Robert McKeagney at – robert.mckeagney@ct.gov
[121] For more information, contact Dr. Brett Rayford at – brett.rayford@ct.gov
[122] For more information, contact Dr. Michael Schultz at – michael.schultz@ct.gov, or Jodi Hill-Lilly at – jodi.hill-lilly@ct.gov.
[123] In addition to these three legislative changes, other changes in federal and state law are summarized and published by the Connecticut Association of Foster and Adoptive Parents at -- //cafap.com/cgi/site/spring11leg.pdf
[124] Online at -- www.cga.ct.gov/2011/ACT/Pa/pdf/2011PA-00116-R00HB-06336-PA.pdf

might serve as a child's foster parent or temporary custodian and (2) convene a working group to determine how to maximize kinship care for children in the department's care and custody.

This bill will enable the department to expand the group of kinship families who are eligible to serve as foster families in Connecticut. This statutory change is effective on October 1, 2011, except for the new working group which is effective July 2011.

An Act Concerning Placement of Children with Special Study Foster Parents (Public Act 11-166)[125]

This act eliminates the minimum age requirement with which the Department of Children and Families must comply to temporarily place a child with a special study foster parent. Special study families are those familiar to the child being placed but not related by blood. Examples are school teachers and coaches. A special study foster parent must be at least 21 years old and not presently licensed by DCF to provide foster care. Passage of this bill allows children of any age to be placed in a special foster parent home while licensing is being completed. This will expand the pool of foster families and improve the timeliness of foster care placements. This statutory change is effective as of July 1, 2011.

An Act Concerning Access to Records of the Department of Children and Families (Public Act 11-167)[126]

This act expands the list of parties to whom the Department of Children and Families must disclose its otherwise confidential records without the consent of the person named in the record. It also expands the list of parties to whom DCF may, at its discretion, disclose records without consent. Among these individuals are "any foster or prospective adoptive parent, if the records pertain to a child or youth currently placed with the foster or prospective adoptive parent, or a child or youth being considered for placement, necessary to address the social, medical, psychological or educational needs of the child or youth." No information may be provided that identifies the birth parent without the permission of that individual. The effective date of this act is October 1, 2011.

Increasing Kinship Placements in Connecticut

A Peer Technical Assistance session was held in January 2011 in Hartford, Connecticut. The session was hosted by Casey Family Programs and included the Connecticut Department of Children and Families and peer consultants from Allegheny County, Pennsylvania and Tennessee. This session resulted in the identification of barriers to increasing kinship care in Connecticut, as summarized below.

Barriers to Increasing Kinship Placements in Connecticut
Staff Roles and Responsibilities • Front-line workers are unaware or did not "own" responsibility for kinship care as an aspect of their work **Staff Understanding and View of Support Services for Kinship Foster Families** • Front line staff were unaware of or did not own responsibility for identifying, locating and providing support services to kinship care providers

[125] Online at -- www.cga.ct.gov/2011/ACT/Pa/pdf/2011PA-00167-R00SB-01043-PA.pdf
[126] Online at -- www.cga.ct.gov/2011/act/pa/pdf/2011PA-00167-R00SB-01043-PA.pdf

- Staff felt that relatives should care for their own and are not entitled to the same level of support/services as non-relatives
- Staff did not acknowledge the importance of community supports or their involvement in the success of child welfare cases
- Front-line staff reported that they were unaware of existing community resources and/or supports for relative caregivers

Policy and Service Access Barriers

- Families licensed by the Department or who move to guardianship are not eligible for other services
- Once cases are closed, workers cannot refer families to contract providers for services.

Waivers

- Staff continue to believe that "nothing" can be waived, the process is too cumbersome, and when a waiver is sought and refused, the worker does not push back. Some staff believe that they will get into trouble if they seek a waiver.

Special Study Homes

- This type of foster family setting is not promoted among staff as a viable option, and staff view special studies families as "less than kin."

As the result of this Peer Technical Assistance session, department staff developed a short term work plan to act on barriers that had been identified. As a direct result, legislative changes were sought and passed, and the number of kinships placements has dramatically increased over the period from January through September. The number of children in relative placements has increased from 699 in January to 846 in mid-September. Special study placements have increased from 181 in January to 188 in September. The use of waivers also increased. For the entire last year, 32 waivers were granted by the Director of the Office of Foster and Adoptive Services. Between January and September 2011, 60 waivers have been granted. [127] This represents a nearly 100% increase in waivers to support kinship placements.

