Ned Lamont
GOVERNOR
STATE OF CONNECTICUT

July 21, 2021

Bob Cavanaugh - Program Manager
Children's Bureau
Department of Health and Human Services Region 1
JFK Federal Building, Rm 2000
15 Sudbury Street
Boston, MA

Dear Mr. Cavanaugh,

The State of Connecticut Department of Children and Families is pleased to submit Connecticut's Family First Prevention Plan for approval.
Connecticut is committed to the well-being of all children, youth, and families as demonstrated by our ongoing efforts to implement evidence-based and promising practices that will respond to the needs of children and families we serve. The attached document is Connecticut's plan - not solely the child welfare agency's plan - reflective of the cross-system collaboration we are proud to uphold in our state.

In partnership with over 400 individuals from state agencies, community-based providers, advocates, youth and families with lived-experiences, the State of Connecticut's Family First Prevention Plan was developed to strengthen families, prevent unnecessary placements into foster care and ensure that children can reside safely in their own homes.

Connecticut proudly presents an innovative and comprehensive plan of well-supported, evidence-based practice models and services for children and families known to Connecticut's Department of Children and Families. However, what makes this prevention plan unique is that Connecticut has taken a bold approach to expand access to prevention services to children and their caregivers "upstream" who present with particular needs or characteristics that ultimately may result in DCF involvement -- identified through a community pathway.

Connecticut's vision is to shift from a system solely focused on child protection, where action is taken after harm to a child has occurred, to a collaborative child well-being system focused on prevention and early intervention.

We look forward to your feedback and continued partnership.

Sincerely,

Ned Lamont
Governor
State of Connecticut

Vannessa L. Dorantes, LMSW
Commissioner
Connecticut Department of Children & Families

210 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106
TEL (860) 566-4840 • www.governor.ct.gov
Governor.Lamont@ct.gov

Enclosures:

Connecticut's Family First Prevention Plan
Attachment I State Title IV-E Prevention Reporting Assurance
Attachment II State Request for Waiver of Evaluation
Requirements for a Well-Supported Practice - Functional Family Therapy
Multisystemic Therapy
Brief Strategic Family Therapy
Parent Child Interaction Therapy
Nurse Family Partnerships
Healthy Families America
Attachment III State Assurance of Trauma-Informed Service Delivery
Attachment IV State Annual Maintenance of Effort (MOE) Report
Attachment B State Plan for Title IV-E of the Social Security Act:
Prevention Services and Programs - State of Connecticut

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Governor.Lamont@ct.gov

2021

Connecticut Family First Prevention Plan

STATE OF CONNECTICUT

DEPARTMENT OF CHILDREN AND FAMILIES

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Introduction

The State of Connecticut's child welfare system values families and believes children are best served safely in their own homes. A strength of the system is a fundamental belief that the well-being of children and families is a shared responsibility with all members of the community. When a need is identified, families predominately require local "support" versus government "surveillance."

Connecticut practices within an integrated child welfare structure; one which collaborates, sets priorities, and supports families remaining together. CTDCF, sister state agencies, community-based organizations, early childhood, K-12 education, healthcare, law enforcement, judicial/courts, housing, behavioral health, labor and social service systems are all on the same team, working together to achieve optimal outcomes for children, youth, families and communities.

Connecticut has embraced the values and principles of the Family First Prevention Services Act[1] (Family First). Family First represents a shift in federal policy as it extends the use of Title IV-E funds beyond foster care and adoption assistance to prevention services intended to stabilize families and keep them together. Specific prevention services that are newly eligible for federal reimbursement include evidence-based mental health treatment programs, substance abuse prevention and treatment programs, and in-home parenting skill-based programs rated on the Title IV-E Prevention Services Clearinghouse.

Family First is being utilized as a tool, as part of Connecticut's overall prevention strategy, to assist in building upon an existing infrastructure, and its already diverse array of services and evidence-based programs (EBPs), with the goal to prevent maltreatment and children entering foster care. Connecticut's vision is to expand upon its collaborative child well-being system through enhanced focus on prevention and early intervention.

This prevention plan is Connecticut's plan - not solely the child welfare agency's plan - designed to enhance the lives of all of Connecticut's children, youth, and families.

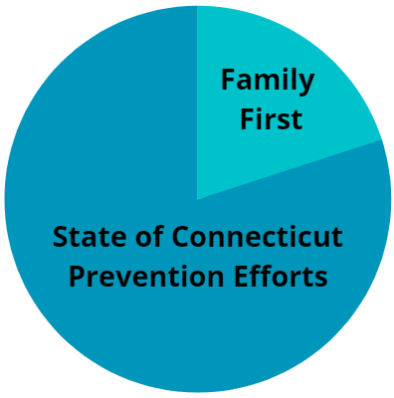


Figure 1. Connecticut prevention

This plan is also aligned with several other strategies currently being utilized in Connecticut, devoted to equitably meeting a family's needs, and which will be detailed throughout this plan. Connecticut's vision is to shift from a system solely focused on child protection, where action is taken after harm to a child has occurred, to a collaborative child well-being system focused on prevention and early intervention.

Connecticut has reimagined its system to not only serve those families who come to the attention of the child welfare agency, but to also develop supports for families "upstream," resulting in families being diverted from involvement with the child welfare agency. By empowering and supporting families, the well-being of Connecticut's

1 For a full summary of the Family First Prevention Services Act, including the prevention provisions, see the Children's Bureau's Information Memorandum, ACYF-CB-IM-18-02 available on https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf.

children, youth and families will be enhanced across systems making for a more promising future.

Connecticut is grateful to the hundreds of community partners, especially those parents and youth with lived experience, who have provided valuable insight into our planning process. Their voices influenced each section of this plan.

How We Have Approached the Work

The State of Connecticut Department of Children and Families (CTDCF) led a structured and collaborative process to develop a plan that advances a prevention-oriented system.

Over 400 community partners were involved, including parents and youth with lived experience, decision makers throughout state government, community organizations, advocates, and contracted providers. The priority was to ensure that children and families were truly at the center of the work.

Equally important to the inclusion of multiple partners was complete transparency of the process. To that end, a CT Family First website was established: https://portal.ct.gov/DCF/CTFamilyFirst/Home . All workgroup charters, meeting schedules, meeting minutes and documents used throughout the process have been posted and maintained within the website. A mailbox, DCF.CT.Family.First@ct.gov was established for community partners to ask questions and receive information about our planning.

To ensure cross-system collaboration and decision-making, Connecticut convened a Governance Committee and seven workgroups. The Governance Committee, comprised of CTDCF leadership and state and community partners, served to review evidence and community informed recommendations from each of the workgroups. After engaging in dialogue and receiving feedback to inform decision-making and ensure a connection between the prevention plan and other strategies designed to support children, youth and families, recommendations were provided to the CTDCF Commissioner.

The seven workgroups were co-led by an internal CTDCF staff member and an external community partner; the group participants were comprised of internal CTDCF staff and community partners.

An overview and description of each workgroup is as follows:

Candidacy - The workgroup strategized which populations of Connecticut children and their families were best positioned to benefit from Family First prevention services to address risk factors for maltreatment and prevent entry into foster care.

Community Partnerships and Youth and Family Engagement – The workgroup engaged with parents, youth, legislative officials, community providers, and other state agencies in the planning, development, and communication of Connecticut's planning process. This engagement included consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children who are at risk of foster care entry and their parents or kin caregivers and pregnant or parenting foster youth.

Fiscal and Revenue Enhancement – The workgroup completed fiscal modeling and provided recommendations regarding the fiscal and revenue impact of identified options.

Infrastructure Policy and Practice – The workgroup recommended modifications or additions to current policy, practice, and internal infrastructure to align with the revised model of care under Family First.

Kinship and Foster Care – The workgroup developed core recommendations to increase Connecticut's ability to support children's safe, supportive, and nurturing care in the most family-like caregiving setting possible when children cannot be with their parents.

Programs and Service Array – The workgroup aligned Connecticut's vast array of services and programs to the identified needs of the children and families served in candidacy groups, while ensuring a focus on quality services and interventions.

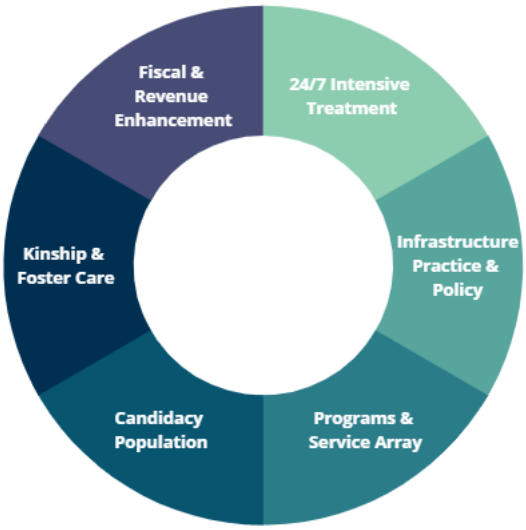


Figure 2. Family First Workgroups

24/7 Intensive Treatment QRTP (Qualified Residential Treatment Program) – The workgroup established expectations to achieve QRTP standards of care and supported providers throughout the planning process leading up to QRTP certification.

Figure 3. Parents as Experts process overview

In addition to the aforementioned workgroups, the Department was intentional about capturing the parent voice as evidenced by three focus groups in which the emphasis was the caregivers' lived expertise. "Parents as Experts" conversations were designed to actively seek input from families on their perspectives about how services can best be delivered to prevent maltreatment and promote family well-being. The discussions allowed for knowledge to be gathered about:

- What constitutes a good referral and service experience for a family
- How parents wish to be treated when considering and seeking support/when being supported in caring for their children
- What resources and methods engage children and families most effectively

The response to invitations to participate in these sessions was extraordinary. More than 100 families responded, with a total of 44 families being actively involved across all three sessions. Their feedback was thoroughly documented and shared with the Governance Committee. Caregivers appreciated the opportunity to share and express perspectives that were unique to their experiences. Overall themes included

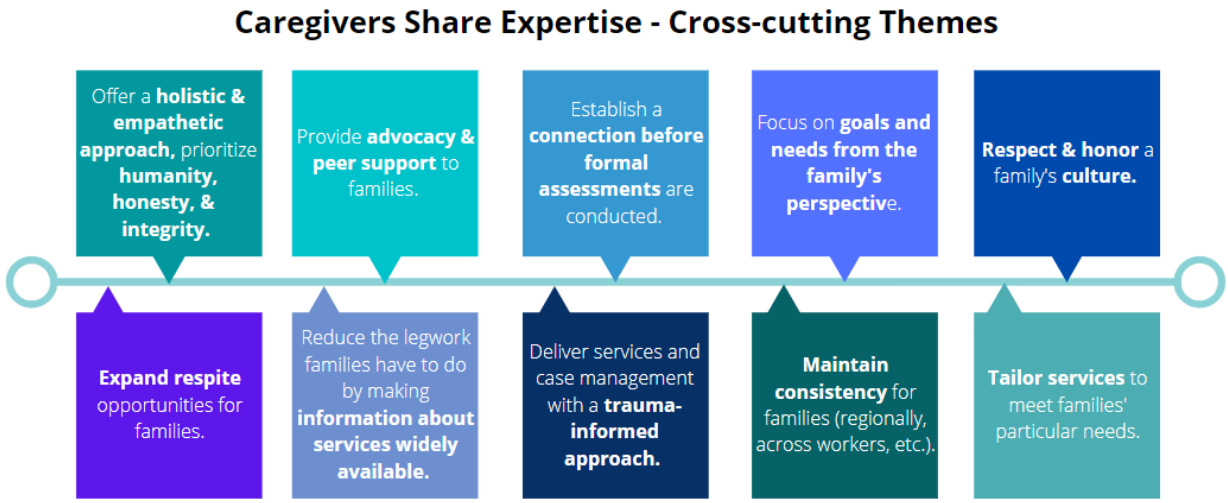


Figure 4. Caregivers share expertise, cross-cutting themes.

The Vision for Connecticut's Child Well-being System

CTDCF intends to maintain its foundational mandate to keep children safe with their families but strives to evolve our mission, vision and strategies to become an agency that empowers families to thrive by walking in partnership alongside them. In order to continue this evolution, CTDCF will need to rely on the collective thinking and collaborative contributions of sister agencies, providers, community partners, and most importantly our families, to build trust and reimagine our system.

Connecticut views Family First as an opportunity to continue and augment this transformation into a system of well-being; in part, by extending prevention services to families earlier and continuing to realign objectives towards prevention more broadly. Family First has already facilitated meaningful collaboration between partners in Connecticut to reimagine a coordinated system designed with and for families. Connecticut's youth and family serving agencies - including the Departments of Education, Social Services, and Mental Health and Addiction Services - have been engaged in planning for this work, relying on each agency's strengths, resources and opportunities to create collective positive impact for our families.

Along with expanding access to prevention services and fostering coalition building, one of the most exciting ways in which Connecticut intends to leverage Family First is as a tool to rethink which families are eligible for preventive services and the manner in which CTDCF plans to manage their cases. Connecticut developed a broad target population (families eligible for Family First services) definition that includes two population groups:

1) Those that are already "known-to-CTDCF" either through a call to the Careline, prior involvement in the system, or current involvement (pregnant and parenting youth in foster

care). This group of families will constitute Connecticut's initial candidacy population for Family First prevention services.

2) Families that will be referred through a "community pathway." This group of families will be served during the second phase of Family First implementation when the appropriate partnerships, infrastructure, and fiscal support are sufficiently established.

The community pathways population includes "upstream" families experiencing specific behavior, conditions, or circumstances that are likely to have an adverse impact on a child's development or functioning and for whom research establishes that such characteristics or conditions place them at increased risk for maltreatment, involvement with the child welfare system, or out-of-home placement. (See Section 2 for more information on candidacy.)

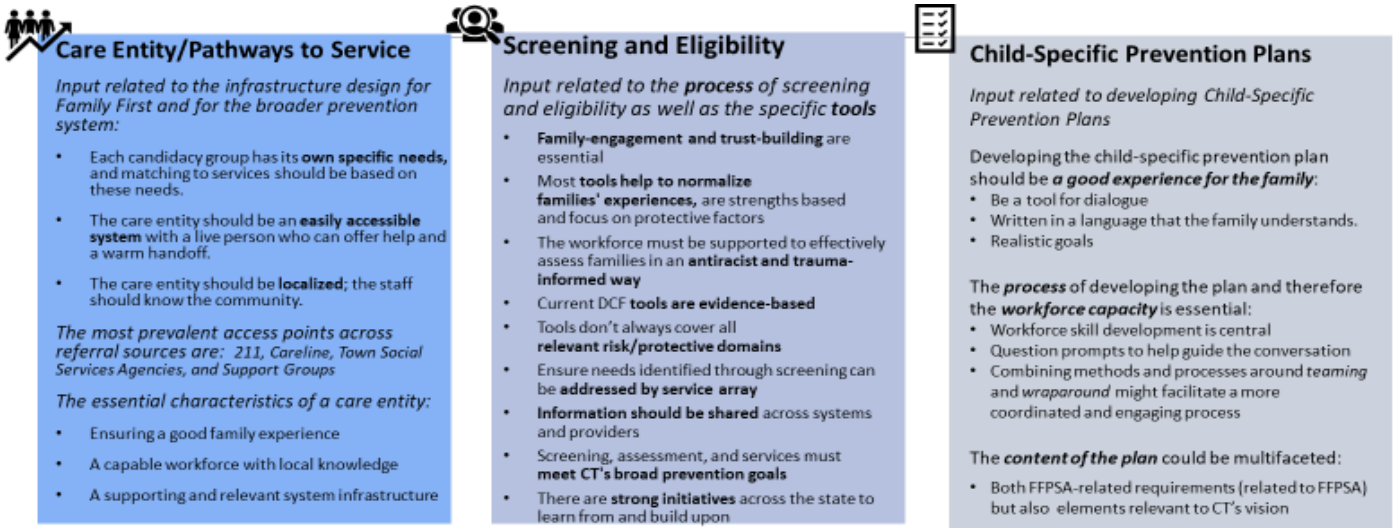
Families with certain characteristics that will be identified through a community or neighborhood pathway and eligible for services are:

- Families accepted for Voluntary Services *(Voluntary Care Management as of May 1, 2020)*
- Children who are chronically absent from preschool/school or are truant from school
- Children of incarcerated parents
- Trafficked youth
- Unstably housed/homeless youth
- Families experiencing interpersonal violence
- Youth who have been referred to a juvenile review board, youth service bureau, other diversion program, or who have been arrested
- Caregivers or children who have a substance use disorder, mental health condition or disability that impacts parenting
- Infants born substance-exposed as defined by the state's Child Abuse Prevention and Treatment Act (CAPTA) notification protocol[2]

Connecticut sees this pathway as a tremendous opportunity to provide services earlier to families to establish stability and family well-being, and to prevent foster care entry. To engage these families earlier, CTDCF heard directly from families and partners that it was important to develop an entity outside of the Department to assist in these families' cases. Therefore, as available funding allows, CTDCF plans to contract with a Care Management Entity (CME) to engage these "community pathways" families, provide case management, manage service referrals, and monitor ongoing progress. In response to feedback from

[2] CT definition of infants born substance-exposed for the purposes of the CAPTA notification: A newborn: (1) exposed in utero to methadone, buprenorphine, prescription opioids, marijuana, prescription benzodiazepines, alcohol, other illegal/non-prescribed medication, and/or the misuse of prescription/over the counter medication; (2) with withdrawal symptoms; (3) diagnosed with Fetal Alcohol Syndrome.

Figure 5. Infrastructure, Practice, and Policy workgroup strategies to improve CT practice

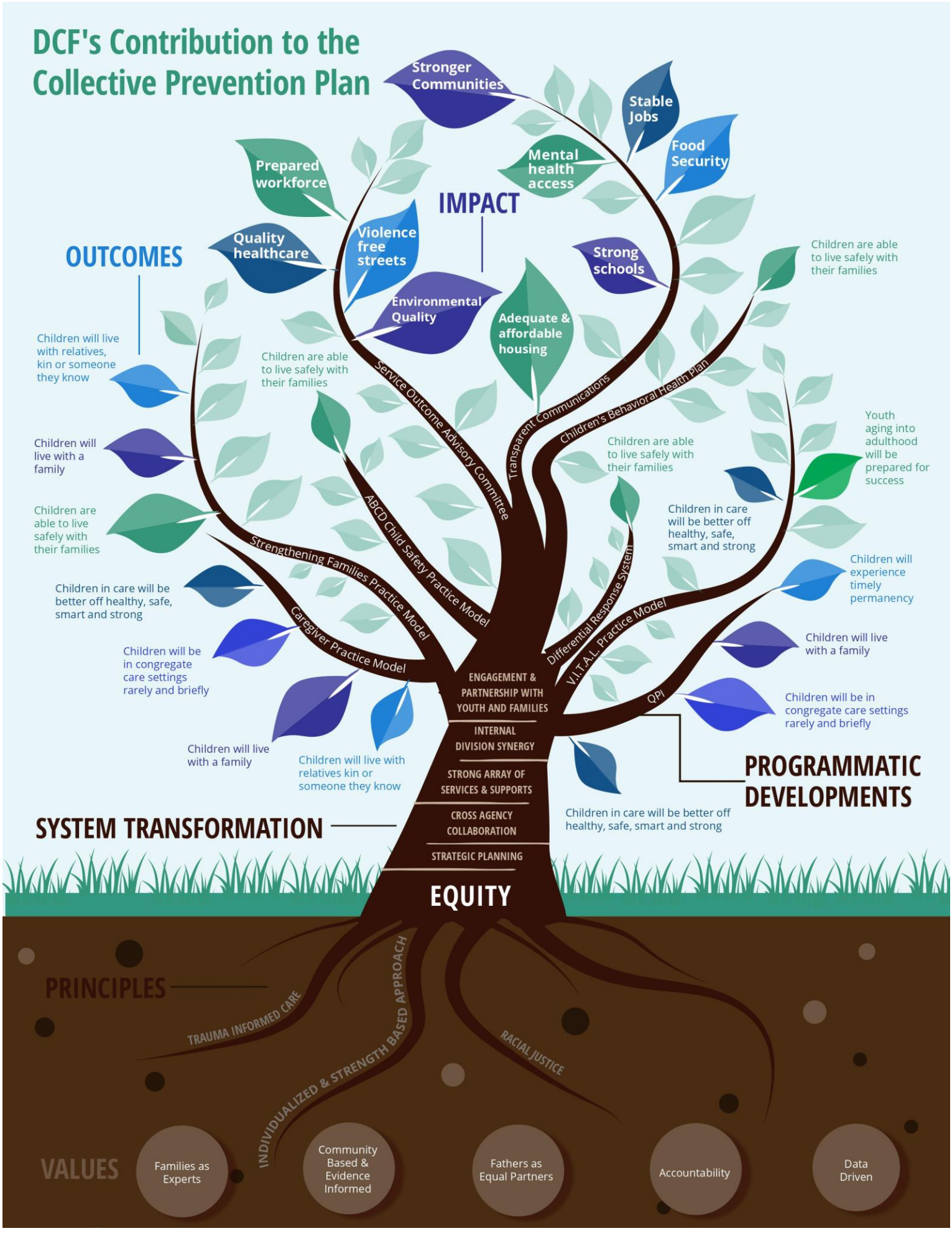


families and partners, CTDCF is eager to establish this relationship to capitalize on the ground-breaking Family First opportunities without magnifying CTDCF surveillance.

While Family First offers Connecticut opportunities for innovation in prevention, it is only one mechanism among many that Connecticut intends to employ. For example, Connecticut recognizes that the list of evidence-based programs on the Prevention Services Clearinghouse does not capture the full range of needs of Connecticut families. Therefore, Connecticut intends to continue investment in efforts that address family and community economic supports, services that are developed with and for communities of color, and evidence-based practices that address the full continuum of mental, behavioral, and physical health needs of Connecticut children and families.

Connecticut is enthusiastic about developing a well-being system and implementing Family First as the next step of its transformation journey, and invites its sister agency partners, communities, and families to continue to participate in this transformation and to help shape the system we envision for our families.

DCF's Contribution to the Collective Prevention Plan



Overview – Connecticut Department of Children and Families

The Connecticut Department of Children and Families' legislative mandates include prevention, child protective and family services, children's behavioral health, and educational services. With an annual budget of approximately $800 million, the Department operates a central office, fourteen (14) area offices, and two (2) residential facilities. CTDCF operates a Wilderness School that offers high-impact wilderness programs intended to foster positive youth development through experiential therapeutic recreational activities; and a Unified School District that provides quality education and support services that lead to educational success for children in foster care, those placed in a private residential facility by the Department with no other educational nexus, or who are receiving psychiatric treatment within one of the DCF-operated facilities.

CTDCF seeks to sharpen the safety lens by strengthening primary prevention across the child welfare system through five strategic goals: ***Safety, Permanency, Racial Justice, Well-being, and Workforce***.

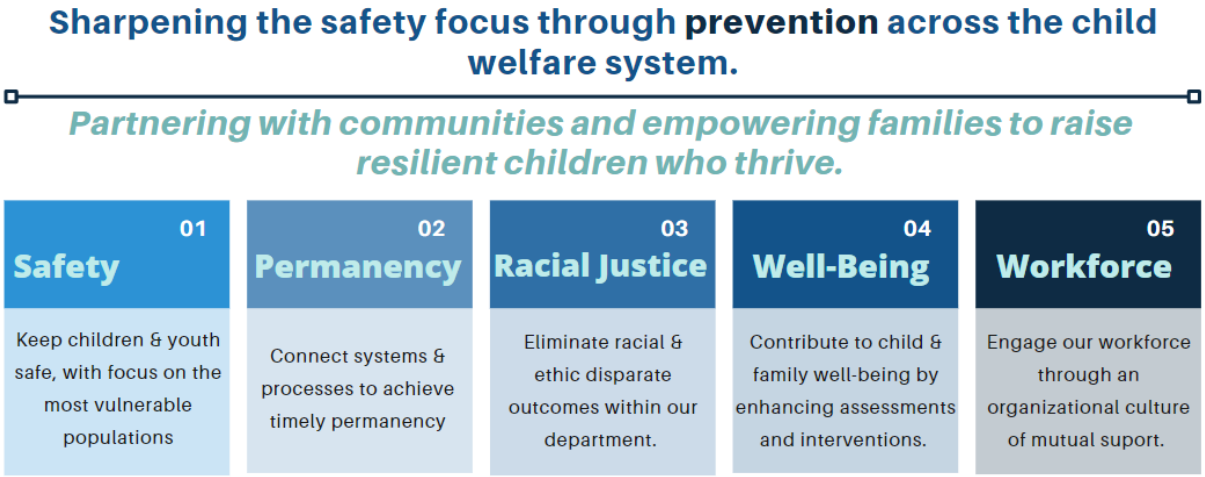


Figure 6. CTDCF Five Strategic Goals

CTDCF believes that children do best when living safely at home with their family of origin. When living at home with a parent is not reasonably safe, the best alternative is to live with relatives, kin, or someone the child knows who can provide a safe and nurturing home. If no family member or kin can provide a suitably safe home that meets the child's needs, the child should receive care and services in an appropriate foster home or a setting that is able to meet their needs in a timely manner. If absolutely required, a child who needs to be placed into a congregate care setting for an identified treatment need should only remain there until they are stabilized enough to return to a home where treatment can continue in a family setting.

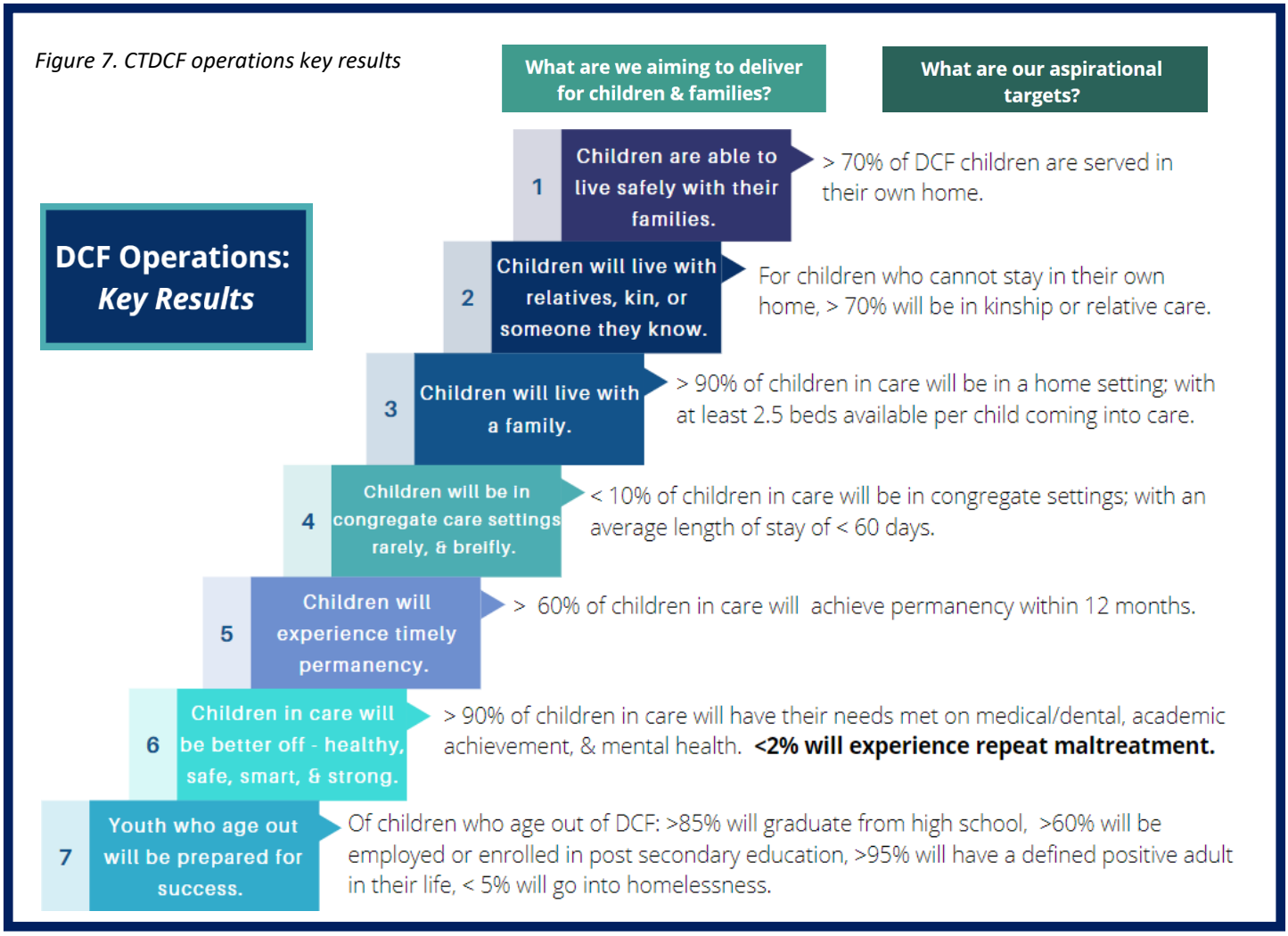
The mission of CTDCF is grounded in a core set of seven Key Results that drive the Department's Strategic Goals for how to best meet the needs of and serve Connecticut's children and families.

CTDCF Mission

"Partnering with communities and empowering families to raise resilient children who thrive."

These strategies are about what CTDCF aims to do, but it is just as important to set the expectations for how CTDCF will work to achieve its goals. To this end, it is important that the agency's 3,200 staff members work with purposeful pride and passion for practice, and people. Prioritization of people further highlights our commitment to partnerships. We recognize that the basis for achieving a system of well-being through a dedicated stakeholder partnership is paramount as we cannot, and should not, do this work in isolation.

Figure 7. CTDCF operations key results



Programmatic Developments Essential for Systems Transformation

Connecticut continues to demonstrate its commitment to practice through various programmatic developments, strategies, and initiatives. Supported by the pillars mentioned above the following programmatic descriptions highlight Connecticut's prime positioning to implement Family First.

1. CTDCF Strengthening Families Practice Model

Recognizing the importance of a structured approach to practice, in 2011, the Department began its transformation through the development and operationalization of a Strengthening Families Practice Model, which is a framework of the agency's shared values and strategies applied to the work with families.

The practice model is built on a foundation of family engagement and family-centered assessment. Strategies actualized through this approach include purposeful visitation, initial and ongoing assessments of safety and risk, individualized services as well as supervision and management.

The seven cross-cutting themes that guide the mission and strategies of the practice model are:

- Implementing strength-based family policy, practice, and programs
- Applying the neuroscience of early childhood and adolescent development
- Expanding trauma-informed practice and culture
- Addressing racial inequities in all areas of our practice
- Building new community and agency partnerships
- Improving leadership, management, supervision, and accountability
- Becoming a learning organization

Implementation of the practice model leads to consistent and effective engagement across Department offices and improves the quality of work and supervision. Intended outcomes include:

- Prevention will lead to fewer families in need of CTDCF Services
- Children remain safely at home, whenever possible and appropriate
- Children who must come into CTDCF care achieve more timely permanency
- All children in our care and custody are healthy, safe and learning; they are successful in and out of school; and they are supported to find and advance their special talents and to give something back to their communities
- Youth who transition from CTDCF are better prepared for adulthood

With a firm emphasis on strengthening and preserving families, the practice model lends itself to the Family First vision through keeping children safely with their families and avoiding the traumatic experience of entering care.

2. Fathers as Equal Partners

As continued evidence of the commitment to family engagement and adherence to the Strengthening Families Practice Model, CTDCF is also firmly committed to meaningful fatherhood engagement. It is well documented that fatherhood involvement, particularly in communities of color, is vital to child development and strengthening the family. To that end, the Department has developed robust fatherhood programs to ensure active engagement by fathers in their children's lives. While the Department's focus has been on children in the care of CTDCF, the programming extends well beyond

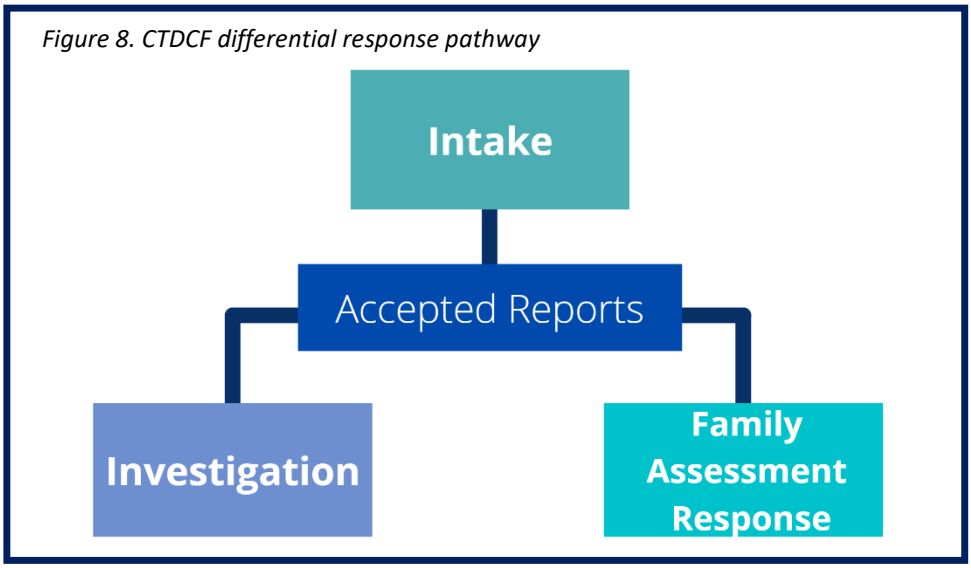
those committed to the Department, seeking to prevent the separation of families and strengthen the father's and paternal family's role in a child's life.

3. Differential Response

The Differential Response System is a core part of CTDCF's move to a more family-centered practice. It affords CTDCF the opportunity to customize its response to accepted reports of child maltreatment by using one of two response tracks: Traditional Investigation or Family Assessment Response.

In a traditional investigation, the family involuntarily works with the Department and, after facts are gathered, a formal determination is made as to whether maltreatment has occurred. When a family is the subject of a Family Assessment Response (FAR), the family is provided the opportunity to voluntarily work with the Department, and at the end of the assessment period the agency does not make a formal finding of child maltreatment.

Figure 8. CTDCF differential response pathway



A Family Assessment Response and a traditional investigation shares many of the same principles described below:

- Focuses on the safety and well-being of the child
- Promotes permanency within the family whenever possible
- Recognizes the authority of CTDCF to make decisions about removal, out-of-home placement, and court involvement
- Acknowledges that other community services may be more appropriate and beneficial to families in some cases rather than receiving services from a child protection agency, such as “Community Support for Families” or the “Integrated Family Care and Support” program

4. Community Support for Families

CTDCF offers a voluntary, family-driven, individualized program entitled Community Support for Families (CSF), administered by seven community partner agencies throughout the state. CSF is for families that are discharged from a Family Assessment Response (FAR) but are still in need of additional support. CSF utilizes a wraparound philosophy and approach designed to:

- Promote child and family well-being
- Build and strengthen natural and community-based supports
- Connect families to resources and services in their community
- Place the family in the lead role of its own service delivery

CSF is a time limited program utilizing evidence-based tools to assess strengths and needs of families to help inform service delivery. The program utilizes flexible funding to meet basic, concrete needs.

5. Integrated Family Care and Support

Integrated Family Care and Support (IFCS) engages families while connecting them to concrete, traditional and non-traditional resources in their community, utilizing components of a Wraparound Family Team Model approach. Families have access to the full array of Department funded services.

Families are referred to the IFCS program after a traditional investigation has ended with an unsubstantiated finding but identified risk factors and service needs indicate the family would benefit from care coordination services. Traditionally, these families would have instead been transferred to CTDCF Ongoing Services. The family must be willing to engage in services and agree to the IFCS transfer.

The program was developed with the belief that families would be better served in their own community without CTDCF involvement and aligns well with Family First and the Department's prevention mandate.

6. Considered Removal - Child and Family Team Meetings

A Considered Removal Child and Family Team Meeting (CR-CFTM) is required when the Department identifies one or more safety factors that will lead to the immediate removal of a child from the family home unless the safety factor can be mitigated. The meeting is held prior to the removal of a child unless the family situation requires an emergency removal to ensure child safety.

Meeting participants include parents/guardians, children/youth, extended family, natural supports, service providers, and CTDCF staff. The process helps to identify the family's strengths, resources, and protective capacities.

The Structured Decision Making (SDM) tool is used during the considered removal meeting to inform removal decisions. The meetings are run by an independent trained facilitator outside of the decision-making chain of command. The purpose of the CR-CFTM is to:

- Mitigate safety factors to prevent removal by identifying and utilizing the family's natural/formal supports
- Address risk factors that impact child safety
- Engage families and their supports in safety planning and placement-related decisions
- Identify roles/responsibilities of team members and develop strategies to help keep the child safe
- Explore and identify extended family and kin as potential placement resources for the child should removal be necessary

Connecticut Children's Behavioral Health Plan

CTDCF submitted the Connecticut Children's Behavioral Health Plan in fulfillment of the requirements of Public Act 13-178. The public act was one component of the Connecticut General Assembly's response

to the December 2012 tragedy in Newtown, Connecticut, in which 20 grammar school children and 6 educators were murdered by a young adult who had unmet mental health needs. The legislation called for the development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children."

The plan provides Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and to promote healthy child development. Public Act 13-178 directed CTDCF to include in the plan the following strategies to prevent or reduce the long-term negative impact of mental, emotional, and behavioral health issues on children:

- Employing prevention-focused techniques, with an emphasis on early identification and intervention
- Ensuring access to developmentally appropriate services
- Offering comprehensive care within a continuum of services
- Engaging communities, families and youths in the planning, delivery, and evaluation of mental, emotional, and behavioral health care services
- Being sensitive to diversity by reflecting awareness of race, culture, religion, language, and ability
- Establishing results-based accountability measures to track progress towards the goals and objectives
- Applying data-informed quality assurance strategies to address mental, emotional, and behavioral health issues in children
- Improving the integration of school and community-based behavioral health services
- Enhancing early interventions, consumer input and public information and accountability by:
    - (i) In collaboration with the Department of Public Health, increasing family and youth engagement in medical homes
    - (ii) In collaboration with the Department of Social Services, increasing awareness of the 2-1-1 Infoline program
    - (iii) In collaboration with the State Department of Education in ensuring that school districts are identifying and engaging with community providers and partners to provide both inside the schoolhouse and community-based referral sources for students
    - (iv) In collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state, increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing behavioral health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system.

CTDCF has been implementing the children's behavioral health plan, in partnership with 11 other state partner agencies, numerous private agencies and the children and families of Connecticut. An example

of that partnership is the Voluntary Care Management (VCM) program, which serves youth with serious emotional challenges, mental illnesses and/or substance use disorders and their families. The goal is to support families by increasing their access to care. Previously, these families were directly served by CTDCF and now this work is conducted through a private provider, eliminating the need for these families to be involved with the child welfare agency to receive behavioral health support.

7. ABCD Child Safety Practice Model

To further demonstrate commitment to strengthening practice, CTDCF is developing the CT Child Safety Practice Model. First and foremost, this practice model aims to ensure safety throughout all CTDCF's assessments, responses, services, and operations across the entire child welfare continuum. The practice model maps out how agency employees, families and stakeholders conduct their activities in an environment that focuses on keeping children safe from maltreatment. The model guides the daily interactions of employees, families, and community members in their work with the Department in conjunction with the standards of practice to achieve child safety outcomes by:

- Increasing consistency of safety related language
- Increasing consistency of decisions and outcomes
- Clarifying interactive expectations for frontline staff, supervisors, and community-based partners
- Unifying the statewide internal and external understanding of applied safety concepts

The six core components of the child safety practice model are:

- Safe and sound culture and safety science
- Commitment to equitable safety outcomes and racial justice
- Comprehensive assessment, resources, tools, and protocols to support safety and consistent decisions
- Supervision and consultation to inform critical thinking
- Community partners and comprehensive service array focused on safety
- Supports for kin, foster, and adoptive families and young adults

An integral component of strengthening families, development of the Child Safety Practice Model further advances Connecticut's commitment to achieving the safest outcomes for children.

8. V.I.T.A.L. Practice Model Overview

In order to ensure lifelong well-being and success for young adults, the CTDCF Transitional Supports and Success (TSS) Division recently began work with several partners to shape a new practice model for Transitional Age Youth (TAY, young people 16-23 years of age). The purpose was to establish a consistent and recognizable approach to adolescent practice that would improve outcomes. The shared focus of the team was to ensure that all youth have relationships, supports, and opportunities to thrive as they launch into adulthood.

One of the Department's goals is to shift the focus from preparing youth to transition out of the child welfare system, to launching youth towards opportunities. A shared hope is to develop a supportive system that is youth directed, focused on permanency throughout, informed by brain development research, and advances inclusion and equity. Efforts are designed to help youth walk on a path towards becoming civically engaged, having a career, maintaining connections to others, and becoming lifelong

learners. Support and planning efforts coalesced across four case management stages: Engagement and Assessment, Youth Driven Transition Preparation, Launch, and Re-entry. This is especially critical for students with disabilities who continue to be eligible for educational services and attending traditional school or transitional alternative programs until their 21st birthday.

9. Kinship Navigation

Connecticut is developing a Kinship Navigator program to highlight the importance of kin in a prevention-oriented system. The model will strengthen the array of resources and supports available to families outside of the formal CTDCF care system. More specifically, kinship navigation will primarily operationalize an overarching Connecticut Caregiver Practice Model to support an organizing framework for Connecticut's work with families, including birth, adoptive, kin/fictive kin, and core foster families, which will ultimately serve as the foundation for the kinship navigation model.

By ensuring that caregivers have access to the resources they need, assistance in navigating public programs for which they are eligible, and peer networking and support, CTDCF can promote children's stability and improve the well-being of the entire family.

Overview of System Transformation

Connecticut's numerous successful programmatic developments serve as a natural conduit for overall system transformation in collaboration with our sister agencies, community and provider partners, and families and youth with lived experience. Commitment to congregate care reduction, juvenile justice partnerships, and pivotal shifts in organizational culture with a magnified emphasis on racial justice makes Connecticut well positioned to implement Family First for their candidacy populations.

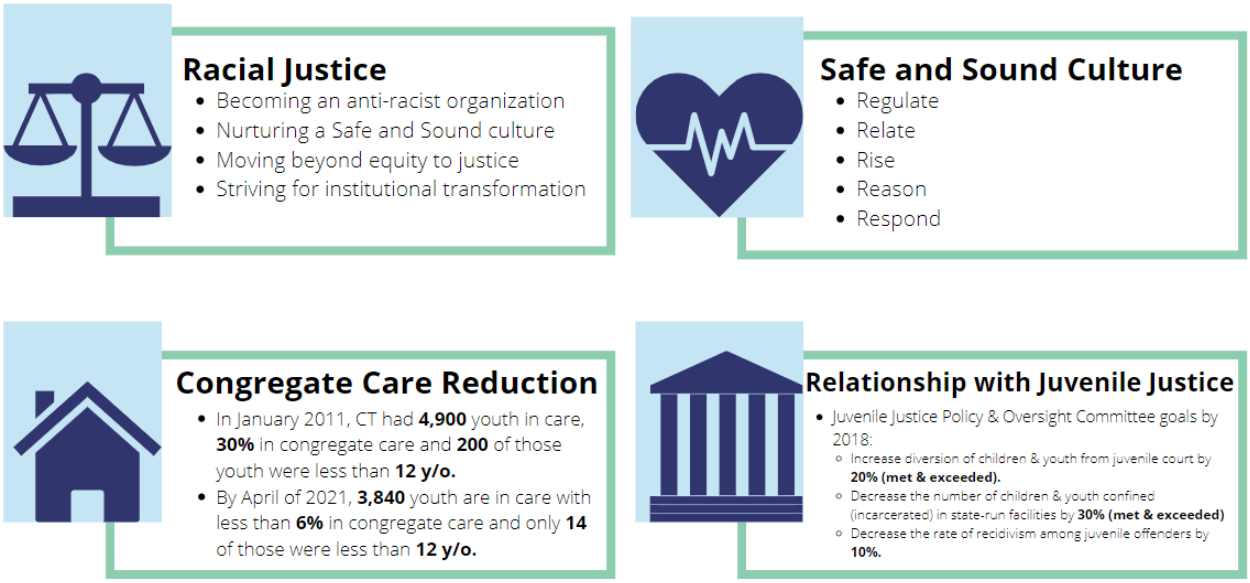


Figure 9. System Transformation Efforts

1. Racial Justice

In 2020, with racial disparities illuminated in a global pandemic and our nation gripped in civil unrest, CTDCF reaffirmed its commitment to becoming an anti-racist organization whose beliefs, values, policies, and practices achieve racially just outcomes. The overarching mission of anti-racist work is to examine and redesign the CTDCF as an authentically anti-racist agency that will be apparent in its structures, partnerships policies, practices, norms, and values. At this time, it is believed that becoming an anti-racist agency is a necessary means to achieving the goal of becoming a racially just organization.

In furtherance of the agency mission, the Department has established four grounding principles, values, and foundations to guide the organization

Figure 10. CTDCF guiding principles, values, and foundations

Becoming an Anti-Racist Organization

As an anti-racist organization, CTDCF will decisively identify, discuss, and challenge issues of race and color and the impact(s) they have on the agency, families, community, staff and external partners. A structured framework has been developed to guide conversations within and outside the Department, with an emphasis on leadership support and development, and reflective of the positional authority necessary to carry racial justice expectations throughout CTDCF. Over the past year, this framework has been utilized across the Department at all levels and now moves to external stakeholders. Also, in 2020, the Department made a commitment to move beyond equity to justice to further ensure that services are individualized and based on a comprehensive assessment of a child's and a family's strengths and needs. CTDCF recognizes that these assessments must occur in partnership with providers, the family, youth and children, in an age and developmentally appropriate manner, shaped by clients' racial, cultural, and linguistic self-identification and needs.

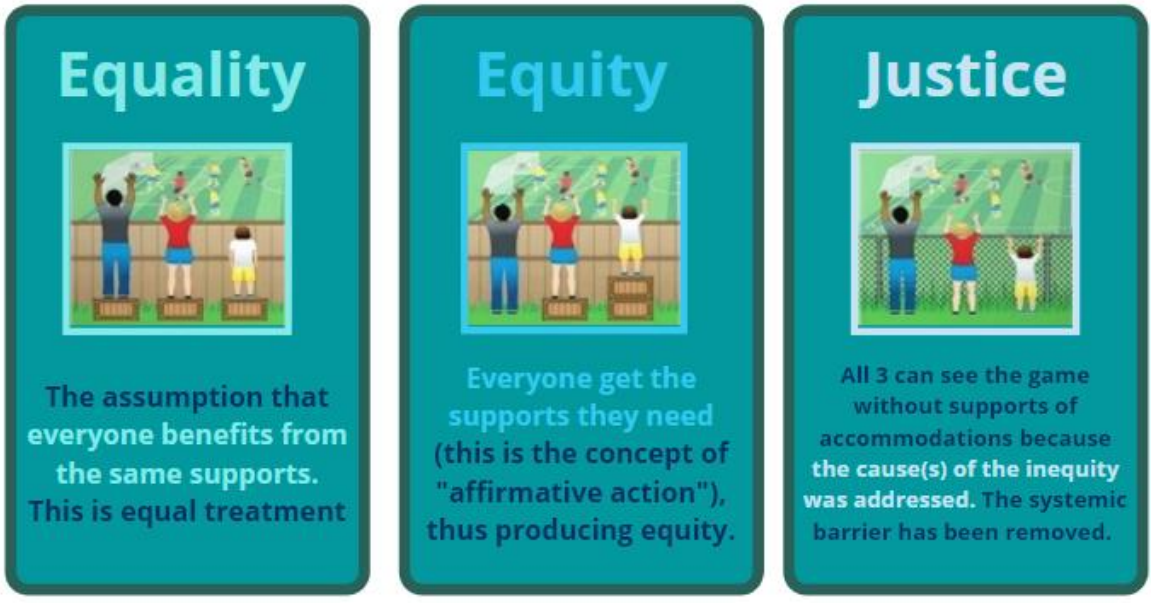


Figure 11. Equality, equity, and justice visual

Striving for Institutional Transformation

Striving for Institutional Transformation looks beyond small transactional changes, but rather makes changes that fundamentally transform the work with children, families, and the greater community.

CTDCF is paying particular attention to our data infrastructure to assess and implement these change initiatives. CTDCF has a strong data infrastructure that is accessible to all staff, one that assists in evaluation of its practices and outcomes through a racial justice lens. The Department has deliberately invested in capabilities that allow for disaggregation of most reports by race and ethnicity. This provides agency leaders the ability to observe trends that can be used for the consideration of strategies to eliminate racial and ethnic disparate outcomes within CTDCF.

2. Safe and Sound Culture

The Department's values, attitudes, and behaviors support an environment that promotes psychological and physical safety for children, families, and staff. Our culture of safety model is "how" our work is done.

As a culture of safety, CT Safe and Sound Culture is rooted in principles of respect, trust, candor, equity, and racial justice. When put into action, this enables the Department to be engaged, supportive, accountable, and open to learning. It empowers sound decisions and competent provision of services that help children and families achieve safe and healthy outcomes.

CTDCF is mindful that this work is hard and oftentimes painful for some; therefore, CTDCF is committed to cultivating and sustaining an environment that is supported and grounded in the context of the Department's Safe and Sound Culture. There are five main principles, branded as the "5R's," that provide a framework for our work within a culture of safety and racial justice:

- Regulate – Mindfulness of physical and psychological well-being
- Relate – To build and sustain relationships and community with respect, trust, and candor
- Rise – To be brave and bold with relevant actions
- Reason - Decision making based on consultation, teamwork, and knowledge
- Respond – To plan with competence, confidence, and compassion

Reflecting Back and Planning Forward

Our Safe and Sound culture creates a learning environment in which we strive to try new ideas, identify and plan for what could go wrong, talk about and learn from our mistakes, tap into others' expertise, and honor the unique skills we each bring to our work.

Figure 12. CTDCF Safe and Sound Culture visual

3. Congregate Care Reduction

CTDCF is proud of our successfully proven efforts to safely reduce congregate care by developing a blueprint for rightsizing.

In January of 2011, Connecticut had 4,900 children in care - 30% in congregate care, 200 of which were less than 12 years of age. By April of 2021, through transformation efforts with an intentional emphasis on increasing kinship care and providing in-home supports to foster parents and kin providers, the number markedly dropped to 3,480 children in care - with less than 6% in congregate care, of which only 14 children were less than 12 years of age. Connecticut is viewed as a national champion for the manner in which children are maintained in a family setting. This work was recently highlighted in a report entitled "Families over Facilities" produced by Children's Rights. The report documents the dramatic reduction in institutional care that Connecticut achieved by adopting many positive practices, including providing preventive services that keep families together and children out of foster care in the first place and by significantly increasing the number of children living with relatives.

CTDCF's efforts to achieve congregate care reduction were guided by the inherent value that, first and foremost, children should be placed into kinship care when they cannot remain safely at home. Specialized community-based services were developed so youth could have wraparound supports within a family setting. Increased recruitment and retention of foster parents were also a focus with the most intensive form of foster care, "Family and Community Ties," developed for children with behaviors consistent with congregate care requiring a specialized plan to be developed for them within a family setting.

4. Relationship with Juvenile Justice

The Juvenile Justice Policy and Oversight Committee (JJPOC) was created by Public Act 14-217 and charged with evaluating policies related to Connecticut's juvenile justice system. The committee was

tasked with recommending changes in state law regarding juvenile justice that would eventually lead to diverting children and youth from juvenile courts, decreasing the number of children and youth confined (incarcerated) in state run facilities, decreasing the rate of recidivism, reducing racial and ethnic disparities of youth within the juvenile justice system and setting appropriate lower and upper age limits for youth involved in the system.

The JJPOC promulgated the following goals to improve youth justice in Connecticut, to be achieved by mid-2018:

- Increase diversion of children and youth from juvenile court by 20%
- Decrease the number of children and youth confined (incarcerated) in state-run facilities by 30%
- Decrease the rate of recidivism among juvenile offenders by 10%

Workgroups and sub-workgroups were established across the state aligning with each of those goals, as well as a Cross Agency Data-Sharing Workgroup. Each year, the Cross-Agency Data Sharing Workgroup Co-chairs present a progress report on the status of the established numerical targets for the goals.

By fall 2018, the state's juvenile justice system exceeded two of the three identified goals. The reduction in incarceration reached more than 50%, far exceeding the goal; the increase in diversion reached 30%, also far exceeding the goal. The reduction in recidivism is not yet at the promised 10% level, but is stalled at 2%, largely due to the changing nature of the juvenile population.

As the timeline for the original goals expired, the JJPOC set new goals to be achieved by mid-2021:

- Limit youth entry into the justice system
- Reduce incarceration
- Reduce racial and ethnic disparities of youth in Connecticut's juvenile justice system
- Right-size the juvenile justice system by setting appropriate lower and upper age limits

Legislation was passed in 2018 shifting funding and programmatic responsibility for key diversion resources, namely Juvenile Review Boards (JRBs) and Youth Service Bureaus (YSBs), to CTDCF. JRBs and YSBs are connected to communities and act as local hubs for juvenile justice diversion. Most of the YSBs (there are 102, covering 143 towns) are connected to JRBs, which are panels evaluating referred youth and providing alternatives to court involvement.

Additionally, legislation was enacted during the 2021 legislative session calling for CTDCF to undertake educational oversight of youth placed in juvenile justice facilities and those that are incarcerated.

Connecticut remains committed to achieving the newly developed goals to limit youth entry into the juvenile justice system to ultimately allow for more positive long-term outcomes for this population.

The Road Ahead

As Connecticut continues its transformation, the implementation of Family First will be an integral landmark on the road to an optimal child and family well-being system illustrative of wide reaching and strengthened community and stakeholder partnerships, attention and integration of the caregiver expertise, racial justice, evidence-based practice and intentional engagement of children, youth and families to achieve the most optimal outcomes for safety and well-being.

Section 2: Eligibility and Candidacy Identification

Connecticut Candidacy Population Overview

Developing Connecticut's target population was foundational to Connecticut reimagining a prevention-oriented system. The Family First Candidacy Workgroup included members from CTDCF, other state agencies, community partners, philanthropic organizations, service providers, advocates, and parents and youth with lived experience. Members reviewed CTDCF data and data provided by partners to consider which groups of children and families may be at imminent risk for foster care and those that could benefit from prevention-related services. The Family First Candidacy Workgroup counted family well-being and racial justice as core tenets when considering how to broaden access to prevention services in Connecticut.

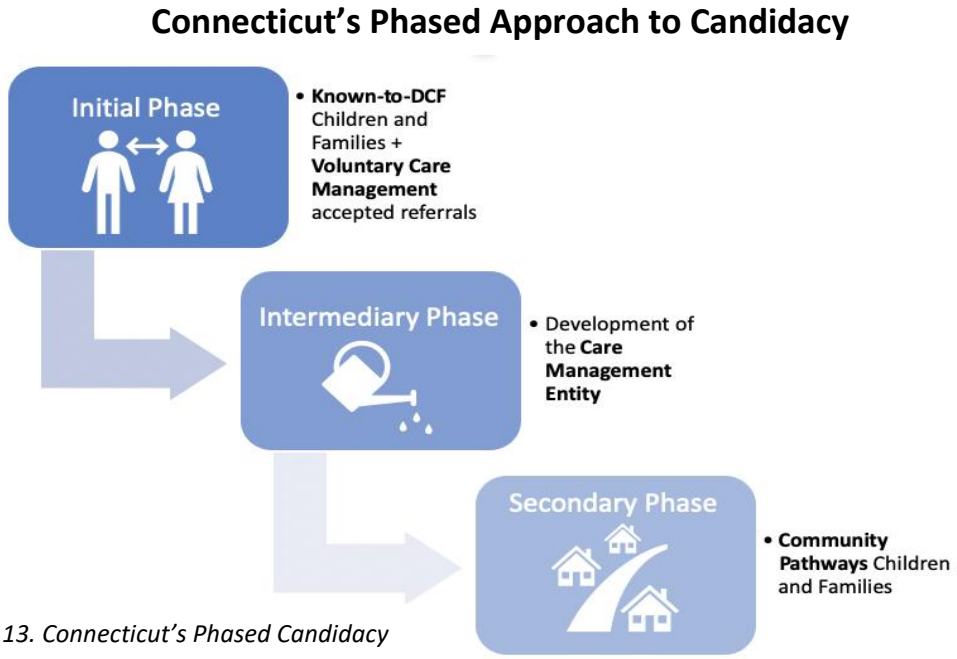


Figure 13. Connecticut's Phased Candidacy Approach

CTDCF's initial candidacy population for prevention services under Family First includes two sub-populations of children at risk of entry into foster care and their caregivers: children and families already **"known-to-CTDCF"** through calls to the CTDCF Careline or through prior foster care involvement and pregnant and parenting youth in foster care.

Connecticut's second population consists of children and their caregivers with particular needs or characteristics that ultimately may result in CTDCF-involvement and that are identified through a **community pathway**.

These sub-populations were recommended by CTDCF's Family First Candidacy Workgroup because Connecticut sees Family First both as an opportunity to strengthen stabilization services for children and families already being served by CTDCF, and as the impetus for a new approach to provide prevention services to families before they have ever been involved with the Department.

For the "known to CTDCF" population, CTDCF was able to review data on rates of foster care or re-entry as well as information from the Structured Decision Making © (SDM) Model employed as families move

from intake through discharge. For the community pathways population, CTDCF sought evidence and data, where available, to form a deeper understanding of each sub-population's risk of foster care entry.

1. Candidacy Populations: "Known-to-CTDCF

Connecticut primarily used data from 2019 as it is likely more representative than the data gathered during the COVID-19 pandemic.

Table 1. "Known-to-CTDCF" candidacy population

"Known–to-CTDCF"	Candidacy Estimates	Date
Families with accepted Careline calls	29,488	2019
Siblings of youth in foster care	1,353	2021
Pregnant and parenting youth in foster care	Estimates	Date
Pregnant and parenting youth in foster care	29	2019

Families with accepted Careline calls

In 2018, there were 107,000 calls made to the Careline; 67,000 of these calls were referrals about concerns related to allegations of child abuse and neglect and 29,000 of those calls were accepted. In Connecticut there are two response tracks for an accepted Careline call: 1) Investigations, and 2) Family Assessment Response (FAR). Results from Connecticut's SDM tool, completed during intake, determine a CTDCF response. FAR is Connecticut's differential response model, in which rather than a formal determination of abuse or neglect, the outcome for a family is a determination of whether services are needed to strengthen the family and promote child safety and well-being.

The number of families with accepted Careline calls being referred to Family Assessment Response (page 12) has gradually increased since FY 2017 and, in FY 2019, 45.4% of families with accepted Careline calls were assigned to this response track. In FY 2018 there was a 27.6% 12-month subsequent report rate and a 6.5% substantiated report rate for families served through FAR. Depending on the evolving nature of a family's circumstance, CTDCF can refer a family from assessment to the Community Support for Families program (page 13).

CTDCF determined that families involved with both Investigations and FAR tracks should be eligible for Family First prevention services in order to provide all families with accepted Careline calls enhanced family supports to prevent occurrence or recurrence of maltreatment and to keep children at home when safe.

Siblings of youth in foster care

The exact number of youth who remain at home but have siblings in foster care is estimated by the Department to be about 1,353 in 2021. While the number is relatively small, CTDCF recognizes that a child's separation from their family impacts the entire family, causes additional trauma, invites additional surveillance and scrutiny into the family and, as such, may put siblings at a heightened risk of out-of-home placement. This heightened risk level indicates that siblings and their parents could benefit from access to services to strengthen the family and prevent more children from entering care. As part of existing intake procedures, Connecticut already assesses all children in the home, therefore identification of siblings and their needs is consistent with current casework.

Pregnant and Parenting Youth in Foster Care

Under Family First, pregnant and parenting youth in foster care are automatically eligible for Family First prevention services.

Table 2. Pregnant and parenting youth in foster care data 2016-2020

Parenting/Expectant Parent	FY 2016 (2015 - 2016)	FY 2017 (2016 - 2017)	FY 2018 (2017 - 2018)	FY 2019 (2018 - 2019)	FY 2020 (3Q and 4Q 2019)
Male	9	6	11	6	3
Female	26	34	30	23	19
Total parenting/pregnant	**35**	40	41	29	22
Total Discharged	276	258	224	270	152
Percentage parenting/expectant parent	12.7%	15.5%	18.3%	10.7%	14.5%

2. Candidacy Populations: Community Pathways

Connecticut is eager to extend prevention services to families with identified children experiencing behaviors, conditions, or circumstances that are likely to have adverse impacts on a child's development or functioning, but do not present immediate safety concerns. By engaging these families earlier and connecting them with the right services, they may never come to the attention of the Department and future incidents of maltreatment or foster care placement can be prevented. However, the varied and thoughtful partners that contributed to the development of this plan cautioned CTDCF about the importance of extending services without increasing surveillance, particularly to communities of color. Furthermore, caregivers specifically shared that they have reservations about involving CTDCF when they need support and prefer to seek assistance from trusted individuals outside the agency. In response to these concerns, it is anticipated that CTDCF will develop a contract with an outside Care Management Entity (CME) to work with families, local providers and CTDCF, to ensure that Connecticut can facilitate preventive services to families who need them to thrive with a racial justice and trauma-informed lens.

Connecticut's community pathways candidates were selected based on available data and the expertise of the Family First Candidacy Workgroup. The broadness in this candidacy population definition is intended to provide prevention services to families that have a heightened risk of out of home placement so that CTDCF may prevent the occurrence of maltreatment likely to lead to foster care placement.

Connecticut recognizes that the services in this plan and on the federal Prevention Services Clearinghouse may not meet the full range of needs families have in the community pathways candidacy sub-groups and therefore intends to supplement Family First prevention services with resources offered by community partners. This candidacy sub-group offers exciting opportunities to strengthen cross-system support of families in Connecticut.

Because of the resources, infrastructure, and culture shift required to effectively serve families in the community pathways target population, Connecticut intends to serve these families in its second phase of implementation, with the exception of families accepted for Voluntary Care Management services who will be served in the initial phase.

Table 3. Community Pathways candidacy populations

Community Pathways	Candidacy Estimates	Date
Families accepted for Voluntary Services *(Voluntary Care Management as of May 1, 2020)*	294	2019
Youth that have exited foster care	270 discharged to permanency 302 over 18 discharged	2019 2019
Children who are chronically absent from preschool/school or are truant from school	53,191	2018-2019
Children of incarcerated parents	Unknown	N/A
Trafficked youth	547 referred to CTDCF for human trafficking concerns	2015-2017
Unstably housed/homeless youth and their families	7,823 children and youth	2019
Families experiencing interpersonal violence	4,274 accepted CTDCF reports were for Interpersonal Violence 4,632 children were victims of Interpersonal Violence	2019
Youth who have been referred to juvenile review boards, youth service bureaus, or another diversion program or who have been arrested	2,307 (statewide Juvenile Review Board referrals)	2018-2019
Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting	103,819 adults with diagnosis of substance-use disorder, or mental health disorder Youth 12-17 (~26,000 estimated to use illicit drugs in the past month SAMHSA Behavioral Health Barometer, Connecticut, 2019) Children 0-18 (~74,500 were likely to have had a serious emotional disturbance (SED) defined as a child with a DSM diagnosis that without treatment could lead to out of home/out of community treatment, Williams, Scott, & Aarons, 2017)	2019
Infants born substance-exposed (as defined by the state CAPTA notification protocol)	1,206 notifications	March-December 2019

Families accepted for Voluntary Care Management Services

Connecticut's Voluntary Care Management (VCM) Program serves families with youth under 18 years of age with serious emotional challenges, mental illnesses and/or substance use disorders. Prior to May of 2020, CTDCF managed the care for families receiving voluntary services internally through the Voluntary Services Program but made the decision to contract out that responsibility in order to provide services further upstream and prevent unneeded scrutiny of families. Now, to access VCM, families call the CTDCF Careline to request services. Careline staff gather eligibility information about the family through a questionnaire/referral that is submitted to Beacon Health Options, the contacted provider, and the Office of Health Care Advocate to ensure all potential alternative insurance resources have been explored. In 2019, 302 children were referred to VCM Services and 97.4% were accepted.

Families seek out the VCM Program because they are unable to access services to address the acute needs of their children. Historically, some families saw the only pathway to services for their children with serious emotional or behavioral challenges as involving contact with the child welfare agency, which exposed the families to the possibility of losing guardianship or having their child committed to the Department. In order to ensure that these families have access to the services they need without CTDCF involvement, Connecticut believes it is essential to continue to strengthen the infrastructure and service array of the VCM Program. Therefore, CTDCF anticipates that by extending eligibility to these families and expanding their access to prevention services, Connecticut will be able to better support them and prevent unnecessary out-of-home care.

Families served through Voluntary Care Management initially elect for services by calling the CTDCF Careline, but because CTDCF does not open a case on these families and a contracted provider is responsible for determining and delivering services, Connecticut has decided to categorize these families as part of the “Community Pathways” candidacy population. However, because of the existing referral and service infrastructure, Connecticut will serve these families as part of their initial phase of implementation.