An Expanding Role for the CT Association of Foster and Adoptive Parents

The Connecticut Association of Foster and Adoptive Parents, established as a non-profit organization in 1995, is funded by the Department of Children and Families to provide training, support and advocacy for the foster and adoptive family community. Under contract, the Association recruits relative and core foster families,[128] operates a 24/7 HELPLINE,[129] provides post-licensure training, mentoring and local support services, and publishes a regular newsletter for parent and other interested parties. The association is staffed by 31 employees and operates with an annual budget of $1.99 million.

[127] Note: These data represent waivers issued at the highest level. Nearly 140 lower-level waivers were also issued.
[128] Core foster families are those who are not relatives, special study families or participants in the Connecticut private provider managed Therapeutic Foster Care Program.
[129] Online information at -- //cafap.com/cgi/site/support.php

During the spring of 2011, a working group of departmental foster and adoptive staff, representatives of the CT Association of Foster and Adoptive Parents, members of the DCF Congregate Care Working Group, and national consultants from the Child Welfare Strategy Group reviewed information about the Connecticut foster family system, including the pre-licensure process. Inefficiencies were identified that may be contributing to the loss of prospective foster families prior to completion of the licensure process. As the result of this analysis, planning is underway for the Connecticut Association of Foster and Adoptive Parents to assume responsibility for the entire process of pre-licensure training for core foster and prospective adoptive parents. Implementation is targeted for early in calendar year 2012.

To better support the training provided the Connecticut Association of Foster and Adoptive Parents, the Department is moving to tightly align this work with the DCF Academy for Family and Workforce Knowledge and Support.[130] The new Academy represents a significant expansion of the department's current child welfare and protective services training to include agency-wide and private sector teaching and learning opportunities anchored in the five cross-cutting themes identified earlier.

The Continuum of Care Partnership

In September of 2011, the Department launched the Continuum of Care Partnership, a new formal public-private partnership that includes 10 private sector leaders, 10 department leaders and is co-chaired by the Deputy Commissioner for Operations and the DCF Chief of Planning and Quality. The purpose of the Partnership is to advance the mission, policy goals and cross-cutting themes of the Connecticut Department of Children and Families through a public-private partnership that includes representation from core internal and external stakeholders.

The Partnership will concern itself, over time, with issues related to the entire age range of youngsters served by the Department but may decide to focus on certain ages or certain parts of the Connecticut continuum of care in order to prepare timely reports to the Commissioner of the Department.

The Continuum of Care Partnership will function in an advisory capacity to the Commissioner of the Connecticut Department of Children and Families. At its inception, it is tasked to:

- Identify the implications for the private sector related to current policy initiatives of the Department
- Identify additional areas of service needed for the Department to achieve its goals for children and families
- Identify joint training opportunities across the private sector and the DCF Academy for Family and Workforce Knowledge and Development
- Prepare a first formal report to the Commissioner during the month of December 2011.

Members of the Continuum of Care Partnership include senior staff from the Department of Children and Families, two members of the Connecticut General Assembly, and the follow private sector representatives:

- Children's League of Connecticut
- Connecticut Association of Nonprofits

130

- Connecticut Community Providers Association
- Connecticut Council of Child and Adolescent Psychiatry/ Connecticut Chapter of the American Academy of Pediatrics
- Connecticut Early Childhood Alliance
- Connecticut Juvenile Justice Alliance
- Connecticut Voices for Children
- FAVOR (Statewide Family Advocacy for Children's Mental Health)
- Hartford Foundation for Public Giving

The Continuum of Care Partnership will be co-chaired by two members of the Commissioner's Senior Leadership Team.

Part VIII: Building a Better System: Strategies for the Future

Insights gained from Parts II through VII of this paper suggest a broad set of steps that can be taken to advance outcomes both for children and for the department's family foster care system. Some of this work is already underway, as described in Part VI of this report. The balance of this paper presents a set of strategies that we believe will advance a vibrant family foster care system in Connecticut and improve the likelihood of better outcomes for the children and youth served by foster families. Some of these strategies can be accomplished quickly and with little additional cost. Other strategies will require the analysis of resource needs and the development of alternative fiscal models and processes. In all cases, the Connecticut Department of Children and Families recognizes that no new state resources will be available to implement these changes, and that the reallocation of existing resources will be required.

Following release of both the Executive Summary and the complete report, the Department will engage in the following next steps. First, the internal process of analysis and cost modeling will continue over the next 90 days in order for the agency to describe its needs for the current year (SFY 11-12) to appropriate executive agencies and to the legislative branch. This analytic process will draw upon the expertise and knowledge of outside groups and organizations, including the Connecticut Association of Foster and Adoptive Parents, the Continuum of Care Partnership, the network of providers associated with the Connecticut Therapeutic Foster Care Program, and both national and regional technical assistance and consultation resources.