Youth that have exited foster care

Youth exiting to permanency

According to Connecticut data, between January 1, 2009 and December 31, 2018, 18,266 children were discharged to permanency; of these children, 28.3% were discharged to adoption, 15.2% to guardianship, 2.7% to relative placement, and 53.8% were reunified with their family. Of the 18,266 children who were discharged to permanency, 2,774 (15.2%) had a reentry. More than half (1,500 of 2,774, or 54%) of the reentries occurred within 12 months following the discharge (an 8.2% reentry rate), with the preponderance occurring during the first eight months. Furthermore, CTDCF is aware that if a family has interacted with the child welfare system, there is an increased likelihood that they may have some level of interaction again in the future. In order to provide support proactively and to offer stabilization services before removals are considered, Connecticut is hopeful that providing additional supports to families leaving CTDCF's care will contribute to increased stabilization and a reduced reentry rate for families, particularly during the first eight months following discharge.

Post-majority youth

In 2019, there were 302 post-majority youth who discharged before age 23 from the Department. Connecticut recognizes that even if a young person feels ready to separate from the Department at 18, they often have ongoing challenges and needs that the Department is able to assist with until age 23. By

reserving the opportunity to wrap these youth in supports and specifically, to provide these youth with mental health, parenting, or substance use treatment, Connecticut believes it could remove barriers that impede the success and stability of this group of young adults. Furthermore, by including this population in Connecticut's candidacy population, CTDCF believes there is an opportunity to support and stabilize these young people without requiring that they remain in or re-enter foster care, so that they have the foundation necessary for their own families to stay healthy, thrive, and disrupt the cycle of CTDCF involvement.

Children who are chronically absent from preschool/school or who are truant from school

In Connecticut, educational neglect is defined to occur when "by action or inaction, the parent or person having control of a child five (5) years of age and older and under eighteen (18) years of age who is not a high school graduate: 1) fails to register the child in school; 2) fails to allow the child to attend school or receive home instruction in accordance with Connecticut law; or 3) fails to take appropriate steps to ensure regular attendance in school if the child is registered" (CTDCF, 2021). According to Connecticut data, in 2018 there were 3,618 total reports of educational neglect, with 759 of those reports substantiated. This data reveals a relationship between absenteeism and child welfare involvement.

In Connecticut, chronic absenteeism is defined as missing 10% or greater of the total number of days enrolled in the school year for any reason. It includes both excused and unexcused absences. Connecticut's statewide chronic absenteeism rate for students in Grades K-12 was 10.4% in 2018-19. Although there is significant variation between districts, in 2018-19, a total of 53,191 students qualified as chronically absent (CT State Department of Education, 2019). This population has high comorbidity with other risk factors associated with incidents of maltreatment and removal. The State Department of Education works directly with districts through many initiatives to support district's use of data to drive decisions to support students who are chronically absent – or at risk for chronic absenteeism. Districts use these data to identify and provide specific supports tailored to those needs to reduce the need for reporting families due to educational neglect and to connect them to community and state resources and services to support regular school attendance.

Research indicates that there are a variety of factors related to school absenteeism:

Table 5: Factors related to absenteeism (Jacob & Lovett, 2017)
Student-specific: Teenage motherhood, low academic performance and repeating grades, lack of caring relationships with adults, negative peer influence, bullying
Family-specific: Low family income, low parent involvement, unstable housing, at-home responsibilities, stressful family events, conflicting home and school priorities, language differences
School-specific: Poor conditions or lack of school facilities, low-quality teachers, teacher shortages, poor student-teacher interactions, lack of geographic access to school, less challenging courses and student boredom
Community-specific: Availability of job opportunities that do not require formal schooling, unsafe neighborhoods, low compulsory education requirements, lack of social and education support services
Source: REL Pacific, Review of research on student non-enrollment and chronic absenteeism

Based on the child-specific and family-specific factors related to absenteeism as well as Connecticut's educational neglect data, CTDCF is seeking to make prevention services available to chronically absent

and truant children and their caregivers in order to strengthen families and prevent out-of-home placement.

Children of an incarcerated parent

While Connecticut does not know the exact number of youth who have an incarcerated parent, in January of 2021, there were 9,100 people incarcerated in Connecticut (CT DOC, 2021).

A 2006 study found that while parental incarceration may not be the reason children are placed in foster care, 27% of mothers who had been incarcerated had a child who had been placed in foster care at some point during the child's life demonstrating a relationship between risk factors of incarceration and risk factors of child welfare involvement (Moses, 2006).

There also is clear evidence that there are both financial and developmental consequences for children and families when a parent is incarcerated (Central Connecticut State University, 2007). A 2013 study found that parental incarceration is associated with the following conditions for children: learning disabilities, attention deficit disorder and attention deficit hyperactivity disorder, behavioral or conduct problems, developmental delays, and speech or language problems (Turney, 2014). Based on these heightened risk factors for youth with incarcerated parents, Connecticut intends to offer prevention services when appropriate to support these families and prevent future out-of-home placement.

Trafficked youth

Connecticut's data indicates that between 2015 and 2017, 547 youth were referred to CTDCF due to concerns of human trafficking victimization. Research suggests that there is a significant intersection between youth who are or have been involved in the child welfare system and trafficking victimization (Child Welfare Information Gateway, 2017). By identifying trafficked young people as candidates, CTDCF seeks to expand access to prevention services that may keep children connected to their families when appropriate or address vulnerable youth exiting foster care. The CTDCF has developed specific training modules on human and child trafficking tailored to school staff. These trainings are required under CT state statute and the State Department of Education continues to partner with the CTDCF and state anti-trafficking organizations to make these trainings and other resources available to school leaders, educators and staff.

Unstably housed/homeless youth and their caregivers

Research indicates that unstable or inadequate housing increases the risk of children entering foster care both because of the physical dangers presented by unsafe or unstable living conditions, but also due to the heightened stress imposed on caregivers in these environments (Child Welfare Information Gateway, 2019).

According to Connecticut data collected between January 1, 2011 and December 31, 2016, 5.4% of families undergoing a new child maltreatment investigation demonstrated severe housing problems. Additionally, 21% of families with substantiated child welfare determinations demonstrated significant to severe housing risk.

By identifying unstably housed youth and their caregivers as candidates, Connecticut intends to provide prevention services to address underlying needs and plans to connect families with existing housing initiatives led by partner agencies to help address housing-specific needs. Under the McKinney-Vento Homeless Assistance Act, school districts are required to identify a liaison for identifying and ensuring

immediate and consistent access to education and subsequent support services. The State Department of Education maintains a program manager to oversee the provision of educational and related services, rights and opportunities for students experiencing homelessness or unstable housing.

Families experiencing interpersonal violence (IPV)

Research suggests that families experiencing domestic violence may also be involved with the child welfare system because of children's exposure to violence or the co-occurrence of child abuse and neglect (Child Welfare Information Gateway, 2019a). In Connecticut in 2019, there were allegations of IPV in 4,274 reports and 49.2% of those reports were substantiated. For reports with IPV and substance use allegations, 67.7% of reports were substantiated. By identifying these families as candidates, Connecticut seeks to expand early access to prevention services to families experiencing IPV as well as reduce opportunities for reentry due to IPV.

Youth who have been referred to a Juvenile Review Board (JRB), a Youth Service Bureau (YSB), or another diversion program; or who have been arrested

There is growing evidence of the overlap between the child welfare and juvenile justice systems. This intersection is primarily evidenced by maltreated children who become involved with the juvenile justice system while in care, juvenile justice-involved children with histories of maltreatment, and families that have intergenerational histories with both systems (Wiig, Tuell, & Heldman, 2013). According to the Statewide Juvenile Review Board, there were 2,307 youth referred to a JRB between 2018 and 2019. (While there are other diversionary programs in Connecticut, the most information is available about the Juvenile Review Boards.)

Because national research estimates that nearly 40% of juvenile justice-involved youth are also involved with the child welfare system, Connecticut seeks to expand prevention services to these youth and their families to prevent out-of-home placement in either of these systems. On average, there are about 50 dually involved youth in Connecticut annually. Currently, the Department participates in and co-chairs several interagency workgroups related to juvenile justice and child welfare through the Juvenile Justice Policy and Oversight Committee. The workgroups guide efforts related to diversion, truancy, youth incarceration, and meeting educational needs. Connecticut seeks to better understand and serve dually involved youth in Connecticut through these partnerships and initiatives.

Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting

a. Substance use and mental health

Research suggests that substance use disorder is a risk factor for maltreatment and neglect, as it may affect a parent's ability to function as a caregiver and provide for their children's basic needs (Child Welfare Information Gateway, 2019b). Substance use prevention and treatment is also a service type selected by the Prevention Services Clearinghouse and therefore a priority for addressing to stabilize families. While Connecticut does not have a clear picture of how many caregivers are challenged with substance use disorder, there were 103,819 adults with a diagnosis of substance-use disorder or mental health disorder in 2019 in the state. In 2019, it is estimated that there were approximately 26,000 youth between 12-17 that had used an illicit drug in the past month, and about 74,500 youth 0-18 that had a serious emotional disturbance (SED).

According to Connecticut data, between January 1, 2011, and December 31, 2016, there was a 16% increase in the odds for maltreatment among caregivers with drug misuse, and specifically for caregivers with alcohol use those odds increased to 30%. By expanding the substance use services in Connecticut's continuum, CTDCF seeks to keep families safely intact as caregivers seek treatment.

Like substance use, Family First prioritized services to address the mental health needs of children as well as their caregivers. A 2019 survey indicated that parents with a serious mental illness were approximately eight times more likely to have CPS contact (Kaplan, Brusilovskiv, O'Shea, & Salzar, 2019). According to Connecticut data collected between January 1, 2011, and December 31, 2016, there was a 25% increase in the odds of a subsequent substantiation for caregivers with mental health issues. Based on this heightened risk for child welfare involvement, Connecticut seeks to enhance access to mental health supports to caregivers and families with mental health issues that impact parenting.

b. Disabilities

There is limited understanding in the United States about the incidence of parents with differing cognitive abilities within the child welfare system, but a 2011 study in Canada demonstrated that parents with intellectual disabilities are overrepresented in the child welfare system (McConnel, Feldman, Aunos, & Prasad, 2010). Furthermore a 2010 study reported that 27% of child maltreatment court-involved cases involved at least one parent with an intellectual disability and those parents with various disability labels were two times more likely than their peers without a disability label to experience child welfare involvement (Child Welfare Information Gateway, 2018). While research indicates that the majority of caregivers with disabilities can safely and effectively parent their children, Connecticut is seeking to provide support to those caregivers that report they could benefit from enhanced services to strengthen parenting, to keep their families safely together (Child Welfare Information Gateway, 2019c).

Children with complex needs are at two to three times the risk for abuse or neglect than children without disabilities (Jones, et al., 2012). According to Connecticut data, between January 1, 2011, and December 31, 2016, children with physical or developmental disabilities were 22% more likely to have subsequent substantiations. Connecticut does not have a precise estimate of the number of children with disabilities, but in 2019 there were 27,441 children and young adults, 0-22 years of age, identified as having a mental health disorder, substance use disorder, or disability.

Based on the fact that caregivers and youth with disabilities are overrepresented in the child welfare system, Connecticut would like to extend prevention services to this population. CTDCF leads the Connecticut Parents with Differing Cognitive Abilities Workgroup, which is a statewide partnership among public and private agencies and families seeking to promote system change and enhance capacity of professionals to serve parents of all abilities. Connecticut intends to continue to leverage the expertise of this workgroup to inform prevention planning. Connecticut will also collaborate with community partners to better support the particular needs caregivers and youth with disabilities may have outside of what Family First prevention services can address.

Infants born substance-exposed

Research indicates that infants born substance-exposed are at higher risk of coming into contact with the child welfare system at some point (Young, Gardner, Otero, Dennis, Chang, Earle, & Amatetti, 2009). In response to this heightened risk, Connecticut enacted a law, effective March 15, 2019, requiring birthing hospitals to make an online notification to the Department at the time of the birthing event of

infants born substance exposed and/or those who experience withdrawal symptoms consistent with prenatal substance exposure. Between March-December of 2019, there were 1,206 such “CAPTA” notifications of infants born substance-exposed in Connecticut. CTDCF seeks to provide services to those families as soon as possible in order to prevent out-of-home placement.

Identifying Candidates and Pregnant and Parenting Youth in Foster Care

As outlined in the Family First legislation, only CTDCF staff will determine child-specific eligibility for prevention services. For the "known–to-CTDCF" population, eligibility will be determined initially at the Careline due to the fact that families associated with all accepted Careline calls will be eligible for Family First service. There are various opportunities during intake and routine casework, such as the administrative case review process, for Connecticut CTDCF staff to identify pregnant or parenting youth. Enhancements are being made to intake policy and procedures as well as case planning elements of Connecticut's data system to prompt staff to identify youth that meet these criteria. All "known–to-CTDCF" populations’ eligibility will be documented in Connecticut's data system, “LINK.”

Table 6. Identification and documentation of "known-to-CTDCF" candidacy populations

Candidacy Populations "Known–to-CTDCF"	Staff Responsible for Identifying	Documentation
Families with accepted Careline calls	Careline staff	LINK
Pregnant and parenting youth in foster care	Intake worker or Ongoing Services worker	LINK
Siblings of youth in foster care	Intake worker or Ongoing Services worker	LINK

Families are referred to the VCM program from the CTDCF Careline, and therefore all families that CTDCF refers will be deemed eligible. Once Beacon Health Options assesses a family, a final determination will be made with the family about their needs and ultimate service referrals. The VCM Program is a contracted service, and a separate data system is managed by the contracted partner with relevant data reported to the Department. CTDCF anticipates refining this contract to ensure relevant child-specific data is collected and shared.

For all aspects of Connecticut’s implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families. Once those elements are established, the CME will collaborate with community partners to identify and engage potentially eligible children and families. In order to make an eligibility recommendation, the CME will use a screening tool to determine whether the family meets Family First eligibility, and to which target population the family belongs. The CME will then make a recommendation to CTDCF about eligible candidates and CTDCF will make the ultimate determination regarding candidacy eligibility. Once a family has been determined eligible, CTDCF anticipates that the CME will partner with the family to better understand their strengths, risk factors, and needs through an assessment. This information then will be used to tailor each family's child-specific prevention plan and service referrals. CTDCF plans to develop a community portal for the CME to track all relevant Family First data elements, which will be shared with the Department.

Table 7. Identification and documentation of community pathway candidacy populations

Candidacy Populations Identified through Community Pathways	Staff Responsible for Identifying	Documentation
Families accepted for Voluntary Care Management Services	Careline staff	VCM Data System
Youth that have exited foster care	CME Staff with CTDCF	Community Portal
Children who are chronically absent from preschool/school or are truant from school	CME Staff with CTDCF	Community Portal
Children of incarcerated parents	CME Staff with CTDCF	Community Portal
Trafficked youth	CME Staff with CTDCF	Community Portal
Unstably housed/homeless youth	CME Staff with CTDCF	Community Portal
Families experiencing interpersonal violence	CME Staff with CTDCF	Community Portal
Youth who have been referred to a Juvenile Review Board, a Youth Service Bureau, or another diversion program; or who have been arrested	CME Staff with CTDCF	Community Portal
Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting	CME Staff with CTDCF	Community Portal
Infants born substance-exposed (as defined by the state CAPTA notification protocol)	CME Staff with CTDCF	Community Portal

Section 3: Title IV-E Prevention Services Description and Implementation Plan

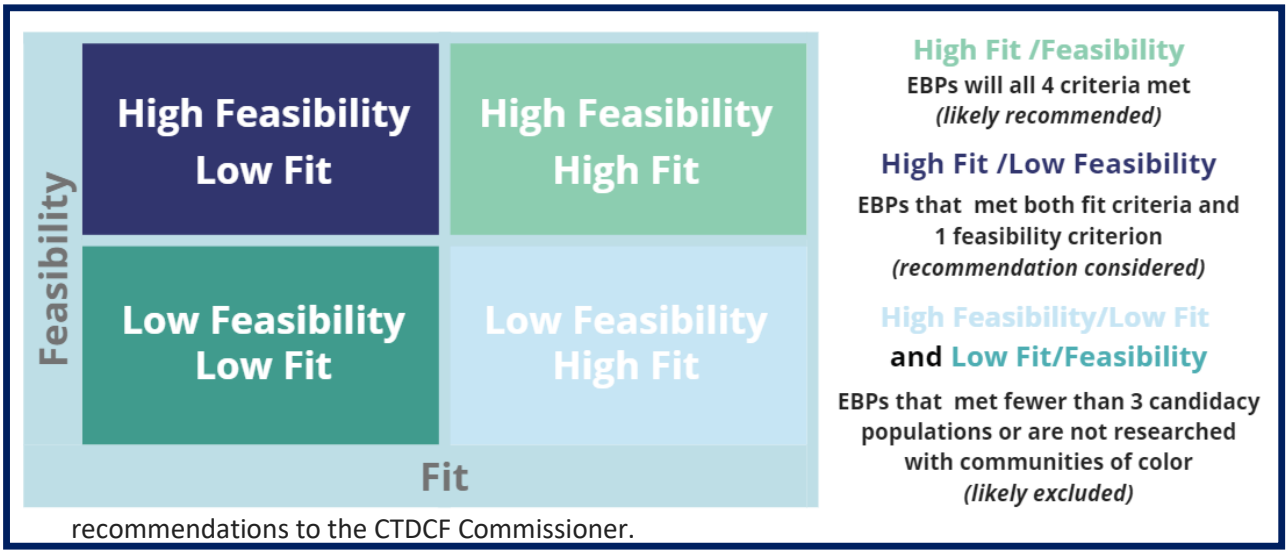
Connecticut's Family First Prevention Plan is intended to enhance its current robust service array of empirically supported services and resources. CTDCF is grateful to the families, advocates, providers, sister agencies and program developers that have cultivated a state landscape equipped to meet a wide array of community needs. Because of this existing strength, Connecticut intends to continue to invest in the services, resources, and supports beyond Family First prevention services in order to serve children and families in a holistic way. Connecticut seeks to leverage Family First as a tool to expand and strengthen its service continuum, recognizing that the services on the Prevention Services Clearinghouse do not meet all the complex needs families may have.

In order to develop Connecticut's Family First prevention service array, the Programs and Services Workgroup engaged over 100 members including model developers, sister state agencies, providers, advocates, and families with lived expertise. This workgroup developed and implemented a rigorous process informed by implementation science to assess the services on the Prevention Services Clearinghouse, as well as programs and services not currently eligible for reimbursement, in order to develop the appropriate array to meet the specific intervention needs of the families that were defined as the candidacy groups for Connecticut's Prevention Plan.

Below are the steps the Programs and Services Workgroup took to make service recommendations to Connecticut's Governance Committee:

1. **Step 1**: The Programs and Services Workgroup utilized the expansive and diverse expertise of its membership to identify the specific intervention needs and desired outcomes for each of the candidacy populations that were identified by the Candidacy Workgroup, in order to ensure that the selection of programs and services could be best matched to strengthen families that would be served under Family First. Appendix A outlines these needs by candidacy population.
2. **Step 2**: The workgroup catalogued all relevant services in Connecticut, including, but not limited to those on the Prevention Services Clearinghouse; documented service information about each program (target population, duration, intensity, service location, research supported outcomes, etc.); and matched each Evidence-Based Program (EBP) to Connecticut's candidacy populations.
3. **Step 3**: Once this service-specific information was collected and organized, the Programs and Services Workgroup organized this list of services based on their levels of evidence:
    - Tier 1: "Well-Supported" programs on the Clearinghouse
    - Tier 2: "Supported" and "Promising" programs on the Clearinghouse
    - Tier 3: Services with the evidentiary support that may be eligible for an Independent Systematic Review (as evidenced by rating on the California Evidence-Based Clearinghouse for Child Welfare (CEBC) or Randomized Control Trials/Quasi-experimental studies)
    - Tier 4: Services in Connecticut that may be highly effective with families and aligned with the goals of Family First and should be considered for the broader Connecticut prevention service continuum
4. **Step 4:** Then, the Programs and Services Workgroup developed a set of criteria related to fit and feasibility to determine which EBPs should be shared with the Fiscal and Revenue Enhancement Workgroup for further consideration.
    a. **Fit Criteria:**
        i. Prioritization of EBPs matching three or more candidacy populations
        ii. Evidence of research with communities of color as evidenced by studies reviewed on the CEBC or the Title IV-E Prevention Services Clearinghouse
    b. **Feasibility Criteria**:
        i. Tier of evidence (1-4)
        ii. Wide availability in Connecticut, as defined by existing within three or more CTDCF regions

Figure 14. Fit and Feasibility matrix



recommendations to the CTDCF Commissioner.

Prevention Services Details and Rationale

Table 8. Connecticut Family First prevention service array

Practice	Target Population	Type of Service	Prevention Services Clearinghouse Rating	EBP model & manual
Functional Family Therapy	Youth 11-18 with behavioral or emotional difficulties and their families	Mental Health	Well-Supported	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy for Adolescent Behavioral Problems. Washington, D.C.: American Psychological Association
Multisystemic Therapy	Youth aged 12-17 with serious emotional/behavioral difficulties and their families	Mental Health & Substance Abuse	Well-Supported	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic Therapy for Antisocial Behavior in Children and Adolescents (2nd ed.). New York: The Guilford Press.
Brief Strategic Family Therapy	Children/adolescents 6-18 who display or are at risk of developing problem behaviors including substance use, conduct problems, and delinquency; and their families	Mental Health & Substance Abuse & Parent Skill-Based	Well-Supported	Szapocznik, J. Hervis, O., & Schwartz, S. (2003). Brief Strategic Family Therapy for adolescent drug abuse (NIH Pub. No. 03-4751). National Institute on Drug Abuse.
Parent Child Interaction Therapy	Children 2-7 and their parents/ caregivers	Mental Health	Well-Supported	Eyberg, S. & Funderburk, B. (2011) Parent-Child Interaction Therapy Protocol: 2011.PCIT International, Inc.
Nurse Family Partnership	First time, low-income mothers of children 0 - 2	Parent Skill-Based	Well-Supported	Consistent with current training and certification per Nurse Family Partnership per https://www.nursefamilypartnership.org/
Parents as Teachers	Families with children age 0-5	Parent Skill-Based	Well-Supported	PAT will be implemented as developed according to core trainings and curriculums found at https://parentsasteachers.org/trainingcurriculagallery#PAT-CORE-TRAINING
Healthy Families America	Families with children age 0-2	Parent Skill-Based	Well-Supported	Consistent with current required model training and manuals for Healthy Families America per https://www.healthyfamiliesamerica.org/

Functional Family Therapy (FFT)

FFT is a clinical, home-based treatment offered to families with an adolescent between the ages of 11-18 years experiencing psychiatric, emotional, or behavioral difficulties including substance misuse. FFT is a strength-based model that looks to build upon protective factors and reduce risk factors that impact adolescent behavior and well-being. The FFT model aims at helping families to identify patterns that

lead to adverse symptoms and behaviors and seeks to support the family in developing more successful interactions and stability.

In Connecticut, FFT is currently provided to children and youth who have returned or are returning home from out-of-home care or psychiatric hospitalization and require intensive community-based services or are at imminent risk of placement due to mental health issues, emotional disturbance, or substance abuse. Connecticut has four providers offering five FFT teams located in four regions throughout the state.

Connecticut selected FFT to be part of its Family First service continuum because it has a strong infrastructure in the state and matches the needs of many of Connecticut's candidacy populations including those where services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Furthermore, there is interest in growing current capacity by the Court Support Services Division (CSSD) of the State of Connecticut Judicial Branch and there are opportunities to expand current provider caseloads and teams throughout the state. FFT data in Connecticut demonstrates strong outcomes indicating youth receiving FFT are more likely to remain in their homes, remain in school, and avoid arrest.

Connecticut selected FFT with the goals of improving outcomes for youth and families and reducing the use of out-of-home placements. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving FFT:

- Child Well-Being:
    - Improved behavioral and emotional functioning
    - Reduced delinquent behavior
    - Reduced substance-use
- Adult Well-Being:
    - Improved family functioning

Table 9. Connecticut FFT outcome data

CT FFT Program Data for youth who completed FFT*			
	2017	2018	2019
% of youth who remained in home	97%	98%	98%
% of youth who remained in school	99%	99%	100%
% of youth with no arrests	95%	93%	96%

*Measures at discharge

Youth Functioning FFT Ohio Scales Results 2019 % Discharges with >= point increase in Functioning			
Race/Ethnicity	Worker Rating	Parent Rating	Youth Rating
White youth	63.9%	50%	44%
Hispanic youth	76.5%	65%	62%

Black Youth	70.0%	60%	45%
Statewide	67.8%	55%	48%

Problem Severity FFT Ohio Scales Results 2019 % Discharges with >= point increase in Functioning			
Race/Ethnicity	**Worker Rating**	**Parent Rating**	**Youth Rating**
White youth	67%	60%	48%
Hispanic youth	74%	72%	61%
Black Youth	75%	73%	58%
Statewide	70%	64.3%	51.3%

Multisystemic Therapy (MST)

MST is an intensive, in-home, community-based treatment for families of adolescents, 12-17 years of age, at risk of out-of-home placement because of delinquent or antisocial behaviors including substance abuse. MST engages the entire family and builds the capacity for caregivers to address current and future problems. MST therapists assess the youth's behavior in the context of the youth's full ecology including their family, peers, school, neighborhood, etc.

In Connecticut, MST is funded jointly by the Court Support Services Division (CSSD) and the Department of Children and Families (DCF) and is available statewide. Advanced Behavioral Health, Inc. (ABH) provides all training and consultation services for the 18 standard MST teams in Connecticut as a Network Partner of MST Services, and serves as the liaison between state contractors, providers, and key community stakeholders. ABH monitors data for quality assurance purposes and analyzes the data to be used for system improvements at the larger system level as well as at the agency and team levels. Connecticut has been implementing MST for more than 20 years.

Connecticut selected MST to be part of its Family First service continuum because, like FFT, it has a strong infrastructure in the state and matches the needs of many of Connecticut's candidacy populations including those where services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Connecticut MST data demonstrates strong outcomes indicating youth receiving MST are more likely to remain in their homes, remain in school, and avoid arrest as evidenced by *Table 10*.

Connecticut selected MST with the goals of improving outcomes for youth and families and serving youth in their homes, thereby reducing out-of-home placements. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving MST:

- Child Well-Being:
    - Reduced out-of-home placement
    - Improved behavioral and emotional functioning
    - Reduced delinquent behavior
    - Reduced substance use

- Adult Well-Being:
    - Improved positive parenting practices
    - Improved parent/caregiver mental or emotional health
    - Improved family functioning

Table 10. Connecticut MST outcome data; includes CTDCF and CSSD cases

CT MST Outcomes				
	2017	2018	2019	**MST Benchmark**
% of youth who remained in home	92%	88%	88%	**80%**
% of youth who remained in school	82%	72%	70%	**80%**
% of youth with no arrests	79%	77%	69%	**72%**

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) is an intervention offered to families with children between the ages of 6-17 years that are at risk for or are displaying problem behaviors including substance use disorder, conduct problems and delinquency. BSFT uses a family systems approach in order to transform family interactions that perpetuate problems into more effective and adaptive interactions.

BSFT does not currently exist in Connecticut, however CSSD previously funded BSFT as part of its programming for moderate risk youth involved with the juvenile court system (from 2005 to 2013), with four providers and 14 teams across the state at its broadest dissemination level. CTDCF intends to learn from those past efforts. As available funding allows, CTDCF will begin to support the infrastructure and implementation of services models in our plan that would be new additions to the CTDCF service array, including BSFT.

Connecticut selected BSFT to be part of its Family First continuum because of its alignment with candidacy populations in which services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Connecticut saw BSFT as an important addition to its continuum because of its broad target population age range, which would expand services to the often-excluded latency age population. Furthermore, due to the fact that BSFT was developed to respond to the cultural/contextual factors that influence youth behavior problems and its promising outcomes with communities of color and Spanish-speaking communities, Connecticut saw the addition of BSFT as an opportunity to provide more equitable, racially just, inclusive, and culturally responsive services.

Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving BSFT:

- Child Well-Being:
    - Reduced delinquent behavior

- Adult Well-Being:
    - Improved family functioning

Parent Child Interaction Therapy (PCIT)

PCIT is a treatment for children ages 2-7 years with emotional or behavioral issues and their parents and caregivers. It utilizes dyadic therapy that is conducted through "coaching" sessions where a therapist monitors parent and child interactions through a two-way mirror and communicates with the parent via a wireless communication device to build caregiver skills to manage the child's behavior.

While PCIT is not currently funded by CTDCF or any other Connecticut state agency, it has been installed by a number of therapists and a few community providers. As available funding allows, CTDCF will begin to support the infrastructure development and implementation of services models in our plan that would be new additions to the Connecticut DCF service array, including PCIT.

Connecticut selected PCIT to be part of its Family First service continuum because it matches the needs of Connecticut's candidacy populations whose services would be initiated based on the behavior and needs of younger children (VCM, siblings of youth in foster care, chronically absent youth, children with behavioral health disorders, etc.). PCIT is also culturally responsive and can be provided in multiple languages. It has demonstrated similar outcomes with parents who are impacted by intellectual and/or developmental disabilities.

Connecticut selected PCIT with the goals of improving outcomes for youth and families and preventing out-of-home placement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving PCIT:

- Child Well-Being:
    - Improved behavioral and emotional functioning
- Adult Well-Being:
    - Improved positive parenting practices
    - Improved parent/caregiver mental or emotional health

Connecticut's Office of Early Childhood (OEC) offers home visiting programs to improve the health of young children by providing supports and services to children and their families. OEC currently offers six different types of home visiting programs that are evidence-based, including Parents as Teachers (PAT) and Nurse Family Partnership (NFP), and released a request for proposals (RFP) in 2021 to expand these home visiting programs and to add Healthy Families America (HFA) and other like services. Prior to the release of the 2021 RFP, Connecticut OEC supported 2,000 home visiting slots statewide. These home visiting services are supported by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, an initiative funded by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF).

Nurse Family Partnership (NFP)

NFP is a home visiting program in which nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the

needs/requests of the parent. It targets young, first-time, low-income mothers from early pregnancy through the child's first two years.

In Connecticut, NFP is funded by OEC with support from the MIECHV program. OEC contracts with two NFP providers who support families across two Connecticut regions. Since 2012, the Visiting Nurse Association of Southeastern Connecticut has been providing NFP to families in New London and Middlesex counties, and in 2020 the New Milford Visiting Nurse Association expanded NFP to serve families in the western part of the state. Again, there is expected expansion of NFP in Connecticut via the recently released OEC RFP. Furthermore, in 2020 NFP merged with Child First - an evidence-based program for vulnerable young children and their families that is implemented across Connecticut. CTDCF expects that this partnership may support implementation and expansion of NFP in CT.

Connecticut selected NFP to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include first time mothers (pregnant and parenting youth in foster care, children with mental health or developmental disabilities, substance-exposed infants). NFP's existing infrastructure, combined with the expected expansion through OEC, exemplifies the strong NFP network in Connecticut.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving NFP:

- Child Well-Being:
    - Improved cognitive functions and abilities
    - Improved physical development and health
- Adult Well-Being:
    - Increased economic and housing stability

Table 11 Connecticut NFP outcome data [3]

NFP Target Outcome	Connecticut 2019 Data
Babies born full term	86%
Mothers initiated breastfeeding	93%
Babies received all immunizations by 24 months	100%
Clients 18+ employed at 24 months	57%

Parents as Teachers (PAT)

Parents as Teachers is a home visiting parent education model that supports new and expectant parents/caregivers to develop positive parenting skills. It aims to increase parent knowledge of early childhood development and prevents child maltreatment by improving parenting practices.

In Connecticut, PAT is funded by the Office of Early Childhood with support from the MIECHV program. OEC contracts with 20 PAT providers who support families statewide. Again, there is potential expansion of PAT in Connecticut via the recently released OEC RFP.

[3] https://www.nursefamilypartnership.org/wp-content/uploads/2020/04/CT_2020-State-Profile-1.pdf

Connecticut selected PAT to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include parents with children under 5 years of age (pregnant and parenting youth in foster care, chronically absent children (the Connecticut State Department of Education indicated there were 5,301 kindergarten students who were chronically absent in 2019), children with behavioral health or developmental disabilities, substance-exposed infants, etc.). PAT's existing statewide infrastructure combined with the potential expansion through OEC, exemplifies the established PAT network in Connecticut.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. The PAT curriculum has a demonstrated impact on improving outcomes for families at risk of child welfare involvement. Additionally, the program is culturally responsive and has shown effectiveness with non-white populations. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving PAT:

- Child Well-Being:
    - Improved social functioning
    - Improved cognitive functions and abilities

Healthy Families America (HFA)

HFA is a home visiting program for new and expectant parents/caregivers with children at a high risk of abuse or neglect or other adverse childhood experiences. When referred from the child welfare system, families may be enrolled if they are caring for a child up to 24 months of age. Most families are offered services for at least three years. HFA seeks to prevent child abuse or neglect by strengthening positive caregiver-child relationships, promoting healthy childhood growth and development, and enhancing family functioning by building protective factors and addressing risks.

HFA is currently implemented in one region in Connecticut; however, the Office of Early Childhood has identified HFA as a promising intervention to expand in the state and will likely begin funding new HFA sites in 2021. New HFA sites supported by OEC will be funded with support from the MIECHV program.

Connecticut selected HFA to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include parents with children under 2 years of age (pregnant and parenting youth in foster care, children with behavioral health or developmental disabilities, substance-exposed infants, etc.). CTDCF seeks to leverage OEC's investment in HFA to build programmatic infrastructure in the state.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving HFA:

- Child Safety:

    - Reduced self-report of maltreatment
- Child Well-Being:
    - Improved educational achievement
- Adult Well-Being:
    - Improved parent/caregiver mental health
    - Improved parenting practices
    - Reduced substance abuse

Future Interventions under Consideration

Connecticut intends to seek additional evaluation partners and financial resources to support the following three EBPs as each has a strong infrastructure in Connecticut and demonstrates favorable outcomes with Connecticut's children and families. Connecticut currently partners with the Child Health and Development Institute (CHDI) of Connecticut for implementation and evaluation support for TF-CBT and seeks to leverage this partnership as it considers future evaluation opportunities.

Table 11. Future EBPs for evaluation and consideration in Connecticut

Service & Description	Target Population	Title IV-E Clearinghouse Rating
Multidimensional Family Therapy (MDFT): MDFT is an integrated, comprehensive, family-centered treatment to address youth problems and disorders and to prevent out-of-home placements.	Adolescents and young adults 9-26 years old with substance use, delinquency, mental health, academic/vocational, and emotional problems	Supported
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): TF-CBT is a clinical model for children and adolescents exhibiting symptoms associated with trauma exposure	Children and adolescents who have experienced trauma	Promising
Triple P – Positive Parenting Program – Standard (Level 4): Triple P-Standard is a parenting intervention for families with concerns about their child's moderate to severe behavioral problems	Families with children up to age 12 who exhibit behavior problems or emotional difficulties	Promising

Connecticut plans to continue to engage the Programs and Services Workgroup as well as the Fiscal and Revenue Enhancement Workgroup in order to evaluate additional EBPs to meet gaps in addressing candidacy population needs.

There are a number of EBPs currently implemented in Connecticut that are on the Prevention Services Clearinghouse or in the Clearinghouse's queue that Connecticut intends to consider for future iterations of the Prevention Plan. As previously mentioned, Connecticut has a wide array of well-established treatment programs with strong bodies of evidence that demonstrate their efficacy. Connecticut intends

to take a more in-depth look at the research base of these EBPs in order to determine whether an independent systematic review may be a viable option for future reimbursement.

Trauma-Informed Framework

Connecticut intends to build upon its existing trauma-informed, mental and behavioral health infrastructure, in order to deliver Family First EBPs within a trauma-informed framework. One of CTDCF's six cross-cutting values is Trauma-Informed Practice, which means delivering services to children and families with an understanding of the impact that trauma can have on their lives and using interpersonal skills to ensure that our work is supportive of trauma recovery and not re-traumatizing. It requires a partnership with all those involved with the child (caregivers, providers and other stakeholders), using the best available science to facilitate and support the recovery and resiliency of the child and family. Reflective of CTDCF's Strengthening Families Practice Model and the six Principles of Partnership, trauma-informed child welfare practice emphasizes the development of family-focused, strengths-based relationships with families to ensure the safety and well-being of their children.

In 2011, CTDCF was awarded a $3.2 million, five-year federal grant to develop the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT), in order to integrate trauma practices into all levels of the child welfare system. Through CONCEPT, CTDCF engaged the Child Health and Development Institute of Connecticut, Inc. (CHDI) and The Consultation Center, Inc. at Yale to develop the core components of CONCEPT and a statewide trauma-informed system of care has been built.

Training and support for child welfare staff has been prioritized to cultivate an understanding of childhood trauma and to build strategies around how to support children and families who have experienced adverse circumstances. CTDCF has since adopted the National Child Trauma Stress Network's (NCTSN) Child Welfare Trauma Training Toolkit, training more than 2,500 child welfare staff and implementing a Trauma-Informed Therapeutic Childcare model. Other relevant trauma-informed infrastructure developed as a result of the CONCEPT grant include:

- The development of a trauma screening tool (the Child Trauma Screen) to identify children suffering from trauma and who are in need of services
- The institutionalizing of trauma-informed policies
- Expansion of trauma-informed interventions like TF-CBT and Child and Family Traumatic Stress Intervention (CFTSI)

While there is existing language around delivering trauma-informed care in provider contracts, CTDCF intends to integrate the core tenets developed out of the CONCEPT framework into all Family First contracts including language about trauma training, trauma-informed policy alignment, and trauma-screening. CTDCF will co-create with providers, standard reporting methods and metrics to ensure services are being delivered in a trauma-informed manner.

CTDCF anticipates annual monitoring of this trauma-informed framework in alignment with the existing contract review and continuous quality improvement strategies. This includes asking contracted providers a set of questions to ensure programming includes key trauma-informed activities including:

- Trauma-informed written policies
- Training for staff and families regarding trauma and its impact on youth, families, and communities

- Supervisors equipped to guide case managers on trauma-informed care
- Trauma screening

Implementation Approach

Connecticut utilized a fit and feasibility matrix to determine which EBPs should be selected for its Plan. In terms of feasibility, Connecticut specifically considered levels of evidence, infrastructure and availability in Connecticut, as well as particular details regarding staff qualifications and service delivery. Connecticut has demonstrated a long-standing commitment to implementation of a wide array of EBPs with sustained focus on model fidelity, evaluation, and positive outcomes. This experience will be leveraged in the implementation of Family First.

Connecticut intends to serve its "known-to-DCF" candidacy population as well as families accepted for Voluntary Care Management services first. Furthermore, it will prioritize services with an existing infrastructure in Connecticut for initial implementation.

Well-Established EBPs in Connecticut

MST, FFT, NFP, and PAT are well established in Connecticut's service continuum and have existing provider networks that range from serving three regions of the state to a nearly statewide presence. This will allow Connecticut to build on existing efficiencies while also providing an opportunity for needed expansion. As these programs are already embedded in Connecticut, they have some level of quality assurance and fidelity monitoring in alignment with those developed by the model purveyor. Connecticut plans to initiate Family First implementation by leveraging existing contracts and/or expanding contracts and Memorandum of Understanding (MOU) with sister agencies for those programs primarily supported through other public agencies.

Emerging EBPs in Connecticut

HFA is newer to Connecticut and has a growing provider network which will likely be strengthened and expanded by Connecticut's 2021 Office of Early Childhood home visiting RFP. As the service provider network and quality assurance infrastructure develops as a result of the OEC's actions, CTDCF will partner with OEC, contracted providers, and the HFA model developers for implementation.

As previously noted, PCIT is not currently funded by any public agencies in Connecticut, but there are a few therapists and community providers offering PCIT throughout the state. Connecticut has been communicating with peer jurisdictions to learn more about their efforts to develop and expand PCIT in order to build a strong implementation rollout. There are particular training needs and start-up costs associated with PCIT to accommodate the model's two-way mirror and wireless communication device coaching strategy. As available funding allows, CTDCF will begin to support the infrastructure and implementation of services models in our plan that would be new additions to the Connecticut DCF service array.

EBPs new to Connecticut

BSFT does not currently exist in Connecticut, however the Court Support Services Division previously funded BSFT as part of its programing for moderate risk youth involved with the juvenile court system, with four providers and 14 teams across the state at its broadest dissemination. CTDCF intends to learn from those past efforts. As available funding allows, CTDCF will begin to support the infrastructure and implementation of services models in our plan that would be new additions to the Connecticut DCF service array.

Implementation of the Connecticut Prevention Plan will be informed by the ongoing guidance of the Governance Committee, the Implementation Team, and the CQI Workgroup. These teams include representatives from the provider community, sister agencies, families and youth, advisory and advocacy groups, and university partners.

This implementation structure promotes:

- Routine refinements and improvements during implementation planning and rollout
- Identification and (re)allocation of resources as needed
- Timely decision-making around policy- and program-related elements
- Ongoing monitoring of progress towards prioritized outcomes
- Executing and sustaining the desired transformation

Information gathered by the CQI Workgroup will be reviewed to ensure Connecticut's Prevention Plan is aligning with agency and statewide goals. This structure will facilitate the development of collaborative strategies to respond to any organizational or systemic challenges that arise. CTDCF's Continuous Quality Improvement Strategy Section will provide additional information regarding Connecticut's plan to implement Family First services successfully and with fidelity.

Section 4: Child-Specific Prevention Plan

Process for assessing service need

For Connecticut's "known-to-CTDCF" population, there are several tools and resources CTDCF case workers currently use to assess a family's service needs including the Family Strengths and Need Assessments (part of the SDM process), the Protective Factors Survey and the North Carolina Family Assessment Scale for General Services (NCFAS-G). These tools provide insight into strengths, needs, and goals of a family, and the results of the assessments are captured as part of the family's case plan.

For the community pathways population, Connecticut will ensure that the Care Management Entity[4] prioritizes family engagement as the first opportunity to begin understanding the strengths and needs of a family. CTDCF will work with the CME to utilize an initial needs assessment after families have been determined eligible candidates to identify with the family, the appropriate services needed to ensure family stabilization, child safety and well-being, as well as prevention of foster care.

As part of Connecticut's conversations regarding ways to improve collaboration with and empowerment of families, caregivers recommended that workers should establish a connection with the family before conducting formal assessments and noted the importance of focusing on the goals and needs that the family has determined for themselves. Therefore, Connecticut plans to build workforce capacity to use assessments as a tool for enhanced family engagement, in order to authentically partner with families to identify needs and capitalize on family expertise. Connecticut believes that stronger engagement practices will ultimately lead to improved assessment and identification of family needs.

[4] For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families.

"Wrap CT" was funded in 2006 in Connecticut in order to provide comprehensive mental health care to children and families through the Wraparound evidence-based service delivery model. Connecticut intends to leverage and build upon the existing workforce capacity around Wraparound values and principles in order to improve partnership and assessment of family needs.

Process for developing child-specific prevention plans

Family First requires that each eligible child must have a written prevention plan. For foster care candidates, the prevention plan must include the services to be provided as well as a foster care prevention strategy to ensure the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver. For parenting or pregnant youth in foster care, the prevention plan must list the services to be provided to or on behalf of the youth and describe the foster care prevention strategy for any child born to the youth.

Connecticut's process for developing a child-specific prevention plan aligns with the Department's commitment to a family-centered practice. Prevention plans will:

- Serve as a tool for dialogue and be completed in collaboration with the family
- Be written in language that the family understands
- Demonstrate that the goals are realistic and developed with a thorough understanding of the family's situation

For all of the "known-to-CTDCF" target populations, assessment of Family First eligibility as well as the child-specific prevention plan will be captured within Connecticut's child welfare information systems, including CT-LINK, PIE, and/or CT-KIND.

Voluntary Care managers will enter child-specific prevention plans for families receiving voluntary services into their data system, Service Care Connect, and will report the necessary child-specific data elements to CTDCF.

For Connecticut's community pathway population[5], CTDCF anticipates that child specific data will be entered into a community portal and the CME will share the relevant child-specific data elements with CTDCF to ensure Connecticut has the data necessary for Family First claiming and reporting. Services will be selected, and the child-specific prevention plan will be developed in partnership with the family while drawing on the results of the identified standardized assessment tools.

The completion date of the child-specific prevention plan will be captured in the following data systems:

- "Known-to-CTDCF" populations (i.e., pregnant and parenting youth in foster care, siblings in foster care) will be captured in CT-LINK.
- VCM families will be captured in Service Care Connect.
- Community pathway populations will be captured in a community portal.

For Connecticut's "known-to-CTDCF" population, eligibility will be determined using existing infrastructure at the Careline, reflecting the fact that all families associated with accepted Careline calls

[5] For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families.

will be eligible for Family First. The child-specific prevention plan will be initiated at the Careline, as some demographic information is captured, but will not be completed until the case is assigned to an Investigations or FAR track. As caseworkers and families build a partnership and identify needs and strengths, they will collaboratively select and document appropriate services and finalize the child-specific prevention plans.

For pregnant and parenting youth in foster care, eligibility will be captured in CT-LINK and the identified services will be documented in the child-specific prevention plan which will be embedded into the youth's case plan. For the candidacy population of siblings of youth in foster care, CTDCF case workers will develop the child-specific prevention plan during intake when all members of the household are assessed.

For the community pathways population, Connecticut plans to integrate the child-specific prevention plan requirements into the eligibility assessment conducted by the CME. It is anticipated that child specific data will be entered into a community portal and the CME will share the relevant child-specific data elements with CTDCF. After eligibility is determined, CTDCF plans to ensure that the CME will engage with the family to assess their needs and strengths and partner with them to select the appropriate services. Services will be selected in partnership with the family while drawing on the results of the identified standardized assessment tools. The required child-specific data elements will then become integrated into the youth and family's ongoing treatment plan.

For families accepted for VCM, Family First eligibility will be determined by the CTDCF Careline workers. Once services are identified through Beacon Health Options, services and the remaining elements of the child-specific prevention plan will be documented in their electronic system, Service Care Connect.

For all Family First candidacy populations, Connecticut intends to use a standardized referral process. For the "known-to-CTDCF population," CTDCF will build upon existing referral processes, but plans to provide training to ensure greater uniformity across DCF regions and divisions.

For the community pathways population, Connecticut plans to develop standardized referral processes informed by the same approaches and resources used with the “known-to-CTDCF” populations. In order to develop this form and these processes, CTDCF plans to collaborate with its statewide partners and build upon best practices. The CME will be responsible for filling out referrals with a standardized set of criteria for community pathway families.

For both the “known-to-CTDCF” population and the community pathways population, CTDCF staff and Care Management Entity staff, respectively, will maintain frequent and regular contact with service providers and families to support service provision, assess progress made, and/or support needed adjustments to services.

CTDCF will document the candidacy determination date for each child and plans to monitor case progress through case planning and communication with families, service providers, and the CME. Case workers for pregnant and parenting youth and siblings of youth in foster care will be prompted via a tracking process that will leverage administrative case reviews, and the CME will be prompted through the community portal that the annual redetermination decision is approaching. Case workers and CME staff will ensure a collaborative meeting between the family and service providers prior to the 12-month

mark to discuss whether ongoing services are needed. Following that meeting, CTDCF will make the redetermination decision and will document it in CT-LINK.

Section 5: Monitoring Child Safety

Connecticut sees monitoring child safety as directly tied to effectively assessing family needs and seeks to leverage Family First to prevent safety threats by addressing needs early. Furthermore, Connecticut intends to engage families and their natural supports as essential partners in monitoring, preventing, and addressing family safety concerns.

Initial and ongoing assessments of safety and risk are central to the work of Connecticut's child welfare staff. All of the "known-to-CTDCF" candidates undergo the SDM CT Family Safety and Risk Assessment as part of the intake process. Furthermore, case planning is done collaboratively and in close partnership with children and their families, which typically provides a more comprehensive understanding of the family's circumstances and needs. Case workers also regularly connect with professional partners such as educators, medical providers, and clinicians who are monitoring family safety as well. Finally, child and family team meetings are used as a forum for the full child and family team to identify strengths, needs, risk, and/or safety concerns and to collaboratively develop a plan to address risks or concerns as they arise. CTDCF will use these existing practices to ensure child safety for the "known-to-CTDCF" candidates receiving in-home services, including: (1) families with accepted Careline calls, 2) siblings of youth in foster care, or (3) pregnant and parenting youth in foster care. Furthermore, for pregnant and parenting youth in foster care, workers will ensure weekly visits for the first 30 days of foster care, and then move to monthly visits.

The Voluntary Care Management (VCM) program works with families to help connect youth to high needs behavioral health services and support. The engagement process includes an explanation of the program, a review of behavioral health needs, and creating a crisis plan with the family. Crisis plans are developed to ensure that families have identified supports and contacts to connect with should a behavioral health incident occur. This crisis plan becomes part of the families' care plan and is revisited on a monthly basis with the families, even after clinical services have begun. The VCM program provides authorization for clinical services and meets with providers and families on a regular basis to ensure the appropriate services are in place and that the youth's behavioral health needs are being met. Once a youth begins receiving services, VCM staff meet with families at least monthly, and with service providers at least every two months, to ensure progress towards treatment goals and authorize on-going services, if needed. When youth need to receive out-of-home treatment, the VCM team will include a safe return to the home with supportive community-based services in place as part of the treatment goals.

For the community pathways candidacy population[6], it is anticipated that the CME will utilize a safety assessment tool at intake to identify safety risks and build a safety plan. This safety assessment information will be documented in the community portal and shared with CTDCF quarterly in aggregate in order to ensure CTDCF continues to refine the resources and services needed to address the needs, safety issues, and risks that emerge. Results from the safety assessment tool will contribute to

[6] For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families.

determining which services the family is referred to and will be integrated into the ongoing case plan and goals. Caregivers in Connecticut articulated the need for objectivity and standardization in terms of monitoring safety and a willingness on CTDCF's part to offer ongoing assessment and monitoring in locations where families feel most comfortable. To that end, CTDCF anticipates that after the CME refers families to services, they will monitor case progress as well as progress on safety plans in partnership with the family and the service provider. In the event that families are not making progress on their identified risk or safety areas, the CME will reevaluate the appropriateness of services and consider new referrals. What will assist in the overall assessment of safety is Connecticut's ABCD Child Safety Practice model referenced earlier in this document. The purpose is to align a common understanding of language and assessment of child safety across stakeholder groups.

Section 6: Evaluation Strategy and Waiver Request

At this time, Connecticut is seeking a federal evaluation waiver for each of the seven "well-supported" programs included in this Prevention Plan (i.e., FFT, MST, BSFT, PCIT, NFP, PAT, & HFA). In the future, Connecticut intends to pursue an evaluation for the three "promising" and "supported" EBPs named in this Prevention Plan (i.e., MDFT, TF-CBT, and Triple P), to continue to review additional services added to the Clearinghouse, and to consider whether any existing services in Connecticut have the evidentiary support to be considered for an Independent Systematic Review. Connecticut also intends to seek partnerships with data, research, and implementation experts to ensure continuous quality improvement efforts are identified and implemented for each EBP selected in this Prevention Plan.

Evaluation Waivers for Well-Supported Interventions

Connecticut is requesting an evaluation waiver for all EBPs selected in this Prevention Plan. The Family First Prevention Services Act suggests that an evaluation waiver is allowed for EBPs rated "well-supported" on the Clearinghouse as long as jurisdictions are able to meet the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II), as these programs already have a body of evidence demonstrating effectiveness. Connecticut is seeking evaluation waivers for Functional Family Therapy (FFT), Multisystemic Therapy (MST), Brief Strategic Family Therapy (BSFT), Parent Child Interaction Therapy (PCIT), Nurse Family Partnership (NFP), and Parents as Teachers (PAT), and Healthy Families America (HFA) as identified in *Table 12.*

Table 12. Connecticut evaluation waiver request and future evaluation plans

Evidence-Based Program	*CQI (evaluation waiver request)*	*Planned/Future Evaluation*
Functional Family Therapy	√	
Multisystemic Family	√	
Brief Strategic Family Therapy	√	
Parent Child Interaction Therapy	√	
Healthy Families America	√	
Nurse Family Partnership	√	

Parents as Teachers	√	
Multidimensional Family Therapy		√
Trauma-Focused Cognitive Behavioral Therapy		√
Triple P		√

Each of these EBPs has empirical evidence demonstrating positive outcomes in one of the domains highlighted by the Clearinghouse: child safety, child permanency, child well-being and/or adult well-being.

Connecticut is requesting an evaluation waiver for all "well-supported" EBPs selected for its Prevention Plan because each has met the following criteria:

1. Compelling **evidence of improved outcomes** related to child permanency, child safety, child well-being, and adult well-being
2. Research demonstrating **effectiveness and applicability across diverse populations**-- Connecticut children and families come from diverse cultural, ethnic, and linguistic backgrounds which makes wide applicability an important characteristic of EBPs selected for the Connecticut Prevention Plan
3. **Evidence of alignment with a number of Connecticut's candidacy populations**. An important element of fidelity is ensuring that only children and families that meet the eligibility criteria of a specific EBP are referred to that service.

Below is the compiled evidence and waiver justification:

Evidence Review for Well-Supported EBPs

EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Functional Family Therapy (FFT)	FFT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of nine eligible studies indicating favorable effects on child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated FFT as "supported" with medium relevance for child welfare in the outcome areas of behavioral management programs for adolescents in child welfare, disruptive behavior treatment of children and adolescents and substance abuse treatment of adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Well-Being* - *Improved behavioral and emotional functioning* FFT has proven outcomes of addressing child behavioral and emotional needs and improving adolescent depression (Celinska, 2013; Slesnick, 2009). - *Reduced adolescent substance use* One study demonstrated that FFT resulted in reduced adolescent drug and alcohol use (Slesnick 2009). - *Reduced delinquent behavior* Research indicates that FFT reduces delinquent behavior specifically resulting in fewer out of home placements for delinquency and a reduction in reconvictions for property offense (Celinksa, 2018; Darnell, 2015).	Research indicates that FFT is effective with racially diverse populations. FFT has demonstrated positive outcomes in multiple countries and across various states in rural, suburban, and urban settings. Specifically, participants in the 2009 Slesnick study included adolescents and families that were predominantly non-white including Latino, African American and American Indian/Alaska Native youth. Another Clearinghouse-referenced study (Darnell, 2015) demonstrated that FFT resulted in decreased reentry into out-of-home placements for predominantly Latino and African American youth. As mentioned in Section 3, FFT in Connecticut has demonstrated positive	**Families accepted for VCM Services** - Research indicates that FFT can result in improved child behavioral and emotional functioning which is the primary reason youth are referred for VCM services (Celinska, 2013; Slesnick, 2009). **Siblings of youth in foster care** - Because FFT addresses issues within the family context, it is reasonable to conclude that siblings of youth in foster care that are experiencing emotional or behavioral difficulties may benefit from FFT. **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of a substance use disorder, or a behavioral or emotional challenge, there is evidence FFT could address those underlying behaviors (Celinska, 2013; Slesnick, 2009). **Youth who have been referred to a diversion program or who have been arrested** - Research indicates that FFT can result in reduction in delinquent behavior (Celinksa, 2018; Darnell, 2015).

	Adult Well-Being - *Improved family functioning* One study demonstrated that FFT contributed to the improvement of family functioning by reducing family conflict (Slesnick, 2009). As mentioned in Section 3, FFT in Connecticut has demonstrated positive outcomes for reduced out-of-home placement (as measured by remaining in home during the duration of services), reduced delinquency (as measured by no arrests during the duration of services), and improved educational engagement (as measured by remaining in school during the duration of services).	outcomes for communities of color.	**Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Research indicates that FFT can result in a reduced adolescent substance use.
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Multisystemic Therapy (MST)	MST was rated "well-supported" by the Prevention Services Clearinghouse based on the review of 16 eligible studies indicating favorable effects on child permanency as well as child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated MST as "well- supported" with medium relevance for child welfare in the outcome areas of alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment of children and adolescents, and substance abuse treatment of adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Permanency:* - *Reduced out-of-home placement*	Like FFT, MST has demonstrated positive outcomes in multiple countries and various states in a variety of service delivery settings. A number of studies reviewed by the Clearinghouse demonstrate that MST was provided to multi-ethnic, predominately African American, populations and was found to be effective in reducing delinquency-related outcomes including re-arrest rates, time incarcerated, and self-reported offenses	**Families accepted for VCM Services** - Research indicates that MST can result in improved child behavioral and emotional functioning which is the primary reason youth are referred for VCM services (Asscher, 2013; Dekovic, 2012; and Fonagy, 2018). **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of a substance use disorder, or a behavioral or emotional challenge, there is evidence MST could address those underlying behaviors (Asscher, 2013; Dekovic, 2012; and Fonagy, 2018). **Youth who have been referred to a diversion program or who have been arrested**

	MST has been shown to significantly reduce out-of-home placement for youth with problematic behaviors (Vidal, 2017). *Child Well-Being:* - *Improved behavioral and emotional functioning* Multiple studies demonstrate the MST is effective at improving adolescent emotional functioning and both internalizing and externalizing behaviors of adolescents, including antisocial or violent behaviors (Asscher, 2013, 2014; Dekovic, 2012; Fonagy 2018; Henggeler, 1997; Manders, 2013; and Ogden, 2004). - *Reduced delinquent behavior* Evidence indicates that MST is effective at reducing a range of delinquent behaviors including property offenses, subsequent arrests and adjudications, and violent and non-violent crimes (Asscher, 2013, 2014; Borduin, 1995; Butler, 2011; Fonagy, 2018; Henggeler, 1993, 1997; and Vidal, 2017). - *Reduced substance-use* One study indicated that MST is effective at reducing adolescent substance misuse (Fonagy, 2018). *Adult Well-Being:* - *Improved positive parenting practices* Several studies reviewed by the Clearinghouse demonstrate that MST contributed to improvements in positive parenting practices such as positive discipline, increased parental involvement, improvements in monitoring and supervision, and reductions in inconsistent discipline (Asscher, 2013; Dekovic, 2012; and Fonagy, 2018). - *Improved parent/caregiver mental or emotional health* MST has also demonstrated improvement in parent/caregiver mental and emotional health (Borduin, 1995; Fonagy, 2018).	(Borduin, 1995; Henggeler,1991).	- Research indicates that MST can result in a reduction in delinquent behaviors (Asscher, 2013, 2014; Borduin, 1995; Butler, 2011; Fonagy, 2018; Henggeler, 1993, 1997; and Vidal, 2017). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Research indicates that MST can result in reduced adolescent substance use (Fonagy, 2018).

	- *Improved family functioning* MST has been shown to contribute to overall improvements in family functioning, family satisfaction, family cohesion, and family communication (Bourdin, 1995; Fonagy, 2018). As mentioned in Section 3, MST in Connecticut has demonstrated positive outcomes for reduced out-of-home placement (as measured by remaining in home during the duration of services), reduced delinquency (as measured by no arrests during the duration of services), and improved educational engagement (as measured by remaining in school during the duration of services).		
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Brief Strategic Family Therapy (BSFT)	BSFT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of five eligible studies indicating favorable effects on child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated BSFT as "supported" with medium relevance for child welfare in the outcome area of substance abuse treatment of adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Well-Being* - *Reduced delinquent behavior* One study demonstrated that participants in BSFT improved behavioral and emotional functioning by reducing externalizing behaviors. The study also showed reductions in delinquent behaviors such as	BSFT was developed to respond to the cultural/contextual factors that influence youth behavior problems and has promising outcomes with communities of color and Spanish-speaking communities. The study participants of Horigian (2015) were 44% Hispanic/Latino adolescents and 23% African American youth; this study demonstrated positive outcomes in terms of reducing delinquent behaviors by reducing externalizing behaviors. The	**Families accepted for VCM Services** - Research indicates that BSFT can result in improved child behavioral and emotional functioning by reducing externalizing behaviors which is the primary reason youth are referred for VCM services (Horigian, 2015). **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of externalizing behavioral, BSFT could address those behaviors (Horigian, 2015). **Youth who have been referred to a diversion program or who have been arrested** - Research indicates that BSFT can result in a reduction in delinquent behaviors (Horigian, 2015).

	the number of lifetime and past year arrests and incarcerations (Horigian, 2015). *Adult Well-Being* - *Improved family functioning* One study showed that BSFT resulted in overall improvements in family functioning (Santisteban, 2003).	study participants of Santisteban (2003) were predominately Hispanic/Latino youth from various nationalities and demonstrated positive outcomes in family functioning.	
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Parent Child Interaction Therapy (PCIT)	PCIT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of 21 eligible studies indicating favorable effects on child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated PCIT as "well-supported" with medium relevance for child welfare in the outcome areas of disruptive behavior treatment (child and adolescent) and parent training programs that address behavior problems in child and adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Well-Being* - *Improved behavioral & emotional functioning* Studies demonstrate that participation in PCIT improves child behavioral and emotional functioning including child compliance, internalizing and externalizing behaviors, and overall reduction in problematic behaviors (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009, Schuhmann, 1998; and Thomas, 2011). *Adult Well-Being*	Evidence suggests that PCIT has demonstrated positive outcomes for children from diverse backgrounds (Capage, Bennett, & McNeil, 2001; Chadwick Center on Children and Families, 2004; McCabe, 2005). While PCIT was originally evaluated with predominately white children and families, it has since been evaluated with communities of color and has demonstrated positive effects with various populations including African American families (Fernandez, Butler, & Eyberg, 2011), American Indian/Alaska Native families (Bigfoot & Funderburk, 2011) and Latino and Spanish-speaking families (Borrego, Anhalt, Terao,	**Families accepted for VCM Services** - Research indicates that PCIT can result in improved child behavioral and emotional functioning which is the primary reason youth are referred for VCM services (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009; Schuhmann, 1998; and Thomas, 2011). **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of a behavioral or emotional challenge, there is evidence PCIT could address those underlying behaviors (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009; Schuhmann, 1998; and Thomas, 2011). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - PCIT has been shown effective for children with a wide range of underlying

	- *Improved positive parenting practices* Multiple studies show that PCIT enhances positive parenting behaviors including supporting parents to use encouraging commands and praise, enhancing effective child- and parent-led play skills, and reducing the frequency of corporal punishment (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; McCabe, 2009; & Thomas, 2011). - *Improved parent/caregiver mental or emotional health* Two studies demonstrated that PCIT reduced parental stress, depression and anxiety (Leung, 2015, 2017).	Vargas, & Urquiza, 2006; McCabe & Yeh, 2009).	problems and psychological needs, such as ADHD (Leung, 2017), autism (Solomon, 2008), intellectual and developmental disabilities (Bagner, 2007), and disruptive behavior (Abrahamse, 2016). **Children who have exited to permanency** - PCIT has also demonstrated positive outcomes with children who have experienced maltreatment (Thomas, 2011).
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Nurse Family Partnerships (NFP)	NFP was rated "well-supported" by the Prevention Services Clearinghouse based on the review of 10 eligible studies indicating favorable effects on child safety and child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated NFP as "well-supported" with medium relevance for child welfare in the outcome areas of home visiting programs for child well-being, home visiting programs for prevention of child abuse and neglect, prevention of child abuse and neglect (primary) programs, and teen pregnancy services. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Safety* - *Reduced child welfare administrative reports* One study demonstrated that NFP reduced the likelihood of CPS reports (Mejdoubi, 2015). *Child Well-Being* - *Improved cognitive functions and abilities*	While NFP was initially evaluated with predominately white families, subsequent evaluations demonstrated positive outcomes for children from diverse backgrounds, specifically African American families (Kitzman, 1997) and Latino and Spanish-speaking families (Olds, 2002). In Connecticut, 15% of mothers receiving NFP in 2019 were Black or African American and 36% were Hispanic or Latino.	**Pregnant or parenting youth in foster care** - NFP could be offered to expectant or new mothers in foster care. **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Studies indicate that NFP can improve child cognitive functioning and abilities as well as their physical and developmental health (Kitzman, 1997; Robling, 2016; & Thorland, 2017). **Substance-exposed infants** - Since NFP has demonstrated outcomes for child health and cognitive functioning, NFP could be a good match for substance exposed infants (Kitzman, 1997; Robling, 2016; & Thorland, 2017). Furthermore, NFP has demonstrated outcomes for young mothers with health risk factors,

	A number of studies demonstrated that NFP resulted in enhanced child cognitive functions and abilities, specifically regarding improved visual attention and reduced language development concerns (Kitzman, 1997; Robling, 2016; Thorland, 2017). - *Improved physical development and health* A number of studies demonstrated that NFP resulted in enhanced child physical development and health including reduced yeast infections, fewer pre-term and early term births, and fewer instances of very low birth weight (Kitzman, 1997; Robling, 2016; & Thorland, 2017). *Adult Well-Being* - *Improved economic and housing stability* At least one study demonstrated that participation in NFP increased economic stability, specifically increasing the likelihood of a caregiver employment after birth (Olds, 2002). As mentioned in Section 3, NFP has demonstrated positive outcomes in Connecticut specifically related to improved physical development and health as well as improved economic and housing stability.		including those exhibiting behaviors such as alcohol and tobacco use. One study found that pregnant women who smoked and received NFP were more likely to quit smoking than women in the control group. Alcohol and tobacco cessation may have implications for other substance use disorders (Matone et al., 2012). **Unstably housed/homeless youth and their families** - While NFP would not be the only treatment or intervention needed for families experiencing homelessness, one study indicated NFP can increase economic and housing stability (Olds, 2002).
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Parents as Teachers (PAT)	PAT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of six eligible studies indicating favorable effects on child safety and child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated PAT as "promising" with medium relevance for child welfare in the outcome areas of home visiting programs for child well-being and prevention of child abuse and neglect (primary) programs.	PAT has demonstrated positive outcomes across the United States and in other countries. PAT was designed to be delivered to a diverse population of families, demonstrating efficacy with predominately Latina mothers (Wagner,	**Pregnant or parenting youth in foster care** - PAT could be offered to expectant or new mothers in foster care (Casey, 2018). **Children who are chronically absent from preschool/school or who are truant** - When participating in PAT, parents are taught to detect developmental delays earlier in their children and parents are