Second, department staff will work with interested stakeholders, including the Connecticut Association of Foster and Adoptive Parents and the new Continuum of Care Partnership, to review and prioritize proposed action items within each of six strategy areas for modification or implementation over the period January – June 2012, and July to June 2013.

This collaborative work will result in a strategic work plan for advancing and expanding a vibrant, effective family foster care system for the State of Connecticut. The work plan is expected to be completed as soon as possible, but in no case later than January 30, 2012.

1. Strategies to retain current and newly recruited foster families

a. Culture: Rebuild a culture of respect among foster families and department staff by including foster families as true partners in the Strengthening Families Practice Model's core elements (family engagement, purposeful visits, family assessment, and family teaming in the case process). With the Child Welfare Strategy Group and the DCF Academy for Family and Workforce Knowledge and Develop, design and implement a "culture of change" campaign for supervisory and managerial staff at the Department.

b. Communications and Engagement: Improve the communications process between area office staff and foster families, including prompt, welcoming and informative email, phone and in-person contacts, and respond rapidly to requests for help. Conduct automatic reviews of all foster homes that have not been used in the first 45 days, to inform and counsel them if there are agency reservations about their future use or, if the agency intends to place children, to engage them in ongoing reviews of children needing placements.

c. Feedback: Strengthen the feedback process between foster families, the CT Association of Foster and Adoptive Parents and the Department through regular review of foster parent satisfaction information. Work quarterly with the DCF Ombudsman's Office to review complaints and problems reported by foster families. Contact all foster families at the point at which children in their care are moved to support them through this transition. This is especially important if the placement has been of long duration.

d. Community Supports: Assist families to access community supports, including such programs as the Earned Income Tax Credit, Food Stamps (now called SNAP), WIC nutrition programs, 211 Information and Referral services, 211 Child Development Infoline, adult education and workforce development programs.

e. Family Supports: Improve access to family supports, including formal and informal mentoring, faith-based support networks, fatherhood programs, grandparent support groups, preschool and afterschool programs and educational advocates for children in their care, Connecticut's Help Me Grow Program and address issues related to the use of respite care

f. Crisis Intervention: Assure that foster families can get access to 24-hour emergency assistance and support when behavioral problems emerge with the children and youth in their care.

g. Training: Provide or link families with training and learning opportunities that match the care and treatment needs of children and youth living with them, including education on child and adolescent development, the special needs of infants, and how to recognize and deal with trauma-induced behaviors. Assure that training offered both before and after licensure reflects the department's six cross-cutting themes. Assure agency policy requires comparable training (including both time and content) across all types of foster families.

h. Cost Projections for Service/Support Expansion: Develop cost estimates for expanded wrap around services (child-specific) and family supports needed to retain families in the foster care system. Request authority to utilize a variety of fiscal strategies to ensure that sufficient funds are available for both child-specific services and family-supports in the current fiscal year,

i. Cost Projections for Expanded and New Family Foster Care Models: Research and develop alternative service delivery models and companion performance outcomes for resourcing and compensating foster families. Develop new fiscal policies, as needed, to implement expanded and new family foster care models, including such policies as "money follows the child," one-time transfers of funds *from* the board and care account for residential and other forms of congregate care *to* the foster family care and community services accounts, and transfers across accounts using the existing governmental Finance Advisory Committee (FAC) process.

2. Strategies to improve outcomes for children and youth in foster family care

a. Developmental Assessments: Develop agency policy requiring foster families with young children to participate in Connecticut's free Help Me Grow program, including the use of the Ages and Stages Questionnaire to track growth and development in children ages birth to six. As required by federal law and internal departmental policy, assure that all children under the age

of three years placed in family foster care are referred to the Department of Developmental Services for mandated B-3 Program assessment and services

b. Youth Involvement: Modify the case planning process to include youth and foster parents in team meetings to improve placement matches and reduce placement disruptions and multiple placements.

c. Sibling and Family Contact: Implement procedures to make it easier for children and youth in foster family placements to maintain contact with birth parents (as appropriate), siblings and extended family members.

d. Child-Specific Services: Develop and implement procedures for foster families to access child-specific services based on individual development needs and trauma histories of the youngsters in their care. These services may include developmental assessments, clinical assessment, in-home and/or community therapeutic services, special education services and supplementary academic supports such as tutoring, independent living, work and learn programs. Note: This work involves both assuring that services are available (access) but also that foster youth participate in them (utilization).

e. Educational Supports: Assure that foster families, departmental staff and youth have access to educational records in order to support the academic progress of youngsters in foster family care. Engage with volunteer educational advocates to assure that students receive IDEA and other services for which they are eligible. Encourage youth to aim for a high school degree rather than a GED.

f. Health Services: Examine the feasibility of creating a "health passport" for foster children and youth that captures information about the health status and needs of individual children and moves with them throughout their engagement with the Department of Children and Families.

g. Special Talents and Community Service: Develop a process, as part of foster children's plan of care, to identify and promote their special talents, skills and interests and to link them with volunteer and civic opportunities to give back to their communities.

h. Transitions: With youth and representatives of the foster family and congregate care sectors, develop and implement a "tool kit" to guide and support children and youth during transitions in and out of placement. Because studies show that youth transitioning out of the foster care system seek to re-establish or maintain contacts with birth family members, siblings and foster parents, transition planning must support and foster these ongoing connections.