	<u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Safety* - *Reduced child welfare administrative reports* One study demonstrated that participation in PAT has been shown to increase child safety by reducing the occurrence of substantiated incidents of abuse and neglect. Specifically, there was a 22% decreased likelihood of substantiated cases of child maltreatment as reported by CPS for PAT families compared to non-PAT families (Chaiyachati, 2018). *Child Well-Being* - *Improved social functioning* PAT demonstrates favorable and statistically significant improvements on child social functioning including children scoring at or above their chronological age on the Self-Help Development Scale (Wagner, 1999). - *Improved cognitive functions and abilities* Two studies demonstrate that PAT improves child cognitive functions and abilities, specifically in regard to expressive language and general cognitive development (Neuhauser, 2018; Wagner, 1999). One of the studies reviewed by the Prevention Services Clearinghouse, was conducted in Connecticut with 7,386 participants between 2008-2011. This evaluation demonstrates that PAT already has positive outcomes in Connecticut, specifically related to reducing the occurrence of substantiated cases of child maltreatment (Chaiyachati, 2018).	1999) as well as African American mothers (Wagner, 2002).	better able to support school readiness and success (Neuhauser, 2018; Wagner, 1999). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Studies indicate that participation in PAT results in improved social functioning and improved cognitive functions and abilities for children as parents are taught to recognize and respond to developmental or health issues (Neuhauser, 2018; Wagner, 1999).
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations

Healthy Families America (HFA)	*Child Safety:* - *Reduced self-report of maltreatment* Participation in HFA has resulted in an increase to child safety due to a reduction in neglectful parenting behaviors, frequency of minor physical aggression, psychological aggression and frequency of severe and very severe physical abuse (Duggan, 2004; Mitchell-Herzfeld, 2005). *Child Well-Being:* - *Improved behavioral and emotional functioning* HFA has been shown to improve behavioral and emotional functioning by reducing both internalizing and externalizing behaviors (Caldera, 2007). - *Improved cognitive functions and abilities* HFA has proven efficacy in its ability to improve child cognitive functions and abilities as exhibited by an increase in scores on an infant mental health development index (Caldera, 2007). - *Reduced delinquent behavior* One study suggested that HFA results in reduced delinquent behavior, measured by a reduction in children skipping school (DuMont, 2010). - *Improved educational achievement and attainment* HFA has been shown to result in improved educational achievement and attainment, specifically measured by the learning children retain in 1st grade (Kirkland, 2012). *Adult Well-Being* - *Improved positive parenting practices* HFA has proven outcomes related to improved positive parenting practices evidenced by observations of parents guiding their children through various tasks (DuMont, 2008). - *Improved parent/caregiver mental or emotional health*	Research indicates that HFA is an effective intervention for families from diverse backgrounds. One study demonstrated that HFA is effective in reducing adverse birth outcomes for socially disadvantaged pregnant women; two thirds of those participants were Black or Hispanic women (Lee, 2009). Furthermore, another study found that pregnant American Indian adolescents who received HFA had significantly better outcomes including higher parent knowledge scores and maternal involvement scores as compared to mothers in the control group (Barlow, 2006).	**Pregnant and parenting youth in foster care** - HFA could be offered to expectant or new mothers in foster care (Jacobs, Easterbrooks, Bumgarner, Raskin, Fosse, & Fauth, 2015). **Children who are chronically absent from preschool/school or who are truant** - Not only does HFA have proven outcomes for improved educational achievement and attainment (Kirkland, 2012), it also demonstrates an improvement in child behavioral and emotional functioning, child cognitive functions and abilities, and positive parenting practices; all of which could address underlying contributors to chronically absent children (Caldera, 2007; Dumont 2008). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - HFA has demonstrated outcomes that could address both child emotional and behavioral functioning (Caldera, 2007) and parent/caregiver mental or emotional health (Duggan, 2004; Duggan, 2007; McFarlane, 2013). **Families experiencing IPV** - HFA has proven outcomes for mothers with reported instances of intimate partner violence; specifically, mothers receiving HFA reported lower rates of physical assault victimization and significantly lower rates of perpetration

	Participation in HFA has resulted in improved parental mental health and decreased stress (Duggan, 2004; Duggan, 2007; McFarlane, 2013). - *Improved family functioning* HFA has demonstrated positive outcomes in family functioning and reductions in domestic violence (Bair-Merritt, 2010). HFA has been successfully implemented in Massachusetts and a number of the studies reviewed by the Clearinghouse were completed in Massachusetts (Easterbrooks, 2012, 2013; Jacobs, 2015, 2016; Tufts Interdisciplinary Evaluation Research, 2017). Connecticut and Massachusetts have geographical, regional, and demographic similarities; for example, in 2010, 88% of Connecticut's residents lived in cities and 92% of Massachusetts' residents lived in cities. These similarities and others suggest that implementation of HFA in Connecticut may be successful based on its success in Massachusetts.		relative to the control group (Bair-Merritt, 2010).

Continuous Quality Improvement (CQI) Strategy

CTDCF will partner with an experienced CQI entity to enhance CQI strategies for the "well-supported" evidence-based programs included in Connecticut's Prevention Plan as well as the activities of the Care Management Entity. CTDCF will also collaborate with the Office of Early Childhood, the current administrator of the early childhood home visiting programs in Connecticut's Prevention Plan (i.e., NFP, PAT, and HFA). Relatedly, CTDCF will work with the Court Support Services Division, the current MST contract holder in Connecticut. CTDCF intends to collaborate with a number of other partners including university colleagues, model developers, contracted providers, and youth and families with lived expertise.

CQI processes will be guided by *A Measurement Framework for Implementing and Evaluating Prevention Services (Framework)* developed by Chapin Hall at the University of Chicago (2020). The *Framework* identifies metrics to better understand the **reach** of the selected prevention services, to monitor the **fidelity and quality** of the selected prevention services and determine whether the EBP-specific **outcomes** and the overall Connecticut Family First **outcomes** are being achieved in order to course correct if needed.

Evaluation and CQI questions for Connecticut's Well-Supported EBPs

Informed by the *Framework,* CTDCF has developed a list of cross-cutting research questions that will be applied to all EBPs in Connecticut's Prevention Plan. All evaluation and CQI questions will be examined from the standpoint of racial equity; Connecticut plans to engage a diverse set of stakeholders and data to ensure it approaches Family First CQI with racial justice at the forefront.

A. Cross-EBP evaluation and CQI questions related to **reach**:
    a. Are Connecticut's Family First candidate children/families being identified and referred to prevention services?
    b. Are referred children/families enrolling in prevention services once they are referred?
    c. What are the characteristics of the Family First candidate children/families receiving prevention services and how/do they differ from referred children/families that are not receiving services? (i.e., is Connecticut equitably serving referred children/families referred to services)
    d. What is the length of time between referral to services and when children/families actually start services?
    e. What is the duration and intensity of children/families' prevention services involvement?
    f. How often do children/families complete services?
    g. Is there regional variation in referrals, service receipt, and service completion?
B. Cross-EBP evaluation and CQI questions related to **fidelity and quality**:
    a. Do the Family First candidate families being referred to prevention services meet the specific EBP eligibility requirements?
    b. To what extent are prevention services being delivered as outlined by the EBP model developers and associated manual/curriculum, (i.e., are service being delivered with fidelity to the model)?
    c. Are the same number of service sessions as outlined in the EBP model being delivered to Family First candidate families?

d. Are prevention services being delivered with quality?

C. Cross-EBP research questions related to **outcomes**:
   a. Well-being
      i. Do children/families that receive prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (*this will be tailored to the EBP-specific program goals*)?
      ii. Do children/families that complete prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (*this will be tailored to the EBP-specific program goals*)?
   b. Safety
      i. Does receipt of prevention services reduce maltreatment? Are children referred or re-referred for suspected child maltreatment within 12 months of the child-specific prevention plan start date? Within 24 months?
      ii. Does prevention service completion reduce maltreatment? Are children referred or re-referred for suspected child maltreatment within 12 months of EBP service completion? Within 24 months?
   c. Permanency
      i. Does receipt of prevention services reduce foster care entry? Do children enter foster care within 12 months of the child-specific prevention plan start date? Within 24 months?
      ii. Does completion of prevention services reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?
   d. Racial Equity
      i. Are prevention services reducing the racial and ethnic disparities in Connecticut's substantiated cases or foster care entry rate?
      ii. Are Connecticut families of color experiencing better mental health, substance abuse, and parenting outcomes as prescribed by each EBP?
      iii. Are there differences in how families experience prevention services provision across racial and ethnic groups?

CQI Implementation Team Structure

CTDCF has developed a rich infrastructure for collaborative program design, implementation, data sharing and service delivery statewide. This infrastructure includes Memoranda of Understanding (MOUs) between EBP model developers, other state agencies, the CT Judicial Branch, academic centers, and a network of community adolescent and family behavioral health providers serving every region of the state. CTDCF will leverage this infrastructure to build its Family First Implementation team as well as its CQI Workgroup. Connecticut will work with its Governance Committee and the emergent Implementation team in order to make decisions around CQI in Connecticut. These teams will include representatives from the provider community, sister agencies, families and youth, advisory and advocacy groups, and university partners.

Intended Family First CQI leads and partners

Internally, the CTDCF Bureau of Strategic Planning will lead the CQI workgroup and CQI efforts in Connecticut in partnership with internal and external groups mentioned below. Like all other Family First workgroups, Connecticut intends to engage partners to co-lead and participate in the CQI workgroup. The Bureau Chief of Strategic Planning and her team will coordinate the CQI workgroup and will meet quarterly to review data reports, plan and monitor improvement goals, and address challenges identified by stakeholders. The CQI team will then report to the Governance Committee and Implementation Team with their findings.

Below are the internal and external partners CTDCF intends to engage for its CQI workgroup and efforts.

Internally, the CTDCF Bureau of Strategic Planning will lead the CQI Workgroup and CQI efforts in Connecticut in partnership with internal and external groups mentioned below. Like all other Family First workgroups, Connecticut intends to engage partners to co-lead and participate in the CQI Workgroup. The Bureau Chief of Strategic Planning and her team will coordinate the CQI Workgroup and will meet quarterly to review data reports, plan and monitor improvement goals, and address challenges identified by stakeholders. The CQI team will then report to the Governance Committee and Implementation Team with their findings.

Below are the internal and external partners CTDCF intends to engage for its CQI Workgroup and efforts.

- The *Bureau of Strategic Planning* encompasses *Quality Improvement (QI), Quality Assurance (QA), and Performance Management (PM):* QI includes all efforts to provide strategies for improvement of the practice; QA provides ongoing review of CTDCF practice; PM includes the provision of performance data and oversight of the overarching performance goals and outcomes for the agency. The Bureau will be responsible for leading and coordinating the CQI strategy and providing the monitoring and management of the well-supported interventions. These responsibilities will include cleaning, analyzing, and reporting data on EBPs and other evaluation and CQI questions described above, as well as engaging EBP providers and other stakeholders in quality improvement activities that address concerns discovered in the evaluation findings.

- *Program Development and Oversight Coordinators (PDOC) and CTDCF Program Leads:* Primarily responsible for the oversight and quality assurance regarding the specific contracted services and ensuring quality implementation and needed program improvement. PDOCS and Program Leads will work with EBP model developers to identify and develop reports on specific outcomes.

- The *Academy for Workforce Development:* Primarily responsible for training and support of field practices that advance the goals of high-quality assessment, referral, case planning, and service delivery in Connecticut.

- *Connecticut Office of Early Childhood:* Primary contractor for home visiting EBPs, and therefore will provide insights and guidance on CQI for HFA, PAT, and NFP.

- *Court Support Services Division:* Contractor for EBPs associated with delinquency and therefore will provide insights and guidance on CQI for FFT, MST, and BSFT.

- *Community pathway partners:* Potential community pathway referral sources (i.e., schools, police departments/fire departments/EMS, courts, healthcare providers, sister agencies, and community- or faith-based organizations, etc.) will provide insight into the referral process and the ability to connect families with Family First services through the care management entity.

- *Contracted provider organizations:* Primary responsibility for implementing Connecticut's prevention services in coordination with CTDCF, OEC, and CSSD. Ongoing responsibilities will include collecting and reporting intervention-specific fidelity monitoring and outcome data and implementing performance improvement activities.

- *Model developers/trainers:* Primarily responsible for training and support of providers implementing Family First EBPs.

- *Youth and Families:* Primary responsibility for providing feedback on service delivery and receipt.

Current CQI strategies

CTDCF intends to build upon the internal and external CQI strategies and frameworks as a starting place for its Family First CQI structure. Below are ongoing strategies Connecticut currently employs to ensure performance and outcome monitoring:

- *Service Development Plan and Corrective Action Plan*: CTDCF utilizes a standardized performance management process that relies on collaborative implementation of a Service Development Plan (SDP) when deficiencies in a program are identified. If the SDP fails to correct the deficiency, a formal Corrective Action Plan is implemented along with the CTDCF Contract Division.

- *Contracted Services*: All contracted services in Connecticut have performance expectations and specific outcomes. The performance and outcome data collected are utilized to assess progress towards intended outcomes for Connecticut's families, and to assess whether services are achieving intended benefits. CTDCF Program Leads meet with provider agencies regularly to review data based on the specific outcome and model fidelity measures that are outlined in contracts. If deficits are identified in the performance expectations and outcomes, the Program Leads along with the model developers meet with agencies to collaboratively identify strategies to improve outcome measures. If continued challenges exist, programs could be placed on a Corrective Action Plan, up to and including termination if the deficiencies fail to be corrected.

- *Training and TA*: CTDCF has a longstanding practice of contracting with model developers for training and technical assistance to ensure model fidelity. CTDCF currently has contracts with all model developers for EBPs currently in place.

- *Data collection*: All EBP models and CTDCF require data systems that collect information on clients served. In addition, the EBP models require information on staff training and progress toward certification in the model. These data include staff participation in initial and booster training sessions, any necessary technical assistance, documentation of sessions (submission of recorded sessions); and track the content, frequency and duration of sessions. For each EBP fidelity reviews are conducted that analyze all the data collected. These reviews typically include CTDCF Program Leads, the EBP model developer, and providers. CTDCF conducts two levels of reviews: system reviews and individual provider reviews. System fidelity reviews look at these

data in aggregate, while the fidelity review of the individual program looks at provider specific data. CTDCF, in partnership with the EBP model developer, will combine these data into dashboard reports and share with providers to inform discussion during fidelity review meetings that occur quarterly.

Data sources:

Data reporting is an essential function of the CTDCF Bureau for Strategic Planning and includes provision of data from Connecticut's LINK, Results-Oriented Management (ROM) Reports, Provider Information Exchange (PIE), and CT-KIND systems.

CT-LINK: LINK is CTDCF's statewide automated child welfare information system (SACWIS), which is being updated to the current federal requirements for child welfare information systems (CCWIS) and will become *CT-KIND*. LINK is CTDCF's system of record utilized by staff to document and record case related activity as well as to reflect and record engagement activities and other data.

ROM: The Results-Oriented Management (ROM) Reports system was built and maintained by the University of Kansas (KU) School of Social Welfare, in conjunction with CTDCF Strategic Planning and Information Systems staff. The system is available to CTDCF staff and contains a collection of automated reports concerning the safety, permanency and well-being of the children that we serve. The system allows staff to view pending work as well as trends in performance over time, and comparisons of unit performance.

PIE: The PIE system is utilized by CTDCF and providers as the data and reporting solution for community-based programs across CTDCF mandate areas, including the EBPs identified in this plan that currently exist (additional EBPs identified in this plan that are not currently in existence will also be added to the PIE system). PIE provides key outcome data regarding our families and service provision and allows staff to assess utilization of services, assess and monitor service quality, and manage programs and contracts with data. PIE includes data for behavioral health programs, child placement programs, and child welfare programs as well as data regarding non-CTDCF clients for some programs as well. The PIE system can produce quantitative data, and qualitative data can be obtained from the PDOCs, Systems Program Directors, CTDCF staff, and the providers as well.

Data reporting is further informed by CTDCF's Statistician who can provide complex analysis of agency data. Qualitative data can be obtained from LINK records in combination with record review and interviews and/or focus groups.

CTDCF and the EBP model developers use web-based HIPAA and HITECH compliant databases to record client specific information, to aggregate this information across the network, and to develop reports that document system functioning, as well as individual services and outcomes to monitor program fidelity.

In addition, EBP model developers have their own web-based systems where they collect from providers information related to the type of services clients receive, frequency, content and duration of sessions; EBP skills utilized in sessions; and outcomes data. Connecticut will modify contracts as needed to ensure all necessary quality improvement data is being collected from each provider, including the data

reported to model developers. Connecticut intends to utilize these data systems and others to inform its CQI efforts

Section 7: Child Welfare Workforce Training and Support

Connecticut is well poised and committed to ensuring that quality, effective, and efficient services are provided to children and families throughout the state. To demonstrate this commitment, Connecticut places an emphasis on training support for the CTDCF child welfare and provider workforce so that they are expertly trained on a competency-based, trauma informed curriculum that encompasses best practice through an intentional racial justice lens.

Ensuring that the workforce has a comprehensive understanding of being trauma informed not only supports a well-developed workplace but also reinforces the important professional development perspectives of caregivers with lived experience. As discussed earlier in this plan, community conversations were held with caregivers throughout the state. Among the many identified cross-cutting themes was the need for the workforce to demonstrate a deeper understanding of trauma and the impact it has on children and families.

Caregivers also expressed that in addition to a strong trauma-informed knowledge base, ensuring that the workforce understands the importance of being genuine, flexible, and understanding is key to positive relationship building which leads to positive outcomes for children, youth, families and communities.

Commitment to the caregiver voice and the comprehensive development of the workforce further illustrates Connecticut's prime positioning to leverage Family First. CTDCF provides training through the Academy for Workforce Development, which prepares caseworkers to understand the specific details of Family First and available EBPs. This training is vital as caseworkers are invaluable in the process of identifying, referring, and supporting services available to Connecticut's children and families.

EBP provider workforce

To support implementation of Family First, the EBP provider workforce will be trained on the unique EBP model requirements, to ensure fidelity and long-term sustainability. To that end, the Department recognizes that having a lead entity for EBP workforce training is critical particularly for the ongoing support and coaching that is needed for fidelity. The Department plans to contract with an outside entity to partner in this task, as available funding allows.

For monitoring purposes, the Program Leads will meet with provider agencies regularly to review data based on the specific outcome measures and model fidelity measures that are outlined in CTDCF EBP contracts.

Child welfare agency workforce

Through the Academy for Workforce Development, the Department currently offers a robust training curriculum of pre-service training, in-service training, mandatory trainings, simulation training and leadership development training for its child welfare workforce. These trainings are designed to ensure that the workforce is equipped with the requisite skills and knowledge needed to support a prevention-oriented system. Each training category offers a cadre of courses that are trauma informed, competency-based and reflective of the Department's commitment to racial justice. Courses are also

intentionally aligned with skill building opportunities to demonstrate on the job learning through practical applications.

For example, pre-service offerings for new child welfare staff include a two-day trauma training, behavioral health training, a two-day Structured Decision Making (SDM) training and a course focused on effectively engaging families, to name a few. In-service or ongoing course offerings are ever evolving to meet the diverse training needs of the workforce. Key among the many in-service courses currently offered to support Family First are: Assessing Safety and Risk during the interview process, SDM Safety Planning and Critical Thinking Skills.

To ensure workforce readiness for Family First, the Department plans to develop and launch a Family First Overview training that introduces both new hires in pre-service training and ongoing caseworkers in in-service training to the Family First legislation as well as practice and outcome implications. More specifically, the overview training will introduce a clear process for understanding service eligibility for known-to-CTDCF Family First candidates; and address the newly developed Child Safety Practice Model, the development of child specific prevention plans, the program and service array, and using risk and safety assessments (the SDM tool). The overview training will also further contextualize family engagement in the assessment process, and will be augmented through periodic CTDCF communication strategies, self-guided training opportunities, infographics, micro-learning collaboratives with a coaching component and reinforcement in other Department wide mandatory training opportunities.

The Academy will ensure that the overview training is reinforced through a series of periodic supplemental trainings. To ensure that a prevention lens is embedded in practice, supplemental trainings will be designed to reinforce skill development in translating the need for services or supports, especially needs to prevent safety issues. The supplemental trainings will also serve to reiterate clear and uniform practices around consistent and clear documentation.

These competency-based trainings will be assessed continually by the Academy in partnership with CTDCF area office leadership. The Academy will take the lead in augmenting the training content to better increase the competency level of staff to ensure increased familiarity with the requirements of Family First. As additional training is needed, supervisors will engage coaching tools and techniques to strengthen practice proficiency in their staff. Adjustments to trainings will be addressed to support the needs of the workforce. Skill building related to racial justice outcomes and work with specialized populations, including those with intellectual developmental disabilities or with autism spectrum disorder, will be enhanced by employing quality improvement strategies, such as case reviews. Adjustments will be made when needed to promote quality casework and increased caseworker time dedicated to achieving positive outcomes for children, youth, and families.

Section 8: Prevention Caseloads

Identifying an appropriate caseload size is one important aspect of equipping CTDCF staff to support families in achieving positive outcomes. As Connecticut transforms into a system of well-being, family engagement and effective case management become even more paramount to successful prevention or intervention services.

Connecticut has developed weighted caseload standards, designed to tailor social worker caseloads based on the circumstances of a case or a family.

Below are Connecticut's maximum caseload standards with the targeted 75% of caseload goals per category:

- Investigators: 17:1; (*12.75:1, 75% of caseload)*
- In-home treatment workers: 15:1; (*11.25:1, 75% of caseload)*
- Adoption and Adolescent specialty workers: 20:1; (*15:1, 75% of caseload)*
- Social workers with a mixed caseload cannot exceed the maximum weighted caseload derived from these caseload standards

For Connecticut's "known-to-CTDCF" population, the caseload standard for social workers with Family First prevention cases will align with the weighted caseload standards determined by the particular circumstances of each candidacy population (e.g., pregnant and parenting youth in foster care likely would be assigned to Adolescent Specialty Workers who have a targeted caseload of 15:1).

For CT's community pathway population, CT will work with the CME to determine appropriate caseload sizes based on the experience levels and expected activities of the staff working with families receiving Family First prevention services.

As Connecticut works to prioritize in-home service delivery alongside family stabilization and preservation, CTDCF will continue to review current strategies and seek opportunities to improve the ways in which the system effectively engages and partners with families.

Section 9: Assurances on Prevention Plan Reporting

Connecticut provides an assurance in Attachment I that CTDCF will report to the Secretary the required information and data regarding the provision of services and programs included in Connecticut's Title IV-E Prevention Plan. Data will be reported as specified in federal guidance (Children's Bureau 2019, 2020). See Attachment I, State Title IV-E Prevention Program Reporting Assurance.

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APPENDICES

APPENDIX A: CT Candidacy Population Identified Population Needs

1. **Families with accepted Careline calls**
   Identified population needs:
   a. Reducing trauma reaction
   b. Reducing substance use
   c. Addressing behavioral health needs
   d. Maternal depression
   e. Behavioral health needs of and parenting strategies for children with special health care needs or developmental or intellectual disabilities
   f. Increasing supports within the natural ecology
   g. Parenting skill focus (to reduce abuse)
   h. Reducing family violence
   i. Pre-natal treatment for mothers

2. **Pregnant and parenting youth in foster care**
   Identified population needs:
   a. Appropriately matched for this developmental stage
   b. Promotes independent living skill development
   c. Assists with long-term planning (e.g. education, employment)
   d. Promotes self-sufficiency
   e. Promotes youth connections (social network and community supports)
   f. Needs assessment and connection to services/resources (e.g. mental health or substance use treatment; entitlements; healthcare)
   g. Supports youth in finding and maintaining stable housing
   h. Parenting education (milestones, prenatal care, caring for newborn/infant)
   i. Added assessment of need and coordination of care for medical, pediatric, childcare, early childhood resources, etc.
   j. Good pregnancy outcome
   k. Promotes healthy attachment/bonding and infant health/mental health

3. **Siblings of children in foster care**
   Identified population needs:
   a. Reducing trauma reaction
   b. Addressing grief and loss concerns
   c. Treating anxiety due to separation and other relational issues
   d. Strengthening attachment and bonding of meaningful relationships
   e. Addressing behavioral health needs

4. **Families who have been accepted for VCM Services**
   Identified population needs:
   a. Reducing trauma reaction
   b. Addressing grief and loss concerns
   c. Treating anxiety due to separation and other relational issues
   d. Strengthening attachment and bonding of meaningful relationships
   e. Addressing behavioral health needs

5. **Youth that have exited foster care**
   Identified population needs:
   a. Appropriately matched for this developmental stage
   b. Promotes Independent living skill development
   c. Assists with long-term planning (e.g. education, employment)
   d. Promotes self-sufficiency
   e. Promotes youth connections (social network and community supports)
   f. Needs assessment and connection to services/resources (e.g. mental health or substance use treatment; entitlements; healthcare)
   g. Supports youth in finding and maintaining stable housing

6. **Children who are chronically absent from preschool/school or are truant from school**
   Identified population needs:
   a. Improved school attendance;
   b. improved academic performance;
   c. reduced disciplinary action in school (arrest, suspension);
   d. improved relationship with parents/caregivers;
   e. connection to pro-social peers and activities;
   f. reduced drug/alcohol use (where this is identified as a concern)

7. **Children with incarcerated parents**
   Identified population needs:
   a. Reducing trauma reaction
   b. Need for space within prisons to promote parent-child visits that are child friendly
   c. Addressing behavioral health needs
   d. Need for transportation for visits during incarceration
   e. More programs targeting dads
   f. Including transitional housing programs for dads with kids

8. **Trafficked youth**
   Identified population needs:
   a. Youth will have supportive caregivers/adults they are connected to
   b. Youth will be connected to prosocial peers and activities
   c. Youth will demonstrate reduced symptoms related to trauma
   d. Youth will be connected to educational and/or vocational activities (school and/or work) with defined goals (and strategy) for future
   e. Youth's basic needs are met
   f. Youth proficient in multiple life skills domains

9. **Families experiencing interpersonal violence**
   Identified population needs:
   a. Reducing trauma reaction
   b. Parenting skills
   c. Parental acceptance or responsiveness
   d. Increased non-violent parent and child bond
   e. Decreased parental depression
   f. Increased child resiliency

g. Increased child self-regulation
h. Reduced internalizing for children
i. Increased problem solving and adaptive functioning abilities in children

10. **Youth who have been referred to a Juvenile Review Board, a Youth Service Bureau, or another diversion program; or who have been arrested**
    Identified population needs:
    a. Improved school attendance
    b. Improved academic performance
    c. Reduced disciplinary action in school (arrest, suspension)
    d. Improved relationship with parents/caregivers
    e. Connection to pro-social peers and activities
    f. Reduced drug/alcohol use (where this is an identified concern)
    g. Youth following rules at home and in community
    h. Improved positive parenting strategies

11. **Caregivers with a substance use disorder that impacts parenting**
    Identified population needs:
    a. Abstinence/decreased use AND
    b. Stable mental health
    c. Attunement with child's needs both physical and emotional and developing attachment
    d. Peer support
    e. Capacity to care for family
    f. Increased education or job training
    g. Increased employment
    h. Housing stability in a "drug-free' environment
    i. Health care for all family members
    j. Integration into the community
    k. Wraparound services to provide ongoing stability

12. **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting**
    Identified population needs:
    a. Stable mental health
    b. Attunement with child's needs both physical and emotional and developing attachment
    c. Peer support
    d. Capacity to care for family
    e. Increased education or job training
    f. Increased employment
    g. Housing stability in a "drug-free' environment
    h. Health care for all family members
    i. Integration into the community
    j. Wraparound services to provide ongoing stability

13. **Caregivers who have a child with a substance use disorder and is in need of services**

Identified population needs:

a. Abstinence/decreased use AND
b. Stable mental health
c. Engagement with prosocial peers and activities
d. Attending school and succeeding
e. Enhanced family relationships – Living within family unit
f. Enhance parenting skills to monitor and guide teens
g. Lack of criminal involvement
h. Stable housing

14. **Caregivers who have a child with a mental health condition or physical/intellectual/developmental disabilities**

Identified population needs:

a. Stable mental health
b. Engagement with prosocial peers and activities
c. Attending school and succeeding
d. Enhanced family relationships – Living within family unit
e. Enhance parenting skills to monitor and guide teens
f. Lack of criminal involvement
g. Stable housing

15. **Substance exposed infants as defined by the state CAPTA notification protocol**

Identified population needs:

a. Healthy child development:
    i. Social-emotional
    ii. Cognitive
    iii. Language
    iv. Physical
b. Safe environment
c. Nurturing, responsive parent-child relationship with secure attachment
d. Stimulating environment
e. Stable and secure housing
f. Physical health
g. Caregivers who do not abuse substances

State Title IV-E Prevention Program Reporting Assurance

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(5)(B)(x) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the assurance below.

In accordance with section 471(e)(5)(B)(x) of the Act, Connecticut Department of Children & Families, (Name of State Agency) is providing this assurance consistent with the five-year plan to report to the Secretary such information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:45:21 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Brief Strategic Family Therapy (BSFT) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:39:50 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Functional Family Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:43:45 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Healthy Families America (HFA) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:30:39 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Multisystemic Therapy (MST) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:42:00 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Nurse Family Partnerships (NFP) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:35:56 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Parents as Teachers (PAT) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:33:58 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Parent Child Interaction Therapy (PCIT) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

07/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:37:53 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Assurance of Trauma-Informed Service-Delivery

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

The Department of Children & Families (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

06/13/21	Jodi Hill-Lilly Digitally signed by Jodi Hill-Lilly Date: 2021.07.13 11:14:16 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES
Administration on Children, Youth and Families
Children's Bureau

State Annual Maintenance of Effort (MOE) Report

State: Connecticut	FFY: 2021
Baseline Year:	2014
Baseline Amount: $	-0-
Total Expenditures for Most Recent FFY:	$11,538,955 (FFY 2020)

This certifies that the information on this form is accurate and true to the best of my knowledge and belief.
This also certifies that the next FFY foster care prevention expenditures will be submitted as required by law.

Signature, Approving Official:
Jodi Hill-Lilly
Digitally signed by Jodi Hill-Lilly
Date: 2021.04.23 10:52:35 -04'00'

Typed Name, Title, Agency:
Olga Coleman-Williams, Director of Revenue Enhancement,
Connecticut Department of Children and Families

Date: April 23, 2021

OMB Approval No: 0970-0433
Expiration Date: 11/30/2022

B. STATE PLAN FOR TITLE IV-E OF THE SOCIAL SECURITY ACT: PREVENTION SERVICES AND PROGRAMS

STATE OF CONNECTICUT

U.S. Department of Health and Human Services
Administration for Children and Families
Children's Bureau
November 2018

As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (hereinafter, the Act), the

Connecticut Department of Children and Families

submits here a plan to provide, in appropriate cases, Prevention Services and Programs under title IV-E of the Act and hereby agrees to administer the programs in accordance with the provisions of this plan, title IV-E of the Act, and all applicable Federal regulations and other official issuances of the Department. This Pre-print is provided as an option for title IV-E agencies to use over the course of the five years that the Prevention Services and Programs Plan is in effect.

The state agency understands that if and when title IV-E is amended or regulations are revised, a new or amended plan for title IV-E that conforms to the revisions must be submitted.

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
Section 1. Services Description and Oversight		
471(e)(1)	A. SERVICES. The state agency provides the following services or programs for a child and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care: 1. MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child. 2. IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.	Attachment 1: Connecticut Family First Prevention Plan pp 4 – 11 Standards of Practice Section 1. DCF Family First Prevention Services Overview – A. Services
471(e)(5)(B)(i)	B. OUTCOMES. The state agency provides services and programs specified in paragraph 471(e)(1) is expected to improve specific outcomes for children and families.	Attachment 1: Connecticut Family First Prevention Plan pp 12 Standards of Practice Section 1. DCF Family First Prevention Services Overview – B. Outcomes

[1] Statutory references refer to the Social Security Act. Regulatory references refer to Title 45 of the Code of Federal Regulations (CFR).

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
471(e)(5)(B)(iii)(I)(IV) **471(e)(4)(B)**	C. PRACTICES. With respect to the title IV-E prevention services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of— 1. the services or programs selected by the state, and whether the practices used are promising, supported, or well supported; 2. how the state plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices; 3. how the state selected the services or programs; 4. the target population for the services or programs; 5. an assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit **Attachment III** for each prevention or family service or program); and 6. how each service or program provided will be evaluated.	Attachment 1: Connecticut Family First Prevention Plan pp 5 pp 31 – 32, 42 - 43 pp 31 32 pp 7- 9 pp 66 pp 43 Standards of Practice Section 1. DCF Family First Prevention Services Overview – C. Practices

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
Section 2. Evaluation strategy and waiver request		
471(e)(5)(B)(iii)(V)	A. PRACTICES. With respect to the prevention family services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary, unless a waiver is approved for a well-supported practice; and	Attachment 1: Connecticut Family First Prevention Plan pp 59 - 63 Standards of Practice Section 2. Practices – A. Practices CT DCF Office of the Chief of Quality and Planning
471(e)(5)(C)(ii)	B. REQUEST FOR WAIVER OF WELL DESIGNED, RIGOROUS EVALUATION OF SERVICES AND PROGRAMS FOR A WELL-SUPPORTED PRACTICE. The state must provide evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II) with regard to the practice.	Attachment 1: Connecticut Family First Prevention Plan pp 46 - 58 Standards of Practice Section 2. Practices – B. Request for Waivers **Attachment II**
Section 3. Monitoring child safety		
471(e)(5)(B)(ii)	The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.	Attachment 1: Connecticut Family First Prevention Plan pp 46 – 47 Standards of Practice Section 3. Monitoring Safety CT DCF Structured Decision Making Policy and Practice Guide

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
		CT DCF The Family Response (FAR) Practice Guide
Section 4. Consultation and coordination		
471(e)(5)(B)(iv) and (vi)	A. The state must: 1. engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers and 2. describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.	Attachment 1: Connecticut Family First Prevention Plan pp 5 - 7 Attachment 1: Connecticut Family First Prevention Plan pp 16 Standards of Practice Section 4. Consultation and Coordination
Section 5. Child welfare workforce support		
471(e)(5)(B)(vii)	The state agency supports and enhances a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including—	Attachment 1: Connecticut Family First Prevention Plan pp 64

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
	A. ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well supported practice models selected; and B. developing appropriate prevention plans, and conducting the risk assessments required under clause (iii) of section 471(e)(5)(B).	Standards of Practice Section 5. Workforce Support
Section 6. Child welfare workforce training		
471(e)(5)(B)(viii)	The state provides training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.	Attachment 1: Connecticut Family First Prevention Plan pp 33 – 42 and 64- 65 Standards of Practice Section 6. Training Appendix E: Evidence-based Training modules
Section 7. Prevention caseloads		
471(e)(5)(B)(ix)	The state must describe how caseload size and type for prevention caseworkers will be determined, managed, and overseen.	Attachment 1: Connecticut Family First Prevention Plan pp 65 - 66 Standards of Practice Section 7. Caseload
Section 8. Assurance on prevention program reporting		

Federal Regulatory/Statutory References[1]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
471(e)(5)(B)(x)	The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).	Attachment 1: Connecticut Family First Prevention Plan pp 30-31 and 62-63 Standards of Practice Section 8. Reporting
Section 9. Child and family eligibility for the title IV-E prevention program		
471(e)(2)	A. CHILD DESCRIBED.—For purposes of the title IV-E prevention services program, a child is: 1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e). 2. A child in foster care who is a pregnant or parenting foster youth.	Attachment 1: Connecticut Family First Prevention Plan pp 65 Standards of Practice Section 9. Child and family Eligibility

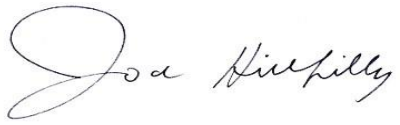
OMB Approval No: 0970-0433
Expiration Date: 11/30/2022

Title IV-E Plan – State of Connecticut

PLAN SUBMISSION CERTIFICATION

Instructions: This Certification must be signed and submitted by the official authorized to submit the title IV-E plan, and each time the state submits an amendment to the title IV-E plan.

I, Jody Hill-Lilly hereby certify that I am authorized to submit the title IV-E Plan on behalf of Connecticut. I also certify that the title IV-E plan was submitted to the governor for his or her review and approval in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Date 07/20/21 

(Signature)

Deputy Commissioner for Administration
(Title)

APPROVAL DATE:

EFFECTIVE DATE:

(Signature, Associate Commissioner, Children's Bureau)

Appendix B: Standards of Practice

Section 1. Services Description and Oversight

CTDCF Family First Prevention Services Overview

Mission

Working together with families and communities for children who are healthy, safe, smart and strong. The strength of the CTDCF system is a fundamental belief that the well-being of children and families is a shared responsibility with all members of the community. Prevention services are intended to stabilize families and keep them together. As part of the overall prevention strategy, Family First' vision is to expand upon its collaborative child well-being system through enhanced focus on prevention and early intervention, to prevent maltreatment and children entering foster care.

Definitions

Mission means the unique purpose and function of the organization. It serves as the focus of attention and the common rallying point of the efforts of the Department of Children and Families.

Strategies are coherent sets of actions that contribute to the accomplishment of the agency's mission and goals. Strategies may include the actions and contributions of external partners as well as the work of CTDCF staff.

Cross-Cutting Themes

The following cross-cutting themes shall guide all CTDCF operational units in advancing the **Cutting** mission and strategies of Family First Prevention:

1. Offer a holistic and empathetic approach, prioritize humanity, honesty, and integrity.
2. Provide advocacy and peer support to families.
3. Establish a connection before formal assessments are conducted.
4. Focus on goals and needs from the family's perspective.
5. Respect and honor a family's culture.
6. Expand respite opportunities for families.
7. Reduce the legwork families have to do by making information about services widely available.
8. Deliver services and case management with a trauma-informed approach.
9. Maintain consistency for families (regionally, across workers, etc.).
10. Tailor services to meet families' particular needs.

CTDCF Strategies informed by the ten cross-cutting themes, Family First is aligned with several other strategies currently being utilized in Connecticut, devoted to keeping children safe and equitably meeting a family's needs. CTDCF will determine the families eligible for Family First prevention services and the manner in which these cases are managed.

- Employing prevention-focused techniques, with an emphasis on early identification and intervention.
- Ensuring access to developmentally appropriate services.
- Offering comprehensive care within a continuum of services.

- Engaging communities, families, and youths in the planning, delivery, and evaluation of mental, emotional, and behavioral health care services.
- Being sensitive to diversity by reflecting awareness of race, culture, religion, language, and ability.
- Establishing results-based accountability measures to track progress towards the goals and objectives.
- Applying data-informed quality assurance strategies to address mental, emotional, and behavioral health issues in children.
- Improving the integration of school and community-based behavioral health services.
- Enhancing early interventions, consumer input and public information and accountability by:
    1. In collaboration with the Department of Public Health, increasing family and youth engagement in medical homes.
    2. In collaboration with the Department of Social Services, increasing awareness of the 2-1-1 Infoline program.
    3. In collaboration with the State Department of Education in ensuring that school districts are identifying and engaging with community providers and partners to provide both inside the schoolhouse and community-based referral sources for students.
    4. In collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state, increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options.

A. Services

Connecticut has embraced the values and principles of the Family First Prevention Services Act (Family First). Family First represents a shift in federal policy as it extends the use of Title IV-E funds beyond foster care and adoption assistance to prevention services intended to stabilize families and keep them together. Specific prevention services that are newly eligible for federal reimbursement include evidence-based mental health treatment programs, substance abuse prevention and treatment programs, and in-home parenting skill-based programs rated on the Title IV-E Prevention Services Clearinghouse.

B. Outcomes

Intended outcomes include:

- Prevention will lead to fewer families in need of CTDCF Services
- Children remain safely at home, whenever possible and appropriate
- Children who must come into CTDCF care achieve more timely permanency
- All children in our care and custody are healthy, safe and learning; they are successful in and out of school; and they are supported to find and advance their special talents and to give something back to their communities
- Youth who transition from CTDCF are better prepared for adulthood

With a firm emphasis on strengthening and preserving families, the practice model lends itself to the Family First vision through keeping children safely with their families and avoiding the traumatic experience of entering care.

C. Practices

Connecticut's vision is to shift from a system solely focused on child protection, where action is taken after harm to a child has occurred, to a collaborative child well-being system focused on prevention and early intervention. Connecticut has reimagined its system to not only serve those families who come to the attention of the child welfare agency, but to also

develop supports for families "upstream," resulting in families being diverted from involvement with the child welfare agency. By empowering and supporting families, the well-being of Connecticut's children, youth and families will be enhanced across systems making for a more promising future.

While Family First offers Connecticut opportunities for innovation in prevention, it is only one mechanism among many that Connecticut intends to employ. For example, Connecticut recognizes that the list of evidence-based programs on the Prevention Services Clearinghouse does not capture the full range of needs of Connecticut families. Therefore, Connecticut intends to continue investment in efforts that address family and community economic supports, services that are developed with and for communities of color, and evidence-based practices that address the full continuum of mental, behavioral, and physical health needs of Connecticut children and families. Connecticut is enthusiastic about developing a well-being system and implementing Family First as the next step of its transformation journey, and invites its sister agency partners, communities, and families to continue to participate in this transformation and to help shape the system we envision for our families.

Connecticut is grateful to the hundreds of community partners, especially those parents and youth with lived experience, who have provided valuable insight into our planning process. Their voices influenced each section of this plan.

In order to develop Connecticut's Family First prevention service array, the Programs and Services Workgroup engaged over 100 members including model developers, sister state agencies, providers, advocates, and families with lived expertise. This workgroup developed and implemented a rigorous process informed by implementation science to assess the services on the Prevention Services Clearinghouse, as well as programs and services not currently eligible for reimbursement, in order to develop the appropriate array to meet the specific intervention needs of the families that were defined as the candidacy groups for Connecticut’s Prevention Plan. To make service recommendations to Connecticut's Governance Committee the Programs and Services Workgroups was convened to select the programs and services that could be best matched to strengthen families that would be served under Family First. The workgroup catalogued all relevant services in Connecticut, including, but not limited to those on the Prevention Services Clearinghouse; documented service information about each program (target population, duration, intensity, service location, research supported outcomes, etc.); and matched each Evidence-Based Program (EBP) to Connecticut's candidacy populations. Once this service-specific information was collected and organized, the Programs and Services Workgroup organized this list of services based on their levels of evidence:

☐ Tier 1: “Well-Supported” programs on the Clearinghouse
☐ Tier 2: “Supported” and “Promising” programs on the Clearinghouse
☐ Tier 3: Services with the evidentiary support that may be eligible for an Independent Systematic Review (as evidenced by rating on the California Evidence-Based Clearinghouse for Child Welfare (CEBC) or Randomized Control Trials/Quasi-experimental studies)
☐ Tier 4: Services in Connecticut that may be highly effective with families and aligned with the goals of Family First and should be considered for the broader Connecticut prevention service continuum

Implementation of the Connecticut Prevention Plan will be informed by the ongoing guidance of the Governance Committee, the Implementation Team, and the CQI Workgroup. These teams include representatives from the provider community, sister agencies, families and youth, advisory and advocacy groups, and university partners.

This implementation structure promotes:

- Routine refinements and improvements during implementation planning and rollout
- Identification and (re)allocation of resources as needed
- Timely decision-making around policy- and program-related elements
- Ongoing monitoring of progress towards prioritized outcomes
- Executing and sustaining the desired transformation

Information gathered by the CQI Workgroup will be reviewed to ensure Connecticut's Prevention Plan is aligning with agency and statewide goals. This structure will facilitate the development of collaborative strategies to respond to any organizational or systemic challenges that arise. CTDCF's Continuous Quality Improvement Strategy Section will provide additional information regarding Connecticut's plan to implement Family First services successfully and with fidelity.

Connecticut utilized a fit and feasibility matrix to determine which EBPs should be selected for its Plan. In terms of feasibility, Connecticut specifically considered levels of evidence, infrastructure and availability in Connecticut, as well as particular details regarding staff qualifications and service delivery. Connecticut has demonstrated a long-standing commitment to implementation of a wide array of EBPs with sustained focus on model fidelity, evaluation, and positive outcomes. This experience will be leveraged in the implementation of Family First.

a. Fit Criteria:
   i. Prioritization of EBPs matching three or more candidacy populations
   ii. Evidence of research with communities of color as evidenced by studies reviewed on the CEBC or the Title IV-E Prevention Services Clearinghouse

b. Feasibility Criteria:
   i. Tier of evidence (1-4)
   ii. Wide availability in Connecticut, as defined by existing within three or more CTDCF regions

CTDCF intends to maintain its foundational mandate to keep children safe with their families but strives to evolve our mission, vision and strategies to become an agency that empowers families to thrive by walking in partnership alongside them. In order to continue this evolution, CTDCF will need to rely on the collective thinking and collaborative contributions of sister agencies, providers, community partners, and most importantly our families, to build trust and reimagine our system.

Connecticut views Family First as an opportunity to continue and augment this transformation into a system of well-being; in part, by extending prevention services to families earlier and continuing to realign objectives towards prevention more broadly. Family First has already facilitated meaningful collaboration between partners in Connecticut to reimagine a coordinated system designed with and for families. Connecticut's youth and family serving agencies - including the Departments of Education, Social Services, and Mental Health and Addiction Services - have been engaged in planning for this work, relying on each agency's strengths, resources and opportunities to create collective positive impact for our families.

Along with expanding access to prevention services and fostering coalition building, one of the most exciting ways in which Connecticut intends to leverage Family First is as a tool to rethink which families are eligible for preventive services and the manner in which CTDCF plans to manage their cases.
Connecticut developed a broad target population (families eligible for Family First services) definition that includes two population groups:

1) Those that are already "known-to-CTDCF" either through a call to the Careline, prior involvement in the system, or current involvement (pregnant and parenting youth in foster care). This group of families will constitute Connecticut's initial candidacy population for Family First prevention services.

2) Families that will be referred through a "community pathway." This group of families will be served during the second phase of Family First implementation when the appropriate partnerships, infrastructure, and fiscal support are sufficiently established.

The community pathways population includes "upstream" families experiencing specific behavior, conditions, or circumstances that are likely to have an adverse impact on a child's development or functioning and for whom research establishes that such characteristics or conditions place them at increased risk for maltreatment, involvement with the child welfare system, or out-of-home placement.

Families with certain characteristics that will be identified through a community or neighborhood pathway and eligible for services are:

- Families accepted for Voluntary Services (Voluntary Care Management as of May 1, 2020)
- Children who are chronically absent from preschool/school or are truant from school
- Children of incarcerated parents
- Trafficked youth
- Unstably housed/homeless youth
- Families experiencing interpersonal violence
- Youth who have been referred to a juvenile review board, youth service bureau, other diversion program, or who have been arrested
- Caregivers or children who have a substance use disorder, mental health condition or disability that impacts parenting
- Infants born substance exposed as defined by the state's Child Abuse Prevention and Treatment Act (CAPTA) notification protocol[1]

Connecticut sees this pathway as a tremendous opportunity to provide services earlier to families to establish stability and family well-being, and to prevent foster care entry. To engage these families earlier, CTDCF heard directly from families and partners that it was important to develop an entity outside of the Department to assist in these families' cases. Therefore, as available funding allows, CTDCF plans to contract with a Care Management Entity (CME) to engage these "community pathways" families, provide case management, manage service referrals, and monitor ongoing progress. In response to feedback from families and partners, CTDCF is eager to establish this relationship to capitalize on the ground-breaking Family First opportunities without magnifying CTDCF surveillance.

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[1] *ACT definition of infants born substance-exposed for the purposes of the CAPTA notification: A newborn: (1) exposed in utero to methadone, buprenorphine, prescription opioids, marijuana, prescription benzodiazepines, alcohol, other illegal/non-prescribed medication, and/or the misuse of prescription/over the counter medication; (2) with withdrawal symptoms; (3) diagnosed with Fetal Alcohol Syndrome.*

Connecticut provides an assurance in Attachment I that CTDCF will report to the Secretary the required information and data regarding the provision of services and programs included in Connecticut's Title IVE Prevention Plan. Data will be reported as specified in federal guidance (Children's Bureau 2019, 2020).

Section 2. Evaluation strategy and waiver request

A. Practices

CTDCF will partner with an experienced CQI entity to enhance CQI strategies for the "well-supported" evidence-based programs included in Connecticut's Prevention Plan as well as the activities of the Care Management Entity. CTDCF will also collaborate with the Office of Early Childhood, the current administrator of the early childhood home visiting programs in Connecticut's Prevention Plan (i.e., NFP, PAT, and HFA). Relatedly, CTDCF will work with the Court Support Services Division, the current MST contract holder in Connecticut. CTDCF intends to collaborate with a number of other partners including university colleagues, model developers, contracted providers, and youth and families with lived expertise.

CQI processes will be guided by A Measurement Framework for Implementing and Evaluating Prevention Services (Framework) developed by Chapin Hall at the University of Chicago (2020). The Framework identifies metrics to better understand the reach of the selected prevention services, to monitor the fidelity and quality of the selected prevention services and determine whether the EBP-specific outcomes and the overall Connecticut Family First outcomes are being achieved in order to course correct if needed.

Evaluation and CQI questions for Connecticut's Well-Supported EBPs

Informed by the Framework, CTDCF has developed a list of cross-cutting research questions that will be applied to all EBPs in Connecticut's Prevention Plan. All evaluation and CQI questions will be examined from the standpoint of racial equity; Connecticut plans to engage a diverse set of stakeholders and data to ensure it approaches Family First CQI with racial justice at the forefront.

A. Cross-EBP evaluation and CQI questions related to reach:

a. Are Connecticut's Family First candidate children/families being identified and referred to prevention services?
b. Are referred children/families enrolling in prevention services once they are referred?
c. What are the characteristics of the Family First candidate children/families receiving prevention services and how/do they differ from referred children/families that are not receiving services? (i.e., is Connecticut equitably serving referred children/families referred to services)
d. What is the length of time between referral to services and when children/families actually start services?
e. What is the duration and intensity of children/families' prevention services involvement?
f. How often do children/families complete services?
g. Is there regional variation in referrals, service receipt, and service completion?

B. Cross-EBP evaluation and CQI questions related to fidelity and quality:

a. Do the Family First candidate families being referred to prevention services meet the specific EBP eligibility requirements?
b. To what extent are prevention services being delivered as outlined by the EBP model developers and associated manual/curriculum, (i.e., are service being delivered with fidelity to the model)?
c. Are the same number of service sessions as outlined in the EBP model being delivered to Family First candidate families?
d. Are prevention services being delivered with quality?

C. Cross-EBP research questions related to outcomes:
   a. Well-being
      i. Do children/families that receive prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (this will be tailored to the EBP-specific program goals)?
      ii. Do children/families that complete prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (this will be tailored to the EBP-specific program goals)?
   b. Safety
      i. Does receipt of prevention services reduce maltreatment? Are children rereferred for suspected child maltreatment within 12 months of the child-specific prevention plan start date? Within 24 months?
      ii. Does prevention service completion reduce maltreatment? Are children rereferred for suspected child maltreatment within 12 months of EBP service completion? Within 24 months?
   c. Permanency
      i. Does receipt of prevention services reduce foster care entry? Do children enter foster care within 12 months of the child-specific prevention plan start date? Within 24 months?
      ii. Does completion of prevention services reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?
   d. Racial Equity
      i. Are prevention services reducing the racial and ethnic disparities in Connecticut's maltreatment or foster care entry rate?
      ii. Are Connecticut families of color experiencing better mental health, substance abuse, and parenting outcomes as prescribed by each EBP?
      i. Are there differences in how families experience prevention services provision across racial and ethnic groups?

Internally, the CTDCF Bureau of Strategic Planning will lead the CQI Workgroup and CQI efforts in Connecticut in partnership with internal and external groups mentioned below. Like all other Family First workgroups, Connecticut intends to engage partners to co-lead and participate in the CQI Workgroup. The Bureau Chief of Strategic Planning and her team will coordinate the CQI Workgroup and will meet quarterly to review data reports, plan and monitor improvement goals, and address challenges identified by stakeholders. The CQI team will then report to the Governance Committee and Implementation Team with their findings.

Below are the internal and external partners CTDCF intends to engage for its CQI Workgroup and efforts.

- The Bureau of Strategic Planning encompasses Quality Improvement (QI), Quality Assurance (QA), and Performance Management (PM): QI includes all efforts to provide

strategies for improvement of the practice; QA provides ongoing review of CTDCF practice; PM includes the provision of performance data and oversight of the overarching performance goals and outcomes for the agency.

The Bureau will be responsible for leading and coordinating the CQI strategy and providing the monitoring and management of the well-supported interventions. These responsibilities will include cleaning, analyzing, and reporting data on EBPs and other evaluation and CQI questions described above, as well as engaging EBP providers and other stakeholders in quality improvement activities that address concerns discovered in the evaluation findings.

- Program Development and Oversight Coordinators (PDOC) and CTDCF Program Leads: Primarily responsible for the oversight and quality assurance regarding the specific contracted services and ensuring quality implementation and needed program improvement. PDOCS and Program Leads will work with EBP model developers to identify and develop reports on specific outcomes.

- The Academy for Workforce Development: Primarily responsible for training and support of field practices that advance the goals of high-quality assessment, referral, case planning, and service delivery in Connecticut.

- Connecticut Office of Early Childhood: Primary contractor for home visiting EBPs, and therefore will provide insights and guidance on CQI for HFA, PAT, and NFP.

- Court Support Services Division: Contractor for EBPs associated with delinquency and therefore will provide insights and guidance on CQI for FFT, MST, and BSFT.

- Community pathway partners: Potential community pathway referral sources (i.e., schools, police departments/fire departments/EMS, courts, healthcare providers, sister agencies, and community- or faith-based organizations, etc.) will provide insight into the referral process and the ability to connect families with Family First services through the care management entity.

- Contracted provider organizations: Primary responsibility for implementing Connecticut's prevention services in coordination with CTDCF, OEC, and CSSD. Ongoing responsibilities will include collecting and reporting intervention-specific fidelity monitoring and outcome data and implementing performance improvement activities.

- Model developers/trainers: Primarily responsible for training and support of providers implementing Family First EBPs.

- Youth and Families: Primary responsibility for providing feedback on service delivery and receipt.

Current CQI strategies

CTDCF intends to build upon the internal and external CQI strategies and frameworks as a starting place for its Family First CQI structure. Below are ongoing strategies Connecticut currently employs to ensure performance and outcome monitoring:

- Service Development Plan and Corrective Action Plan: CTDCF utilizes a standardized performance management process that relies on collaborative implementation of a Service Development Plan (SDP) when deficiencies in a program are identified. If the SDP fails to

correct the deficiency, a formal Corrective Action Plan is implemented along with the CTDCF Contract Division.

- Contracted Services: All contracted services in Connecticut have performance expectations and specific outcomes. The performance and outcome data collected are utilized to assess progress towards intended outcomes for Connecticut's families, and to assess whether services are achieving intended benefits. CTDCF Program Leads meet with provider agencies regularly to review data based on the specific outcome and model fidelity measures that are outlined in contracts. If deficits are identified in the performance expectations and outcomes, the Program Leads along with the model developers meet with agencies to collaboratively identify strategies to improve outcome measures. If continued challenges exist, programs could be placed on a Corrective Action Plan, up to and including termination if the deficiencies fail to be corrected.

- Training and TA: CTDCF has a longstanding practice of contracting with model developers for training and technical assistance to ensure model fidelity. CTDCF currently has contracts with all model developers for EBPs currently in place.

- Data collection: All EBP models and CTDCF require data systems that collect information on clients served. In addition, the EBP models require information on staff training and progress toward certification in the model. These data include staff participation in initial and booster training sessions, any necessary technical assistance, documentation of sessions (submission of recorded sessions); and track the content, frequency and duration of sessions. For each EBP fidelity reviews are conducted that analyze all the data collected. These reviews typically include CTDCF Program Leads, the EBP model developer, and providers. CTDCF conducts two levels of reviews: system reviews and individual provider reviews. System fidelity reviews look at these
data in aggregate, while the fidelity review of the individual program looks at provider specific data. CTDCF, in partnership with the EBP model developer, will combine these data into dashboard reports and share with providers to inform discussion during fidelity review meetings that occur quarterly.

Data sources:

Data reporting is an essential function of the CTDCF Bureau for Strategic Planning and includes provision of data from Connecticut's LINK, Results-Oriented Management (ROM) Reports, Provider Information Exchange (PIE), and CT-KIND systems.

1. CT-LINK: LINK is CTDCF's statewide automated child welfare information system (SACWIS), which is being updated to the current federal requirements for child welfare information systems (CCWIS) and will become CT-KIND. LINK is CTDCF's system of record utilized by staff to document and record case related activity as well as to reflect and record engagement activities and other data.

2. ROM: The Results-Oriented Management (ROM) Reports system was built and maintained by the University of Kansas (KU) School of Social Welfare, in conjunction with CTDCF Strategic Planning and Information Systems staff. The system is available to CTDCF staff and contains a collection of automated reports concerning the safety, permanency and well-being of the children that we serve. The system allows staff to view pending work as well as trends in performance over time, and comparisons of unit performance

3. PIE: The PIE system is utilized by CTDCF and providers as the data and reporting solution for community-based programs across CTDCF mandate areas, including the EBPs identified in this plan that currently exist (additional EBPs identified in this plan that are not currently in existence will also be added to the PIE system). PIE provides key outcome data regarding our families and service provision and allows staff to assess utilization of services, assess and monitor service quality and manage programs and contracts with data. PIE includes data for behavioral health programs, child placement programs, and child welfare programs as well as data regarding non-CTDCF clients for some programs as well. The PIE system can produce quantitative data, and qualitative data can be obtained from the PDOCs, Systems Program Directors, CTDCF staff, and the providers as well.

Data reporting is further informed by CTDCF's Statistician who can provide complex analysis of agency data. Qualitative data can be obtained from LINK records in combination with record review and interviews and/or focus groups.

CTDCF and the EBP model developers use web-based HIPAA and HITECH compliant databases to record client specific information, to aggregate this information across the network, and to develop reports that document system functioning, as well as individual services and outcomes to monitor program fidelity.

In addition, EBP model developers have their own web-based systems where they collect from providers information related to the type of services clients receive, frequency, content and duration of sessions; EBP skills utilized in sessions; and outcomes data. Connecticut will modify contracts as needed to ensure all necessary quality improvement data is being collected from each provider, including the data reported to model developers. Connecticut intends to utilize these data systems and others to inform its CQI efforts.

B. Request for Wavier of well designed, rigorous evaluation of services and programs for a well-supported practice.

Connecticut is seeking a federal evaluation waiver for each of the seven "well-supported" programs included in this Prevention Plan (i.e., FFT, MST, BSFT, PCIT, NFP, PAT, & HFA). Each of these programs already have a body of evidence demonstrating effectiveness. In the future, Connecticut intends to pursue an evaluation for the three "promising" and "supported" EBPs - MDFT, TF-CBT, and Triple P, to continue to review additional services added to the Clearinghouse, and to consider whether any existing services in Connecticut have the evidentiary support to be considered for an Independent Systematic Review. Connecticut also intends to continue its partnership with Chapin Hall at the University of Chicago to ensure continuous quality improvement efforts are identified and implemented for each EBP selected in this Prevention Plan. Chapin Hall has extensive experience supporting jurisdictions' implementation of Family First evidence-based programs with fidelity.

Connecticut is requesting an evaluation waiver for all EBPs selected in this Prevention Plan. The Family First Prevention Services Act suggests that an evaluation waiver is allowed for EBPs rated "well-supported" on the Clearinghouse as long as jurisdictions are able to meet the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II), as these programs already have a body of evidence demonstrating effectiveness. Connecticut is seeking evaluation waivers for Functional Family Therapy (FFT), Multisystemic Therapy (MST), Brief Strategic Family Therapy (BSFT), Parent Child Interaction Therapy (PCIT), Nurse Family Partnership (NFP), and Parents as Teachers (PAT), and Healthy Families America (HFA) as identified below.

Functional Family Therapy (FFT)
FFT is a clinical, home-based treatment offered to families with an adolescent between the ages of 11-18 years experiencing psychiatric, emotional, or behavioral difficulties including substance misuse. FFT is a strength-based model that looks to build upon protective factors and reduce risk factors that impact adolescent behavior and well-being. The FFT model aims at helping families to identify patterns that lead to adverse symptoms and behaviors and seeks to support the family in developing more successful interactions and stability.

In Connecticut, FFT is currently provided to children and youth who have returned or are returning home from out-of-home care or psychiatric hospitalization and require intensive community-based services or are at imminent risk of placement due to mental health issues, emotional disturbance, or substance abuse. Connecticut has four providers offering five FFT teams located in four regions throughout the state.

Connecticut selected FFT to be part of its Family First service continuum because it has a strong infrastructure in the state and matches the needs of many of Connecticut's candidacy populations including those where services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Furthermore, there is interest in growing current capacity by the Court Support Services Division (CSSD) of the State of Connecticut Judicial Branch and there are opportunities to expand current provider caseloads and teams throughout the state. FFT data in Connecticut demonstrates strong outcomes indicating youth receiving FFT are more likely to remain in their homes, remain in school, and avoid arrest.

Connecticut selected FFT with the goals of improving outcomes for youth and families and reducing the use of out-of-home placements. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving FFT:

- ☐ Child Well-Being:
  - Improved behavioral and emotional functioning
  - Reduced delinquent behavior
  - Reduced substance-use
- ☐ Adult Well-Being:
  - Improved family functioning

Multisystemic Therapy (MST)
MST is an intensive, in-home, community-based treatment for families of adolescents, 12-17 years of age, at risk of out-of-home placement because of delinquent or antisocial behaviors including substance abuse. MST engages the entire family and builds the capacity for caregivers to address current and future problems. MST therapists assess the youth's behavior in the context of the youth's full ecology including their family, peers, school, neighborhood, etc.

In Connecticut, MST is funded jointly by the Court Support Services Division (CSSD) and the Department of Children and Families (CTDCF) and is available statewide. Advanced Behavioral Health, Inc. (ABH) provides all training and consultation services for the 18 standard MST teams in Connecticut as a Network Partner of MST Services, and serves as the liaison between state contractors, providers, and key community stakeholders. ABH monitors data for quality assurance purposes and analyzes the data to be used for system

improvements at the larger system level as well as at the agency and team levels. Connecticut has been implementing MST for more than 20 years.

Connecticut selected MST to be part of its Family First service continuum because, like FFT, it has a strong infrastructure in the state and matches the needs of many of Connecticut's candidacy populations including those where services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Connecticut MST data demonstrates strong outcomes indicating youth receiving MST are more likely to remain in their homes, remain in school, and avoid arrest.

Connecticut selected MST with the goals of improving outcomes for youth and families and serving youth in their homes, thereby reducing out-of-home placements. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving MST:

Child Well-Being:

- Reduced out-of-home placement
- Improved behavioral and emotional functioning
- Reduced delinquent behavior
- Reduced substance use

☐ Adult Well-Being:

- Improved positive parenting practices
- Improved parent/caregiver mental or emotional health
- Improved family functioning

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) is an intervention offered to families with children between the ages of 6-17 years that are at risk for or are displaying problem behaviors including substance use disorder conduct problems and delinquency. BSFT uses a family systems approach in order to transform family interactions that perpetuate problems into more effective and adaptive interactions.

BSFT does not currently exist in Connecticut, however CSSD previously funded BSFT as part of its programming for moderate risk youth involved with the juvenile court system (from 2005 to 2013), with four providers and 14 teams across the state at its broadest dissemination level. CTDCF intends to learn from those past efforts. As available funding allows, CTDCF will begin to support the infrastructure and implementation of services models in our plan that would be new additions to the CTDCF service array, including BSFT.

Connecticut selected BSFT to be part of its Family First continuum because of its alignment with candidacy populations in which services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Connecticut saw BSFT as an important addition to its continuum because of its broad target population age range, which would expand services to the often-excluded latency age population. Furthermore, due to the fact that BSFT was developed to respond to the cultural/contextual factors that influence youth behavior problems and its promising outcomes with communities of color and Spanish-speaking communities, Connecticut saw the addition of BSFT as an opportunity to provide more equitable, racially just, inclusive, and culturally responsive services.

Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services

Clearinghouse for families receiving BSFT:

- ☐ Child Well-Being:
  - Reduced delinquent behavior
- ☐ Adult Well-Being:
  - Improved family functioning

Parent Child Interaction Therapy (PCIT)

PCIT is a treatment for children ages 2-7 years with emotional or behavioral issues and their parents and caregivers. It utilizes dyadic therapy that is conducted through "coaching" sessions where a therapist monitors parent and child interactions through a two-way mirror and communicates with the parent via a wireless communication device to build caregiver skills to manage the child's behavior. While PCIT is not currently funded by CTDCF or any other Connecticut state agency, it has been installed by a number of therapists and a few community providers. As available funding allows, CTDCF will begin to support the infrastructure development and implementation of services models in our plan that would be new additions to the Connecticut CTDCF service array, including PCIT.

Connecticut selected PCIT to be part of its Family First service continuum because it matches the needs of Connecticut's candidacy populations whose services would be initiated based on the behavior and needs of younger children (VCM, siblings of youth in foster care, chronically absent youth, children with behavioral health disorders, etc.). PCIT is also culturally responsive and can be provided in multiple languages. It has demonstrated similar outcomes with parents who are impacted by intellectual and/or developmental disabilities.

Connecticut selected PCIT with the goals of improving outcomes for youth and families and preventing out-of-home placement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving PCIT:

- ☐ Child Well-Being:
  - Improved behavioral and emotional functioning
- ☐ Adult Well-Being:
  - Improved positive parenting practices
  - Improved parent/caregiver mental or emotional health

Connecticut's Office of Early Childhood (OEC) offers home visiting programs to improve the health of young children by providing supports and services to children and their families. OEC currently offers six different types of home visiting programs that are evidence-based, including Parents as Teachers (PAT) and Nurse Family Partnership (NFP), and released a request for proposals (RFP) in 2021 to expand these home visiting programs and to add Healthy Families America (HFA) and other like services. Prior to the release of the 2021 RFP, Connecticut OEC supported 2,000 home visiting slots statewide. These home visiting services are supported by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, an initiative funded by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF).

Nurse Family Partnership (NFP)

NFP is a home visiting program in which nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the needs/requests of the parent. It targets young, first-time, low-income mothers from early pregnancy through the child’s first two years.

In Connecticut, NFP is funded by OEC with support from the MIECHV program. OEC contracts with two NFP providers who support families across two Connecticut regions. Since 2012, the Visiting Nurse Association of Southeastern Connecticut has been providing

NFP to families in New London and Middlesex counties, and in 2020 the New Milford Visiting Nurse Association expanded NFP to serve families in the western part of the state. Again, there is expected expansion of NFP in Connecticut via the recently released OEC RFP. Furthermore, in 2020 NFP merged with Child First - an evidence-based program for vulnerable young children and their families that is implemented across Connecticut. CTDCF expects that this partnership may support implementation and expansion of NFP in CT.

Connecticut selected NFP to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include first time mothers (pregnant and parenting youth in foster care, children with mental health or developmental disabilities, substance-exposed infants). NFP's existing infrastructure, combined with the expected expansion through OEC, exemplifies the strong NFP network in Connecticut.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving NFP:

- ☐ Child Well-Being:
  - Improved cognitive functions and abilities
  - Improved physical development and health
- ☐ Adult Well-Being:
  - Increased economic and housing stability

Parents as Teachers (PAT)

Parents as Teachers is a home visiting parent education model that supports new and expectant parents/caregivers to develop positive parenting skills. It aims to increase parent knowledge of early childhood development and prevents child maltreatment by improving parenting practices. In Connecticut, PAT is funded by the Office of Early Childhood with support from the MIECHV program. OEC contracts with 20 PAT providers who support families statewide. Again, there is potential expansion of PAT in Connecticut via the recently released OEC RFP. Connecticut selected PAT to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include parents with children under 5 years of age (pregnant and parenting youth in foster care, chronically absent children (the Connecticut State Department of Education indicated there were 5,301 kindergarten students who were chronically absent in 2019), children with behavioral health or developmental disabilities, substance exposed infants, etc.). PAT's existing statewide infrastructure combined with the potential expansion through OEC, exemplifies the established PAT network in Connecticut.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. The PAT curriculum has a demonstrated impact on improving outcomes for families at risk of child welfare involvement. Additionally, the program is culturally responsive and has shown effectiveness with non-white populations. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families
receiving PAT:

- ☐ Child Well-Being:

- Improved social functioning
- Improved cognitive functions and abilities

Healthy Families America (HFA)
HFA is a home visiting program for new and expectant parents/caregivers with children at a high risk of abuse or neglect or other adverse childhood experiences. When referred from the child welfare system, families may be enrolled if they are caring for a child up to 24 months of age. Most families are offered services for at least three years. HFA seeks to prevent child abuse or neglect by strengthening positive caregiver-child relationships, promoting healthy childhood growth and development, and enhancing family functioning by building protective factors and addressing risks.

HFA is currently implemented in one region in Connecticut; however, the Office of Early Childhood has identified HFA as a promising intervention to expand in the state and will likely begin funding new HFA sites in 2021. New HFA sites supported by OEC will be funded with support from the MIECHV program.

Connecticut selected HFA to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include parents with children under 2 years of age (pregnant and parenting youth in foster care, children with behavioral health or developmental disabilities, substance-exposed infants, etc.). CTDCF seeks to leverage OEC's investment in HFA to build programmatic infrastructure in the state.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding. Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving HFA:

- Child Safety:
  - Reduced self-report of maltreatment
- Child Well-Being:
  - Improved educational achievement
- Adult Well-Being:
  - Improved parent/caregiver mental health
  - Improved parenting practices
  - Reduced substance abuse

MST, FFT, NFP, and PAT are well established in Connecticut's service continuum and have existing provider networks that range from serving three regions of the state to a nearly statewide presence.

Three additional evidence-based practices with demonstrated favorable outcomes with CTDCF are under consideration for implementation:

Multidimensional Family therapy (MDFT): an integrated, comprehensive, family-centered treatment to address youth problems and disorders and to prevent out-of-home placements. The target population will be adolescents and young adults 9 - 26 years old with substance use, delinquency, mental health, academic/vocational, and emotional problems.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): a clinical model for children and adolescents exhibiting associated with trauma exposure. The target population: Children and adolescents who have experienced trauma.

Triple P- Positive Parenting Program - Standard (Level 4): a parenting intervention for families with concerns about their child's moderate to severe behavioral problems. The target population: Families with children up to age 12 who exhibit behavior problems or emotional difficulties.

Connecticut currently partners with the Child Health and Development Institute (CHDI) of Connecticut for implementation and evaluation support for TF-CBT and seeks to leverage this partnership as it considers future evaluation opportunities. Additionally, Connecticut plans to continue to engage the Programs and Services Workgroup as well as the Fiscal and Revenue Enhancement Workgroup in order to evaluate additional EBPs to meet gaps in addressing candidacy population needs.

While there is existing language around delivering trauma-informed care in provider contracts, CTDCF intends to integrate the core tenets developed out of the CONCEPT* framework into all Family First contracts including language about trauma training, trauma-informed policy alignment, and trauma screening. CTDCF will co-create with providers, standard reporting methods and metrics to ensure services are being delivered in a trauma-informed manner. CTDCF anticipates annual monitoring of this trauma-informed framework in alignment with the existing contract review and continuous quality improvement strategies. This includes asking contracted providers a set of questions to ensure programming includes key trauma-informed activities including:

- Trauma-informed written policies
- Training for staff and families regarding trauma and its impact on youth, families, and communities
- Supervisors equipped to guide case managers on trauma-informed care
- Trauma screening

* Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) a trauma-informed system of care to enhance CTDCF's capacity to identify and respond to children who have experienced trauma and to enhance access to evidence-based and best practice interventions in the community.

Section 3. Monitoring child safety

Connecticut sees monitoring child safety as directly tied to effectively assessing family needs and seeks to leverage Family First to prevent safety threats by addressing needs early. Furthermore, Connecticut intends to engage families and their natural supports as essential partners in monitoring, preventing, and addressing family safety concerns.

All of the "known-to-CTDCF" candidates undergo the SDM CT Family Safety and Risk Assessment as part of the intake process. Case planning is done collaboratively and in close partnership with children and their families, which typically provides a more comprehensive understanding of the family's circumstances and needs. Case workers will regularly connect with professional partners such as educators, medical providers, and clinicians who are monitoring family safety as well. Finally, child and family team meetings are used as a forum for the full child and family team to identify strengths, needs, risk, and/or safety concerns and to collaboratively develop a plan to address risks or concerns as they arise. CTDCF will use these existing practices to ensure child safety for the "known-to-CTDCF" candidates receiving in-home services, including:

1) families with accepted Careline calls,
2) siblings of youth in foster care, or
3) pregnant and parenting youth in foster care.

All pregnant and parenting youth in foster care, workers will ensure weekly visits for the first 30 days of foster care, and then move to monthly visits.

The Voluntary Care Management (VCM) program works with families to help connect youth to high needs behavioral health services and support. The engagement process includes an explanation of the program, a review of behavioral health needs, and creating a crisis plan with the family. Crisis plans are developed to ensure that families have identified supports and contacts to connect with should a behavioral health incident occur. This crisis plan becomes part of the families' care plan and is revisited on a monthly basis with the families, even after clinical services have begun. The VCM program provides authorization for clinical services and meets with providers and families on a regular basis to ensure the appropriate services are in place and that the youth's behavioral health needs are being met. Once a youth begins receiving services, VCM staff meet with families at least monthly, and with service providers at least every two months, to ensure progress towards treatment goals and authorize ongoing services, if needed. When youth need to receive out-of-home treatment, the VCM team will include a safe return to the home with supportive community-based services in place as part of the treatment goals.

For the community pathways candidacy population6, it is anticipated that the CME will utilize a safety assessment tool at intake to identify safety risks and build a safety plan. This safety assessment information will be documented in the community portal and shared with CTDCF quarterly in aggregate in order to ensure CTDCF continues to refine the resources and services needed to address the needs, safety issues, and risks that emerge. Results from the safety assessment tool will contribute to determining which services the family is referred to and will be integrated into the ongoing case plan and goals. Caregivers in Connecticut articulated the need for objectivity and standardization in terms of monitoring safety and a willingness on CTDCF's part to offer ongoing assessment and monitoring in locations where families feel most comfortable. To that end, CTDCF anticipates that after the CME refers families to services, they will monitor case progress as well as progress on safety plans in partnership with the family and the service provider. In the event that families are not making progress on their identified risk or safety areas, the CME will reevaluate the appropriateness of services and consider new referrals. What will assist in the overall assessment of safety is Connecticut's ABCD Child Safety Practice model referenced earlier in this document. The purpose is to align a common understanding of language and assessment of child safety across stakeholder groups.

Section 4. Consultation and Coordination

The State of Connecticut Department of Children and Families (CTDCF) led a structured and collaborative process to develop a plan that advances a prevention-oriented system. The workgroup engaged with parents, youth, legislative officials, community providers, and other state agencies in the planning, development, and communication of Connecticut's planning process. This engagement included consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community based

organizations, in order to foster a continuum of care for children who are at risk of foster care entry and their parents or kin caregivers and pregnant or parenting foster youth.

Over 400 community partners were involved, including parents and youth with lived experience, decision makers throughout state government, community organizations, advocates, and contracted providers. The priority was to ensure that children and families were truly at the center of the work. Equally important to the inclusion of multiple partners was complete transparency of the process. To that end, a CT Family First website was established: https://portal.ct.gov/DCF/CTFamilyFirst/Home . All workgroup charters, meeting schedules, meeting minutes and documents used throughout the process have been posted and maintained within the website. A mailbox, DCF.CT.Family.First@ct.gov was established for community partners to ask questions and receive information about our planning.

To ensure cross-system collaboration and decision-making, Connecticut convened a Governance Committee and seven workgroups. The Governance Committee, comprised of CTDCF leadership and state and community partners, served to review evidence and community informed recommendations from each of the workgroups. After engaging in dialogue and receiving feedback to inform decision-making and ensure a connection between the prevention plan and other strategies designed to support children, youth and families, recommendations were provided to the CTDCF Commissioner. The seven workgroups were co-led by an internal CTDCF staff member and an external community partner; the group participants were comprised of internal CTDCF staff and community partners. An overview and description of each workgroup is as follows:

Candidacy - The workgroup strategized which populations of Connecticut children and their families were best positioned to benefit from Family First prevention services to address risk factors for maltreatment and prevent entry into foster care.

Community Partnerships and Youth and Family Engagement – The workgroup engaged with parents, youth, legislative officials, community providers, and other state agencies in the planning, development, and communication of Connecticut's planning process. This engagement included consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community based organizations, in order to foster a continuum of care for children who are at risk of foster care entry and their parents or kin caregivers and pregnant or parenting foster youth.

Fiscal and Revenue Enhancement – The workgroup completed fiscal modeling and provided recommendations regarding the fiscal and revenue impact of identified options.

Infrastructure Policy and Practice – The workgroup recommended modifications or additions to current policy, practice, and internal infrastructure to align with the revised model of care under Family First.

Kinship and Foster Care – The workgroup developed core recommendations to increase Connecticut's ability to support children's safe, supportive, and nurturing care in the most family-like caregiving setting possible when children cannot be with their parents.

Programs and Service Array – The workgroup aligned Connecticut's vast array of services and programs to the identified needs of the children and families served in candidacy groups, while ensuring a focus on quality services and interventions.

24/7 Intensive Treatment QRTP (Qualified Residential Treatment Program) – The workgroup established expectations to achieve QRTP standards of care and supported providers throughout the planning process leading up to QRTP certification.

In addition to the aforementioned workgroups, the Department was intentional about capturing the
parent voice as evidenced by three focus groups in which the emphasis was the caregivers' lived
expertise. "Parents as Experts" conversations were designed to actively seek input from families on their perspectives about how services can best be delivered to prevent maltreatment and promote family
well-being. The discussions allowed for knowledge to be gathered about:

- ☐ What constitutes a good referral and service experience for a family
- ☐ How parents wish to be treated when considering and seeking support/when being supported in caring for their children
- ☐ What resources and methods engage children and families most effectively?

The response to invitations to participate in these sessions was extraordinary. More than 100 families responded, with a total of 44 families being actively involved across all three sessions. Their feedback was thoroughly documented and shared with the Governance Committee. Caregivers appreciated the opportunity to share and express perspectives that were unique to their experiences. Overall themes included

Section 5. Child welfare workforce support

Connecticut is well poised and committed to ensuring that quality, effective, and efficient services are
provided to children and families throughout the state. To demonstrate this commitment, Connecticut places an emphasis on training support for the CTDCF child welfare and provider workforce so that they are expertly trained on a competency-based, trauma informed curriculum that encompasses best practice through an intentional racial justice lens.

Ensuring that the workforce has a comprehensive understanding of being trauma informed not only supports a well-developed workplace but also reinforces the important professional development perspectives of caregivers with lived experience. As discussed earlier in this plan, community conversations were held with caregivers throughout the state. Among the many identified cross-cutting themes was the need for the workforce to demonstrate a deeper understanding of trauma and the impact it has on children and families.

Caregivers also expressed that in addition to a strong trauma-informed knowledge base, ensuring that the workforce understands the importance of being genuine, flexible, and understanding is key to positive relationship building which leads to positive outcomes for children, youth, families and communities.

Commitment to the caregiver voice and the comprehensive development of the workforce further illustrates Connecticut’s prime positioning to leverage Family First. CTDCF provides training through the Academy for Workforce Development, which prepares caseworkers to understand the specific details of Family First and available EBPs. This training is vital as caseworkers are invaluable in the process of identifying, referring, and supporting services available to Connecticut’s children and families.

Connecticut plans to build workforce capacity to use assessments as a tool for enhanced family engagement, in order to authentically partner with families to identify needs and capitalize on family expertise. Connecticut believes that stronger engagement practices will ultimately lead to improved assessment and identification of family needs.

Section 6. Child welfare workforce training

Connecticut is well poised and committed to ensuring that quality, effective, and efficient services are provided to children and families throughout the state. To demonstrate this commitment, Connecticut places an emphasis on training support for the CTDCF child welfare and provider workforce so that they are expertly trained on a competency-based, trauma informed curriculum that encompasses best practice through an intentional racial justice lens.

Ensuring that the workforce has a comprehensive understanding of being trauma informed not only supports a well-developed workplace but also reinforces the important professional development perspectives of caregivers with lived experience. Among the many identified cross-cutting themes was the need for the workforce to demonstrate a deeper understanding of trauma and the impact it has on children and families. In addition to a strong trauma-informed knowledge base, Ct's caregivers expressed the importance that the workforce understands the importance of being genuine, flexible, and understanding is key to positive relationship building which leads to positive outcomes for children, youth, families and communities.

Commitment to the caregiver voice and the comprehensive development of the workforce further illustrates Connecticut's prime positioning to leverage Family First. CTDCF provides training through the Academy for Workforce Development, which prepares caseworkers to understand the specific details of Family First and available EBPs. This training is vital as caseworkers are invaluable in the process of identifying, referring, and supporting services available to Connecticut's children and families.

The Department of Children and Families' Academy for Workforce Development ("The Academy") shall provide competency-based, culturally-responsive learning opportunities in accordance with national standards for public child welfare practice and in compliance with state law.

Through the Academy for Workforce Development, the Department currently offers a robust training curriculum of pre-service training, in-service training, mandatory trainings, simulation training and leadership development training for its child welfare workforce. These trainings are designed to ensure that the workforce is equipped with the requisite skills and knowledge needed to support a prevention-oriented system. Each training category offers a cadre of courses that are trauma informed, competency-based and reflective of the Department's commitment to racial justice. Courses are also intentionally aligned with skill building opportunities to demonstrate on the job learning through practical applications.

CTDCF Academy classes shall be made available across CTDCF regions and divisions to ensure greater uniformity among those who work with the Family First candidacy populations. An array of professional development training programs shall be offered annually.

Evidence-based provider workforce

To support implementation of Family First, the EBP provider workforce will be trained on the unique EBP model requirements, to ensure fidelity and long-term sustainability. To that end, the Department recognizes that having a lead entity for EBP workforce training is critical particularly for the ongoing support and coaching that is needed for fidelity. The Department plans to contract with an outside entity to partner in this task, as available funding allows.

Child welfare agency workforce

To ensure workforce readiness for Family First, the Department plans to develop and launch a Family First Overview training that introduces both new hires in pre-service training and ongoing caseworkers in in-service training to the Family First legislation as well as practice and outcome implications. More specifically, the overview training will introduce a clear process for understanding service eligibility for known-to-CTDCF Family First candidates; and address the newly developed Child Safety Practice Model, the development of child specific prevention plans, the program and service array, and using risk and safety assessments (the SDM tool). The overview training will also further contextualize family engagement in the assessment process, and will be augmented through periodic CTDCF communication strategies, self-guided training opportunities, infographics, micro-learning collaboratives with a coaching component and reinforcement in other Department wide mandatory training opportunities.

The Academy will ensure that the overview training is reinforced through a series of periodic supplemental trainings. To ensure that a prevention lens is embedded in practice, supplemental trainings will be designed to reinforce skill development in translating the need for services or supports, especially needs to prevent safety issues. The supplemental trainings will also serve to reiterate clear and uniform practices around consistent and clear documentation.

These competency-based trainings will be assessed continually by the Academy in partnership with CTDCF area office leadership. The Academy will take the lead in augmenting the training content to better increase the competency level of staff to ensure increased familiarity with the requirements of Family First. As additional training is needed, supervisors will engage coaching tools and techniques to strengthen practice proficiency in their staff. Adjustments to trainings will be addressed to support the needs of the workforce. Skill building related to racial justice outcomes and work with specialized populations, including those with intellectual developmental disabilities or with autism spectrum disorder will be enhanced by employing quality improvement strategies, such as case reviews. Adjustments will be made when needed to promote quality casework and increased caseworker time dedicated to achieving positive outcomes for children, youth, and families.

These trainings will ensure that the Family First workforce

- has a comprehensive understanding of being trauma informed not only supports a well-developed workplace but also reinforces the important professional development perspectives of caregivers with lived experienced.
- understands the importance of being genuine, flexible, and understanding is key to positive relationship building which leads to positive outcomes for children, youth, families, and communities.
- trained on the unique evidence-based practice models to ensure fidelity and long-term stability.
- Skilled in conducting risk assessments and the development of appropriate prevention plans.

Section 7. Prevention Caseloads

Prevention Caseloads

Identifying an appropriate caseload size is one important aspect of equipping CTDCF staff to support families in achieving positive outcomes. As Connecticut transforms into a system of well-being, family engagement and effective case management become even more paramount to successful prevention or intervention services.

For Connecticut's "known-to-CTDCF" population, the caseload standard for social workers with Family First prevention cases will align with the weighted caseload standards determined by the particular circumstances of each candidacy population (e.g., pregnant and parenting youth in foster care likely would be assigned to Adolescent Specialty Workers who have a targeted caseload of 15:1).

For CT's community pathway population, CT will work with the CME to determine appropriate caseload sizes based on the experience levels and expected activities of the staff working with families receiving Family First prevention services.

CTDCF anticipates annual monitoring of this trauma-informed framework in alignment with the existing contract review and continuous quality improvement strategies. This includes asking contracted providers a set of questions to ensure programming includes key trauma-informed activities including:
State of Connecticut Family First Prevention Plan

- Trauma-informed written policies
- Training for staff and families regarding trauma and its impact on youth, families, and communities
- Supervisors equipped to guide case managers on trauma-informed care
- Trauma screening

Staff Supervision

The Department of Children and Families (CTDCF) is committed to the provision of effective supervision of its employees. Supervision at all levels of the of Family First Prevention Services is critical to ensuring and continually improving the quality of services delivered by CTDCF.

To promote effective supervision and build strong supervisory relationships, supervisors and supervisees shall review The Family First Policy and the related Human Resource Policy on Supervision with each of their supervisees at the beginning of the supervisory relationship.

Definitions

Supervision is a formal, professional relationship in which the supervisor has authority and oversight responsibility for the work and work life of the supervisee. Although supervisors are held accountable for services delivered by their supervisees, supervision is a collaborative relationship in which supervisee hold responsibility, as well, for effectively fulfilling their job duties.

Supervisor refers generically to all individuals who supervise other employees in the organization.

Functions of Supervision
There are four functions of supervision. These are:

- Ensuring the quality of service provided.
- Ensuring that administrative tasks are completed accurately and in a timely way.
- Providing support to employees in their jobs as they face work-related challenges.
- Helping employees to grow and develop their skills.

Documentation of Supervision Session

Family First staff in supervisory positions will use a written structured agenda template to help organize the supervision sessions they provide. This agenda can be tailored in format to meet the needs of Family First in which the supervision is occurring. The form will simultaneously be used to document the supervision provided. A form for each supervision session conducted will be maintained by the supervisor in the supervision file for that supervisee. It must contain the date, duration and format of supervision (individual or group) and a general notation of the content of the sessions.

Managers will regularly review the Session Agenda for their supervisees to provide ongoing feedback and support regarding supervisory duties.

Maintenance In addition to housing completed supervision agendas, the supervision file will contain of Supervision performance-related information. The supervision files are not intended for storage of Files detailed and confidential case-related information about children and families.

Amount and Type of Supervision Frequency

The intention is for supervision sessions to be scheduled, face-to-face, and one hour in length (not a cumulative total of brief or unscheduled discussions). Supervisory sessions canceled by the supervisor or supervisee are to be rescheduled in order to meet the expectations for amount of supervision as outlined above. Specific case consultations for ongoing cases will be documented in the case information system will occur as frequently as is necessary.

Section 8. Assurance on prevention program reporting

CTDCF will report to the Secretary the required information and data regarding the provision of services and programs included in Connecticut's Title IVE Prevention Plan.

CTDCF intends to build upon the internal and external CQI strategies and frameworks as a starting place
for its Family First CQI structure. Below are ongoing strategies Connecticut currently employs to ensure
performance and outcome monitoring:

- Service Development Plan and Corrective Action Plan: CTDCF utilizes a standardized performance management process that relies on collaborative implementation of a Service Development Plan (SDP) when deficiencies in a program are identified. If the SDP fails to correct the deficiency, a formal Corrective Action Plan is implemented along with the CTDCF Contract Division.

- Contracted Services: All contracted services in Connecticut have performance expectations and specific outcomes. The performance and outcome data collected

are utilized to assess progress towards intended outcomes for Connecticut's families, and to assess whether services are achieving intended benefits. CTDCF Program Leads meet with provider agencies regularly to review data based on the specific outcome and model fidelity measures that are outlined in contracts. If deficits are identified in the performance expectations and outcomes, the Program Leads along with the model developers meet with agencies to collaboratively identify strategies to improve outcome measures. If continued challenges exist, programs could be placed on a Corrective Action Plan, up to and including termination if the deficiencies fail to be corrected.

- Training and TA: CTDCF has a longstanding practice of contracting with model developers for training and technical assistance to ensure model fidelity. CTDCF currently has contracts with all model developers for EBPs currently in place.

- Data collection: All EBP models and CTDCF require data systems that collect information on clients served. In addition, the EBP models require information on staff training and progress toward certification in the model. These data include staff participation in initial and booster training sessions, any necessary technical assistance, documentation of sessions (submission of recorded sessions); and track the content, frequency and duration of sessions. For each EBP fidelity reviews are conducted that analyze all the data collected. These reviews typically include CTDCF Program Leads, the EBP model developer, and providers. CTDCF conducts two levels of reviews: system reviews and individual provider reviews. System fidelity reviews look at these data in aggregate, while the fidelity review of the individual program looks at provider specific data. CTDCF, in partnership with the EBP model developer, will combine these data into dashboard reports and share with providers to inform discussion during fidelity review meetings that occur quarterly.

Data sources:

Data reporting is an essential function of the CTDCF Bureau for Strategic Planning and includes provision of data from Connecticut's LINK, Results-Oriented Management (ROM) Reports, Provider Information Exchange (PIE), and CT-KIND systems.

CT-LINK: LINK is CTDCF's statewide automated child welfare information system (SACWIS), which is being updated to the current federal requirements for child welfare information systems (CCWIS) and will become CT-KIND. LINK is CTDCF's system of record utilized by staff to document and record case related activity as well as to reflect and record engagement activities and other data.

ROM: The Results-Oriented Management (ROM) Reports system was built and maintained by the University of Kansas (KU) School of Social Welfare, in conjunction with CTDCF Strategic Planning and Information Systems staff. The system is available to CTDCF staff and contains a collection of automated reports concerning the safety, permanency and well-being of the children that we serve. The system allows staff to view pending work as well as trends in performance over time, and comparisons of unit performance.

PIE: The PIE system is utilized by CTDCF and providers as the data and reporting solution for community-based programs across CTDCF mandate areas, including the EBPs identified in this plan that currently exist (additional EBPs identified in this plan that are not currently in existence will also be added to the PIE system). PIE provides key outcome data regarding our families and service provision and allows

staff to assess utilization of services, assess and monitor service quality, and manage programs and contracts with data. PIE includes data for behavioral health programs, child placement programs, and child welfare programs as well as data regarding non-CTDCF clients for some programs as well. The PIE system can produce quantitative data, and qualitative data can be obtained from the PDOCs, Systems Program Directors, CTDCF staff, and the providers as well.

Data reporting is further informed by CTDCF's Statistician who can provide complex analysis of agency data. Qualitative data can be obtained from LINK records in combination with record review and interviews and/or focus groups.

CTDCF and the EBP model developers use web-based HIPAA and HITECH compliant databases to record client specific information, to aggregate this information across the network, and to develop reports that document system functioning, as well as individual services and outcomes to monitor program fidelity. CTDCF plans to develop a community portal for the CME to track all relevant Family First data elements, which will be shared with the Department. The VCM Program is a contracted service, and a separate data system is managed by the contracted partner with relevant data reported to the Department. CTDCF anticipates refining this contract to ensure relevant child-specific data is collected and shared.

In addition, EBP model developers have their own web-based systems where they collect from provider information related to the type of services clients receive, frequency, content and duration of sessions; EBP skills utilized in sessions; and outcomes data. Connecticut will modify contracts as needed to ensure all necessary quality improvement data is being collected from each provider, including the data reported to model developers. Connecticut intends to utilize these data systems and others to inform its CQI efforts

Section 9. Child and family eligibility for the title IV-E prevention program

Policy
The Department of Children and Families (CTDCF) shall provide title IV-E prevention services to a child who is a candidate and the parents, for foster care but can remain safely at home or in a kinship placement with receipt of services or programs.

ELIGIBILITY

Connecticut intends to leverage Family First is as a tool to rethink which families are eligible for preventive services and the manner in which CTDCF plans to manage their cases. Connecticut developed a broad target population (families eligible for Family First services) definition that includes two population groups:

1) Those that are already "known-to-CTDCF" either through a call to the Careline, prior involvement in the system, or current involvement (pregnant and parenting youth in foster care). This group of families will constitute Connecticut’s initial candidacy population for Family First prevention services.
2) Families that will be referred through a "community pathway.” This group of families will be served during the second phase of Family First implementation when the appropriate partnerships, infrastructure, and fiscal support are sufficiently established. The community pathways population includes “upstream” families experiencing specific behavior, conditions, or circumstances that are likely to have an adverse impact on a child's development or functioning and for whom

research establishes that such characteristics or conditions place them at increased risk for maltreatment, involvement with the child welfare system, or out-of-home placement.

Families with certain characteristics that will be identified through a community or neighborhood pathway and eligible for services are:

- ☐ Families accepted for Voluntary Services (Voluntary Care Management as of May 1, 2020)
- ☐ Children who are chronically absent from preschool/school or are truant from school
- ☐ Children of incarcerated parents
- ☐ Trafficked youth
- ☐ Unstably housed/homeless youth
- ☐ Families experiencing interpersonal violence
- ☐ Youth who have been referred to a juvenile review board, youth service bureau, other diversion program, or who have been arrested
- ☐ Caregivers or children who have a substance use disorder, mental health condition or disability that impacts parenting
- ☐ Infants born substance-exposed as defined by the state's Child Abuse Prevention and Treatment Act (CAPTA) notification protocol[2]

Connecticut sees this pathway as a tremendous opportunity to provide services earlier to families to establish stability and family well-being, and to prevent foster care entry. To engage these families earlier, CTDCF heard directly from families and partners that it was important to develop an entity outside of the Department to assist in these families' cases. Therefore, as available funding allows, CTDCF plans to contract with a Care Management Entity (CME) to engage these "community pathways" families, provide case management, manage service referrals, and monitor ongoing progress. In response to feedback from families and partners, CTDCF is eager to establish this relationship to capitalize on the ground-breaking Family First opportunities without magnifying CTDCF surveillance.

Only CTDCF staff will determine child-specific eligibility for prevention services. For the "known–to-CTDCF" population, eligibility will be determined initially at the Careline due to the fact that families associated with all accepted Careline calls will be eligible for Family First service. There are various opportunities during intake and routine casework, such as the administrative case review process, for Connecticut CTDCF staff to identify pregnant or parenting youth. Enhancements are being made to intake policy and procedures as well as case planning elements of Connecticut's data system to prompt staff to identify youth that meet these criteria. All "known–to-CTDCF" populations' eligibility will be documented in Connecticut's data system, "LINK."

Families are referred to the VCM program from the CTDCF Careline, and therefore all families that CTDCF refers will be deemed eligible. Once Beacon Health Options assesses a family, a final determination will be made with the family about their needs and ultimate service referrals.

For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before

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[2] *ACT definition of infants born substance-exposed for the purposes of the CAPTA notification: A newborn: (1) exposed in utero to methadone, buprenorphine, prescription opioids, marijuana, prescription benzodiazepines, alcohol, other illegal/non-prescribed medication, and/or the misuse of prescription/over the counter medication; (2) with withdrawal symptoms; (3) diagnosed with Fetal Alcohol Syndrome.*

contracting with the CME and serving community pathway families. Once those elements are established, the CME will collaborate with community partners to identify and engage potentially eligible children and families. In order to make an eligibility recommendation, the CME will use a screening tool to determine whether the family meets Family First eligibility, and to which target population the family belongs. The CME will then make a recommendation to CTDCF about eligible candidates and CTDCF will make the ultimate determination regarding candidacy eligibility. Once a family has been determined eligible, CTDCF anticipates that the CME will partner with the family to better understand their strengths, risk factors, and needs through an assessment. This information then will be used to tailor each family's child-specific prevention plan and State of Connecticut Family First Prevention Plan service referrals.

Family First eligible youth will be identified via two pathways:

Known-to-CTDCF candidacy population either through a call to the Careline, prior involvement in the system, or current involvement (pregnant and parenting youth in foster care).

- Siblings of youth in foster care
- Pregnant and parenting youth in foster care
- Families with accepted Careline calls

Community Pathways candidacy population includes "upstream" families experiencing specific behavior, conditions, or circumstances that are likely to have an adverse impact on a child's development or functioning and for whom research establishes that such characteristics or conditions place them at increased risk for maltreatment, involvement with the child welfare system, or out-of-home placement.