3. Strategies to Improve case planning, matching and transitions

a. Family Teaming: Implement a "family teaming model" including the involvement of foster families as the 4th component of the Strengthening Families Practice Model. The use of family teaming means that youth (as appropriate) and family members participate in person at various points in the case process.

b. Trauma-Informed Policy and Practice: Assure that children's trauma history is included as part of information provided during the case planning and matching process. Assure that this information is linked to training in the provision of child-specific behavior management and support strategies for foster families.

c. Transfer Policy and Practice: Ensure that departmental policy requires congregate care providers to include foster families in the treatment and transition process related to children and youth who will enter their care. Evaluate models for possible implementation that compensate congregate care providers to provide follow-up contact and treatment (for up to 90 days) in the homes of foster families who receive children from congregate care placements.

4. Strategies to improve outreach and foster family recruitment

a. Outreach: Utilize electronic, social media and personal contact to reach the general population in Connecticut as well as specific audiences targeted for recruitment. This would include use of the new Electronic Tabloid, forums with the faith community representing African American and Latino families, and other activities specified in the department's emerging Strategic Communications Plan.

b. Improved Recruitment Materials and Tools: Develop a Frequently Asked Questions document for prospective foster and adoptive families that presents current data on children in foster family care in Connecticut. Explore development of a web-based "chat room" for prospective families to support them during the recruitment, licensure and pre-placement period.

c. Recruitment Barriers Analysis: With the Connecticut Association for Foster and Adoptive Families, evaluate the entire recruitment process to identify at what points prospective foster families "drop out" and then devise strategies to remove these barriers to the greatest extent possible.

d. Child-Specific Recruitment: Develop, implement and assess the effectiveness of child-specific recruitment of foster families, beginning with foster family homes for younger children to prevent congregate placements and to return young children now in those placements. Address youth permanency needs by focusing agency attention on creating foster family homes and adult connections for older youth now in congregate care.

e. Cohort-Specific Recruitment: Develop, implement and assess the effectiveness of targeted recruitment strategies for identified cohorts of youngsters served by the Department, including infants and toddlers, sibling groups, medically complicated children and youth, children and youth with complex mental health problems, and gay/lesbian/bi-sexual and transgender youth.

5. Strategies to expand kinship and treatment family foster care

a. Kinship Care: With the Child Welfare Strategy Group and the Connecticut Association of Foster and Adoptive Parents, devise and implement a two-year work plan to increase the recruitment of and support for kinships families, including relatives and special study homes. Continue to modify agency policy and improve practice as necessary to remove barriers to kinship placements. Support kinship families to develop their own support networks to promote self-

help, mutual support, leadership, shared resources and advocacy. Develop performance measures including recruitment target, placement and outcomes by region, track performance and report outcomes over time.

b. Treatment Foster Family Care: Explore the development and/or expansion of Multidimensional Treatment Foster Care and Professional Parent Foster Care for implementation by the Department of Children and Families. Develop cost models, need and utilization projections, and an implementation plan for the period between July 2012 and June 2013.

6. Strategies to improve results accountability and data use and to secure legislative approvals (as needed)

a. Performance Measures: In consultation with the Juan F Court Monitor, Child Welfare Strategy Group, Continuum of Care Partnership and the Connecticut Association of Foster and Adoptive Parents, propose a set of Results Based Accountability (RBA) performance measures for implementation beginning no later than July 1, 2012. The measures should address: how much service is provided (with detail); how well the service is provided (with detail); and the degree to which both foster children and youth and foster families are "better off" as the result of this work and investment.

b. Data Infrastructure, Development, Use and Reporting: In consultation with Casey Family Programs, the Child Welfare Strategy Group and senior departmental leadership, develop a short- and medium-term set of proposals to improve all aspects of data use and support related to the delivery and effectiveness of foster family services in Connecticut. This should include any changes needed to affect data exchange and sharing across state agencies related to case coordination and the provision of services to foster children and foster families by other state agencies.

c. Legislative Action: Develop and submit such legislative proposals as needed to secure clarification of existing policy or law, or new statutory authorizations related to changes in Connecticut's family foster care system.