- Families accepted for Voluntary Services
- Youth that have exited foster care
- Children who are chronically absent from preschool/school or are truant from school
- Children of incarcerated parents
- Trafficked youth
- Unstably housed/homeless youth
- Families experiencing interpersonal violence
- Youth who have been referred to a Juvenile Review Board, Youth Service Bureau, other diversion program, or who have been arrested
- Caregivers or children who have a substance use disorder, mental health condition or disability that impacts parenting
- Infants born substance exposed as defined by the state's Child Abuse Prevention and Treatment Act (CAPTA) notification protocol.

Office of the Chief of Quality and Planning Overview 5-1

Chief of Quality and Planning

The Department of Children and Families' Chief of Quality and Planning shall coordinate efforts to continuously monitor and improve DCF's outcomes and the overall quality of practice, care and services that are provided to Connecticut's children and families. The Chief of Quality and Planning shall ensure that DCF implements recurring, rigorous and comprehensive self-directed assessments of its functioning and progress. These efforts shall be guided by DCF's mission, practice model, cross-cutting themes and legislative mandates.

The Office of Quality and Planning shall ensure that DCF's quality assurance, continuous quality improvement, research, evaluations, practice and service oversight are implemented through a racial justice lens, and shall ensure that the collection, governance, use, sharing, interpretation and dissemination of DCF data occurs in a manner cognizant and mitigating of potential implicit bias, over- and underrepresentation and racial inequities.

Administrative Case Review

DCF shall conduct Administrative Case Reviews in accordance with state law and federal regulations.

Cross-reference: DCF Policy 5-2, "Administrative Case Review."

Ombudsman

The Office of the Ombudsman shall address inquiries and complaints related to DCF services in order to resolve these issues and to help ensure that the rights of individuals involved with DCF are upheld and maintained.

The Ombudsman shall respond to inquiries received from, but not limited to, clients, foster and adoptive parents, the Governor's Office, legislators, providers and DCF staff to resolve disputes with DCF in a manner consistent with the best interests of children and shall act as an information and referral source for these individuals. The Ombudsman shall also respond to certain issues and correspondence on behalf of the Commissioner.

The Ombudsman shall utilize a neutral and collaborative process, by which to facilitate fair and equitable resolutions to concerns that are reported, and shall attempt to facilitate resolutions as amicably as possible.

As required, the Ombudsman, in collaboration with Regional, facility and other Central Office staff, shall consult and problem-solve case-related and systemic issues in order to assist and support DCF staff and management with service provision.

Inquiries received from any source, including but not limited to telephone calls, letters, faxes and emails, shall receive an initial response from the Ombudsman within two business days. Some inquiries may require an immediate response depending on the urgency of the concern or at the Commissioner's discretion.

No person shall be coerced, intimidated or retaliated against by DCF for requesting its Ombudsman services. Any person so aggrieved may seek a resolution through DCF's Human Resource Management.

The Office of the Ombudsman shall be subject to state and federal statutes, regulations, and DCF policies and procedures regarding confidentiality.

Legal references: Conn. Gen. Stat. §4-61dd; Gen. Stat. §17a-28; §17a-101 et seq.

Multicultural Affairs and Immigration Practice

The Office of Multicultural Affairs and Immigration Practice (OMAIP) shall serve as a resource and support with respect to identifying and implementing sound immigration, multicultural and linguistically-competent practices, policies and strategies. OMIAP shall ensure that such practices, policies and strategies are racially just, trauma-informed, gender-responsive and child- and family-centered and that they promote and advance DCF's mission, goals and legislative mandates.

The OMIAP shall serve in a leadership capacity with respect to establishing, maintaining and convening a DCF Statewide Racial Justice Workgroup (SWRJWG). In this capacity, the OMIAP shall serve as one of up to three chairs for the SWRJWG, providing guidance and oversight of this body and any of its subcommittees.

The OMAIP shall partner with various DCF Offices and Divisions (*e.g.,* Office for Research and Evaluation and Community Consultation and Support Division) to create measures, metrics and reporting standards to ensure DCF's accountability with respect to eliminating disproportionality and disparity.

Consistent with DCF policies and practices, and the historical and persistent patterns of inequities, the OMAIP will focus on impacts on communities of color, low-income populations, immigrants and refugees, and limited English-speaking clients. In furtherance of supporting positive outcomes for children and families served by DCF regardless of race, gender and gender identity, class, geography, religion, sexual orientation, disability, age or other aspects of personhood, the OMAIP shall partner with the DCF Office of Diversity and Equity and seek guidance from the SWRJWG to develop, implement and sustain initiatives designed to support the diverse needs of the children and families served by DCF.

OMAIP Responsibilities

The responsibilities of the Office of Multicultural Affairs and Immigration Practice include, but are not limited to:

- advising the DCF Commissioner and the Senior Management Team regarding strategies to eliminate disproportionality and disparities in referral rates, substantiations, placements and retention among racial and ethnic groups known to experience higher rates of adverse child welfare, health and services outcomes because of religion, age, sex, sexual orientation, national origin, socioeconomic status, immigration status, language, ancestry, intellectual or physical disability, mental health status, prior criminal convictions, homelessness, gender identity or expression or geographic areas of residence;
- drafting an annual report detailing DCF's progress in eliminating disparities and disproportionality across DCF's mandates;
- reviewing, advising and making recommendations for expanding existing training programs for building staff capacity and development of skills for supporting racial justice practice;
- providing consultation with respect to establishing and maintaining a standardized data reporting system to support collection of data regarding the race and ethnicity of children and families referred to DCF at key decision points, including, but not limited to referral, substantiation, removal and placement,

(Continued next page)

OMAIP Responsibilities (Continued)

- working collaboratively with the Division of Diversity and Equity to develop and support Diversity Action and Racial Justice Teams across the state;
- monitoring statewide immigrant and refugee data and trends to support recommendations for resource allocation, training, practice and policy changes;
- consulting with DCF leadership and staff and public and private service providers and stakeholders to determine organizational and client linguistic and diversity needs, including deaf and hard of hearing populations;
- providing consultation and support for:
  - U Nonimmigrant Status I-918 B petitions;
  - matters related to obtaining out-of-country travel documents for children in care;
  - interactions with state and federal immigration enforcement regarding refugee resettlement; and
  - matters pertaining to the Unaccompanied Minor Program;
- facilitating requests of birth certificates for children born in Puerto Rico;
- providing human diversity and culturally complex case consultation, immigration practice guidance, CLAS Standards Language access resources, education and training;
- leading, guiding and supporting the charge of the Statewide Racial Justice Workgroup across the agency (SWRJWG).

Statewide Racial Justice Work Group

The OMIAP shall organize and chair a Statewide Racial Justice Workgroup (SWRJWG). This body shall provide advice and offer recommendations to DCF regarding decreasing disproportionality and disparities and improving equitable outcomes across DCF's mandates.

The SWRJWG shall, as warranted, convene subcommittees to focus on core areas, including but not necessarily limited to:

- policy and practice;
- workforce development;
- contracts and procurement; and
- community engagement and partnerships.

Cross references: DCF Policy 7-1, "Office of Diversity and Equity; 21-13, "Immigration;" and 21-3, "Delivery of Services Using a Client's Preferred Communication."

Performance Management

The Office of Performance Management shall serve as the hub for synthesizing and disseminating actionable information about DCF's outcomes. This shall occur in congruence with and in furtherance of DCF's current Performance Expectations. Further, the Office of Performance Management shall support implementation of the DCF's Result's Based Accountability (RBA) efforts.

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Performance Management (Continued)

The duties of this Office shall include, but are not necessarily limited to:

- collecting and cataloging DCF RBA report cards;
- conducting analyses and authoring reports to support DCF Performance Expectation functions;
- engaging in select focus reviews; and
- maintaining the DCF Data Connect website.

In addition, the Office of Performance Management shall be responsible for maintaining the Continuity of Operation Plans and working with senior management to coordinate emergency responses.

Business Continuity Plans

All DCF work locations shall have a Continuity of Operations Plan (COOP) designed to respond to emergency situations including, but not limited to, medical emergencies, fire, the release of hazardous materials, bomb threats and weather-related events. COOP Plans shall be readily available through the Office of Performance Management and posted on the DCF intranet Health and Safety web page.

The most senior administrator for each work location shall:

- communicate the COOP Plan to all staff on a quarterly basis;
- maintain a hard copy of the COOP Plan in a location that is readily accessible to staff;
- revise and update the COOP Plan on a quarterly basis; and
- submit revisions to the Office of Performance Management.

The COOP Plan shall include designated key staff to:

- manage the overall response to an emergency; and
- represent the work location at COOP Plan-related meetings called by DCF Central Office.

The COOP Plan shall include criteria for notification of appropriate DCF officials and outside emergency services to obtain their expertise and participation in decision-making.

Special Qualitative Review and Safety Science

The Office of Special Qualitative Review and Safety Science shall, as directed by the Commissioner or the Commissioner's designee, implement a process for reviewing child fatalities and other significant events. This shall include convening a meeting or conference call between the impacted DCF Region and Area Office or facility, the Commissioner's Office and other necessary Central Office staff to obtain an overview of and briefing about the triggering event.
These Special Qualitative Reviews (SQRs) shall consist of extensive and comprehensive examinations of relevant electronic and paper case records, staff and collateral interviews and, as necessary, consultation with multidisciplinary experts.

The SQR shall be built on the principles of safety science and DCF's cross-cutting theme to be an accountable and learning organization.

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Special Qualitative Review and Safety Science (Continued)

The SQR is, at a minimum, focused on three core areas:

- internal and external practice;
- internal and external policies and procedures; and
- internal and external systems.

The SQR process shall provide DCF with information about challenges and strengths with respect to the aforementioned core areas.

Due to the nature of the types of events that lead to an SQR, individual findings from a SQR shall be documented in a confidential and privileged report, noted to be drafted in preparation for possible litigation. Therefore, the SQR report shall have limited internal distribution and shall only be shared with persons outside of DCF as authorized by the Commissioner or the Commissioner's designee.

Aggregated information from multiple SQRs shall, however, be shared with DCF staff or other stakeholders through Learning and Leadership Forums and other training mechanisms to guide and support professional development and skill-building across DCF and other systems, identify best practices, and direct any needed improvements in the delivery of care and services by DCF and other systems that may touch the lives of Connecticut's children and families.

Office for Research and Evaluation

The Office for Research and Evaluation (ORE) shall be an essential component of DCF's overall quality assurance and continuous quality improvement structure. ORE's core functions are shaping, supporting and conducting research, evaluation and analytic inquiry within DCF. It shall transform DCF data into actionable, useful and relevant information through the application of continuous quality improvement (CQI) and research methodologies to support its vision of guiding sound decisions to strengthen practice and maximize positive outcomes for children, families, groups and communities.

ORE shall have the following responsibilities:

- support the consistency, utility, appropriateness and accuracy of DCF's self-monitoring activities;
- promote coordination of quality assurance and continuous quality improvement activities through collaboration with quality improvement staff from the Regions and DCF facilities;
- provide technical assistance and training to DCF's programs, divisions, Regions and facilities in order to provide support for research, evaluation, quality assurance and quality improvement activities;
- ensure consistency across DCF programs, divisions, Regions and facilities, including:
    - assisting in developing sound methodologies that enable DCF to answer with confidence any research and evaluation questions posed;
    - assisting in developing outcome measurement metrics and monitoring mechanisms;
    - assisting in establishing quality review criteria;

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Office for Research and Evaluation (Continued)

- identifying already-existing data to support research, evaluation, continuous quality improvement and self-monitoring activities; and
- developing continuous quality improvement training for staff in conjunction with the Academy for Workforce Development;
  - o partner with DCF Information Systems in developing, enhancing and sustaining data collection instruments, data files, portals and reports;
  - o collaborate with external and internal partners in the maintenance, enhancement, and development of data collection and reporting systems [*e.g.,* Results Oriented Management (ROM), Provider Information Exchange (PIE) and Case Review System (CRS)]; and
  - o participate in key DCF strategic planning, program development, implementation and evaluation activities.

ORE shall partner with the Regions, facilities and other divisions to validate DCF's quality improvement activities to ensure the continuous measuring and monitoring of DCF performance and outcomes. It shall provide technical assistance with respect to the development of instruments necessary to conduct requisite reviews and evaluations.

Further, ORE shall provide consultation and technical assistance to DCF staff regarding the development of automated reporting systems. Such assistance shall be limited to the provision of business analysis, report specification and testing of reports otherwise constructed per specification by Information Systems staff or contracted vendors.

The Office for Research and Evaluation shall also:

- support the development and updating of DCF data development and research agendas;
- assess that all proposed research and research-related activities align with DCF priorities and impact on DCF staff and other resources prior to review by the DCF Institutional Review Board (IRB) and provide administrative oversight of and technical assistance to the DCF IRB;
- assess proposed non-research activities that impact on human subjects protection and provide guidance when appropriate;
- ensure that all research and non-research projects and activities are designed and conducted in a manner that support racial justice and equity, are guided by ethical standards that include ethical responsibilities to our served populations and utilize resources for positive impact;
- conduct comprehensive evaluations, select focused reviews, engage in research and research-related activities and collaborate with other external partners in research and evaluation that support the interest of DCF;
- utilize the most appropriate research and study methodology in order to conduct focused and other reviews, evaluations, research and research-related activities;
- prepare and disseminate evaluation and select focused review reports and research manuscripts; and
- track and catalog all DCF data and evaluation and research reports.

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Office for Research and Evaluation (Continued)

The Office for Research and Evaluation shall evaluate the quality of care and services, casework practices, research and non-research projects and activities and, where appropriate, make recommendations and implement models and approaches designed to support the achievement of safety, permanency and well-being outcomes. ORE shall accomplish these responsibilities through continuous quality improvement and qualitative reviews and activities that include but are not limited to:

- Risk Management, collecting, documenting, monitoring and tracking significant events and other incidents such as emergency safety interventions (ESI), serious occurrences and adverse events that occur during research and non-research projects, and distributing information regarding select significant events and other incidents;
- producing aggregate, periodic and special reports on events and other incidences to support policy development and the review of service providers' quality;
- implementing the use of a model or other approach that combines the use of predictive analytic, prospective qualitative review and coaching as a means to proactively identify and intervene in cases at an elevated risk for severe child maltreatment or child fatality;
- conducting reviews of out-of-state congregate care facilities, in partnership and consultation with the DCF Office of Children and Youth in Placement (OChYP), for new use and periodic reviews to ensure quality of care and services, racial justice and equity, and suitability of use for initial and ongoing placements; and
- conducting data analyses of casework practices within DCF and across its continuum of services.

Note: OChYP shall have the final approval of use of out-of-state facilities prior to placing any DCF child in such program.

The Office for Research and Evaluation shall support and conduct reviews, continuous quality improvement and evaluation activities, data analysis and reporting required under state and federal statutes and regulations. These include, but are not limited to:

- review and provision of training and technical assistance to providers that support claiming of federal reimbursement for Private Non-Medical Institution (PNMI) services and oversight of the associated Random Moment Time Study;
- Child and Family Services Reviews (CFSR) and the related Program Improvement Plan (PIP) activities;
- National Child Abuse and Neglect Data System (NCANDS) Commentary, agency file submission and other continuous quality improvement activities;
- activities related to the Adoption and Foster Care Reporting System (AFCARS) in collaboration with Information Systems;
- provision of data and information to support the development of the Child and Family Services Plan (CFSP) and its Annual Progress Services Report (APSR); and
- Freedom of Information Act (FOIA) data requests in collaboration with the DCF Office of Legal Affairs.

Within available resources, ORE shall fulfill ad hoc data requests. ORE shall establish and implement a process for receiving, cataloging, vetting, responding to and tracking requests for ad hoc and other data.

Requesting Data from ORE

Employees and other persons and entities may request data from ORE using the DCF-5101, “ORE Request,” and, at the request of ORE, the DCF-5102, “Project Scope.”

The Family Assessment Response (FAR) Practice Guide

Corresponds to Policy 22-2-1: Family Assessment Response
January 2019

Table of Contents

Family Assessment Response Practice Guide

Definitions

Community Partner Agency - Contracted agencies throughout the state who will engage families referred by DCF and connect them to concrete, traditional and non-traditional resources and services in the community. The name of the contracted service is the Community Support for Families Program.

Family Assessment Response Protocol - A LINK-generated form used to document all information gathered during the Family Assessment Response.

Family Team Meeting - A family- and community-centered approach designed to help families have a voice and direct input into plans that are developed to ensure the safety, permanence and well-being of children, meet family needs, and strengthen the family unit. It is the preferred forum for the family and their support systems to come together and develop a plan to address concerns and provide assistance and support on an on-going basis or in times of need.

Formal and Informal Community Supports - Formal Supports are typically contracted community providers who provide services and supports to families. Informal supports are individuals in the community who provide support to the family (neighbor, coach, spiritual leader etc.) or individuals who have a personal relationship with the family. This may include extended family, fictive kin, friends etc.

Protective Factors - Conditions in families and communities that, when present, increase the health and well-being of children and families. Working with families to increase their protective factors helps families build and draw upon their natural support networks within their family and community, promoting long term success.

SDM® Safety Assessment - This SDM Assessment Tool is used by Social Workers to help assess whether children are in immediate danger of serious harm. It assesses families on twelve specified conditions that potentially represent a threat to child safety and identify the interventions needed to control or remediate unsafe conditions.

SDM® Risk Assessment - This SDM Assessment Tool is used by Social Workers to help guide the decision to open or close a case and classifies families into risk levels based on their likelihood of future maltreatment.

Safety Plan - Strategies and interventions identified by the family and their community partners which, when implemented immediately, safeguard the children in the home.

Service Plan - The Service Plan is a family driven, dynamic document intended to guide the activities of the family, their informal and formal community supports, and DCF to

increase the health, safety and well-being of children and families. It is intended to maximize family engagement and overall family satisfaction.

Trauma-Informed Care - Trauma-informed care is an approach to engaging parents and children with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma plays in their lives. The intent of trauma-informed care is to provide more supportive, trauma-specific interventions in order to avoid re-traumatization and promote healing.

Traumatic Life Experiences – Traumatic events are common in the lives of individuals and may include physical abuse; sexual abuse; emotional or psychological abuse; neglect; experiencing or witnessing violence in neighborhoods, schools and homes; sudden loss of a loved one; serious accidental injury or accident; medical trauma; or events such as natural disasters, displacement and terrorism.

Introduction to Differential Response

The Differential Response System affords DCF the opportunity to customize its response by using one of two response tracks. This approach is embedded in DCF's evolving Strengthening Families Practice Model. This practice model defines and supports a purposeful, intentional, respectful and supportive engagement with families who enter the DCF system of services.

The implementation of a Differential Response System is a core part of DCF's move to more family-centered practice, exemplified most clearly in the new DCF Strengthening Families Practice Model. It is also tied to three other key cross-cutting themes. These other themes are: implementation of trauma-informed practice; application of the evolving body of early childhood and adolescent neuroscience; and improvements in agency leadership, management, supervision and accountability processes.

All of this change is designed to advance the single agency goal of promoting the holistic well-being of children. For all children in DCF care and custody, as well as those who are enrolled in DCF-funded programs, DCF seeks improvements in their health, safety and learning, success in and out of school, the advancement of their special talents and the provision of opportunities for them to contribute to their communities.

Differential response shares many of the same principles of a traditional investigation as follows:

- focuses on the safety and well-being of the child;
- promotes permanency within the family whenever possible;
- recognizes the authority of DCF to make decisions about removal, out-of-home placement, and court involvement; and

- acknowledges that other community services may be more appropriate and beneficial to families in some cases rather than receiving services from a child protection agency.

Family Assessment Response

DCF shall have two available responses to an accepted CPS report: Investigations and a Family Assessment Response (FAR).

The Family Assessment Response model is a strength-based, family -centered approach to partnering with families and their supports to protect children and enhance parental capacity.

CT's model recognizes the importance of engaging parents to recognize concerns that affect their ability to parent; empowers and helps families and their supports identify solutions to address problems or concerns; focuses more on understanding the conditions that impact child safety and the factors that need to be addressed to strengthen the family; tailors the approach and services to correspond to the family's strengths, needs, and resources; taps into community services and the family's natural supports; and establishes strong community partnerships that can help support the family in times of need. Families can decide whether they wish to participate in services once safety has been established.

Rather than a formal determination of abuse or neglect, the outcome is a determination of whether services are needed to strengthen families and promote child safety and well-being.

Family Engagement

The Family Assessment Response requires an active engagement and collaboration with families and their communities.

Engaging families to identify possible solutions to mitigate safety factors, reduce risk and address family needs will ultimately promote children's safety, well-being and improve family functioning. Children are safer and families are stronger when communities work together.

Key Practice Points of our Family Assessment Response

Once child safety has been established, the key practice points of DCF's Family Assessment Response are as follows:

- continues to assure the physical and psychological safety of children;
- assesses risk and the underlying issues that may be impacting the family;

- promotes the social, emotional, educational and physical well-being of children;
- utilizes a strength-based approach to partner with the family;
- understands the role of trauma in the lives of children and their caregivers;
- engages informal and formal supports, resources and services to address identified needs;
- provides linkages to supportive community networks (including the Community Support for Families Program) that offer assistance; and
- collaborates with the community regarding available services and supports.

Track Determination

Following completion of the SDM Screening and Response Priority Tools, the Careline will review all accepted CPS reports designated with a 72 hour response time and determine which track the report will be assigned to: investigations or a Family Assessment Response based on "rule out" criteria.

The following rule outs have been identified and will require an investigations assignment (See Careline description for further information):

- a new CPS report on an active ongoing services case (excluding Voluntary Services) or a new report on an active investigation;
  (Note: Includes any report on an open protective services case in Connecticut or another state excluding cases open for FAR, Probate or Voluntary Services and cases in which a household member has an open protective services case)
- congregate care, foster care (excluding allegations involving biological or adoptive children of the foster parent), persons entrusted;(Note: Day care providers are persons entrusted.)
- sexual abuse by parent, guardian or person given access by the parent or guardian; (Note: If the allegation is child sexualized behaviors with no sexual abuse disclosure, this may be coded as physical neglect and not sexual abuse. It is a case-by-case decision.
- prior child fatality due to abuse or neglect; or
- previous adjudication of abuse or neglect in Superior Court for Juvenile Matters or comparable out-of-state court, including prior terminations of parental rights within the last five years.
  (Note: Social Work screeners need to open the legal icons and read carefully. Please remember that the adjudication follows the parent and it does not matter if the report is being made on either parent. If there was a prior removal or OTC but no adjudication as a petition was not filed or was subsequently withdrawn, it would not be considered a rule out.)

Reports accepted for a Family Assessment Response shall be forwarded to the Area Office for assignment.

Prior to case assignment, the Area Office Program Supervisor may modify the type of response from FAR to an investigations response under the following conditions:

- when new information becomes available that makes the case ineligible for a Family Assessment Response (e.g., a Rule Out has been identified); or
- when a new CPS report is accepted and designated as an investigation by the Careline.

Note: CPS reports designated by the Careline as requiring an investigations response cannot be changed to a Family Assessment Response.

For the remaining 72 hour reports, the track will be determined based on an assessment of the family, following face-to-face contact.

Note: If the ISWS believes that the response time, as designated by the SDM Response Priority Tool completed by Careline, should be changed based on additional information available in the Area Office, the ISWS shall obtain the approval of a Program Supervisor prior to downgrading the response time. The rationale for the change in response time shall be documented in the computer system.

Participants in a Family Assessment Response

The following participants may be involved in the Family Assessment Response:

- Careline Social Worker;
- Careline Social Work Supervisor;
- Careline Program Supervisor;
- Area Office Social Worker;
- Area Office Social Work Supervisor;
- Area Office Program Supervisor;
- Regional Resource Group;
- the child and family;
- family-identified supports;
- community providers; and
- community teams, liaisons and advocates.

Social Work Supervisor Responsibilities

Following face-to-face contact with the family, the Social Work Supervisor will consult with the Program Supervisor on cases in which a track change is recommended.

Throughout the family assessment process, the following areas shall be discussed in supervision:

- the family and Social Worker's perceptions and understanding of issues and concerns;
- the family's preferred course of action or approach;
- review of safety factors or concerns;
- a discussion of risk factors;
- the family's support network including family and community supports and services; and
- the family's protective capacities, needs and strengths.

Social Work Preparation

The Social Worker shall take the following steps to prepare for the Family Assessment Response prior to initiating contact with the family:

- review the CPS report;
- call the reporter to discuss additional report information;
- review current and prior DCF encounters with family or case participants that may present risk or currently impact child safety, noting potential trends or patterns in the CPS history;
- when applicable, consult with the Regional Resource Group (RRG);
- determine if there is open DCF involvement with any identified household member and, if so, consult with the currently assigned Social Worker;
- at the commencement of the Family Assessment Response, begin recording all case activity in the Family Assessment Protocol and update it throughout the 45-day family assessment period.

Initial Contact with the Family

Whenever possible the preferred method for initial contact with the family is by telephone.

The Social Worker shall attempt an initial phone call with the family to schedule a face-to-face meeting.

During this initial contact, the Social Worker shall:

- inform the parent or guardian of the receipt of the CPS report, including the details of the allegations;
- schedule a face-to-face meeting within 72 hours of the CPS report; and
- inquire about any supports or providers the family would like included in the face-to-face meeting.

Response Guidelines

Because the allegation(s) in the CPS report must meet the statutory definition of abuse or neglect in order to be accepted by Careline, a thorough assessment of child safety and risk is required. Additionally, the Social Worker shall collaborate with the family and its partners to identify the strengths and needs of the family and to help identify resources and supports to address identified needs. Broader family and community participation elicits support and promotes child well-being.

During the first face-to-face meeting the Social Worker shall:

- inform the family of DCF's protective services mandate and the need to assess the safety of the children and identify potential risk factors that may impact their safety;
- share and discuss the contents of the report;
- address concerns with the family and gain their feedback;
- define Family Assessment Response services and how it can help the family;
- provide the family with a Family Assessment Brochure;
- assess for potential risk factors within the family including domestic violence, substance abuse and mental health concerns;
- observe and conduct interviews with the following:
    - parent(s), including non-custodial parent;
    - the legal guardian of the child, if not the parent;
    - the child(ren) identified in the report;
    - siblings and other children in the home;
    - all household members;
    - family resources and supports; and
    - other persons responsible for the care of the child.
- obtain all demographic information necessary to conduct mandatory background checks for parents, guardian and household members over the age of 16;
- discuss the importance of identifying formal and informal supports and resources;
- discuss the purpose of a Family Team Meeting;
- schedule a follow-up visit to discuss the family's strengths, needs and supports; and
- obtain necessary releases of information.

* The non-custodial parent may be included in case planning even if the child is living with the other parent and even if the other parent does not agree. Protective, restraining and other court orders regarding contact with a non- custodial parent or a third party must be honored.

Interviews with the Children

The Social Worker shall:

- inform the parent(s) that the preferred approach is to interview the child(ren) alone;
- if the parent declines a private interview, interview the child in the presence of a mutually agreed upon person who is a support to the family; and
- document interviews in the Family Assessment Response Protocol.

Note: Efforts will be made to conduct interviews with all the children who are not subject to the report in the home within five business days of the CPS report in order to assess child's safety in the home and to address risk factors. The Social Worker shall inform the Social Work Supervisor of any delays in interviewing the children.

Following the initial contact with the family and the fulfillment of all required case contacts as described above, efforts shall continue to be made to see the primary caregiver and identified victim(s) in the referred household throughout the assessment period.

Collateral Contacts

In order to enhance our assessment of the family, the Social Worker shall request the family sign releases of information for the following collateral contacts:

- school, substitute caretaker, or daycare provider;
- pediatrician; and
- service providers involved with the family or adult caregiver.

Additional releases may be necessary based on concerns or the nature of the CPS report, or concerns and issues that may arise during the assessment process.

If the information to be obtained from a collateral contact is critical to the assessment, the Social Worker or Supervisor may consult with the Program Supervisor, Area Office legal staff, or Regional Resource Group to determine next steps.

The Social Worker will document information gathered from the collateral contacts in the Family Assessment Protocol. If the family refuses to sign releases, the Social Worker will document this in the Family Assessment Protocol.

Case Consultation

The Social Worker shall consult with the following when applicable:

- Regional Resource Group (RRG) for substance abuse, behavioral health issues, medical concerns, domestic violence, and other special needs;
- education consultant; and
- Area Office legal staff.

Assessment

Ongoing assessment of the child's well-being is required throughout the Family Assessment Response. Consideration of safety factors shall be incorporated into each contact with the family.

The Social Worker shall engage the family to gather sufficient information to assess potential safety factors.

The assessment includes but is not limited to the following information:

- nature, type, duration and intensity of any type of maltreatment;
- parents' explanations and responses;
- living conditions;
- alcohol or substance abuse;
- parents' behaviors toward child;
- parents' physical and mental health;
- child's functioning (relationships, school status, social connections, community activities, etc.);
- child's physical and mental health including behavioral and psychological safety;
- parent and child relationship;
- trauma history and symptoms; and
- parents' capacity to care for the child.

If the conditions or behaviors do not meet the threshold of a safety factor, as indicated by the SDM® Safety Assessment and the worker's professional judgment, the child shall be considered "safe." A Service Agreement may be established in partnership with the family and community resources to address issues or concerns relative to the report, to minimize risk factors, or to address the needs of the family.

The Social Worker shall be responsible for assessing child safety during the initial face-to-face contact with the child and family, utilizing the Safety Assessment.

The assessment results shall be documented in LINK within five days of the initial face-to-face contact with the family. The Social Work Supervisor shall approve the Safety Assessment no later than 15 days from its completion.

Protective Factors

The Social Worker shall discuss the protective factors with the family to help identify their strengths and needs to inform service delivery.

Protective factors are conditions in families and communities that, when present, increase the health and well-being of children and families.

Working with families to increase their protective factors helps families build and draw upon their natural support networks within their families and communities. These networks are critical to families' long-term success.

The five protective factors are:

- **Nurturing and Attachment:** Building a close bond helps parents better understand, respond to and communicate with their children.
- **Knowledge of Parenting** - Child and Youth Development: Parents learn what to look out for at each age and how to help their children reach their full potential.
- **Parental Resilience:** Recognizing the signs of stress and enhancing problem-solving skills can help parents build their capacity to cope.
- **Social Connections**: Parents with an extensive network of family, friends and neighbors have better support in times of need.
- **Concrete Supports**: Parents with access to financial, housing and other concrete resources and services that help them meet their basic needs can better attend to their roles as parents.

During the course of the Social Worker's initial visit, the **Family Protective Factors Worksheet, DCF-3011 WS** shall be completed jointly with the family.

Utilizing the Protective Factors Worksheet, the Social Worker will gather information from the family to assess their strengths and needs.

The Social Worker shall review each protective factor with the family and document the discussion from both the perspective of the family and the Social Worker's assessment of the family's strengths and needs based on observations and information collected through interviews and collateral contacts.

Family Team Meetings

The Social Worker shall offer a family meeting once a need has been identified from any source.

Family Team Meetings are family-driven and can be requested by the family at any time. Following DCF's initial face-to-face meeting with the family, the Social Worker will provide the family with information about the purpose, benefits and value of teaming and the family's key role in the teaming process, such as identifying team members, setting the team's agenda, and determining the time, place and frequency of the meetings.

It is a preferred forum for the family and its support systems to come together and develop a plan to address concerns, family needs and provide assistance and support to families on an ongoing basis or in times of need.

A Family Team Meeting is designed to:

- empower families to take charge of their support system and services;
- identify, organize and plan in collaboration with family, family-identified supports and community supports and services;
- help families formulate agreements and a plan of action which can resolve crises and reduce the likelihood of future DCF involvement; and
- build a team that can provide support and resources to the family following the Family Assessment Response process.

The goals of the meeting are to:

- ensure that the family's basic needs are met; and
- equip the family with the skills and support necessary to respond in times of need or crisis.

The objectives of the meeting are to:

- identify family strengths, supports and needs;
- specify how relatives and supportive non-relatives can help to meet these needs;
- build on family strengths; and
- develop a family-driven plan to resolve concerns reported to DCF.

The discussion and outcome of these meetings will help inform the Service Plan.

Service Plan

The Service Plan is a family-driven, dynamic document that focuses on the key elements of the Family Assessment Response. The plan utilizes the protective factors to assess the strengths of a family and empowers them to develop and employ strategies to accomplish their identified goals.

The service plan has the following five components:

1. identify the family needs;
2. identify the family strengths, resources and supports;
3. identify the goals or desired outcome;
4. identify concrete steps the family, DCF and the Community Providers will take to achieve the goal; and
5. identify the benefit of achieving the goal.

Through the development of the Service Plan, the family will benefit by enhancing both their problem-solving skills and their ability to connect to community services.

The Family Assessment Response Service Plan will be developed following the discussion of the protective factors or the outcome of the Family Team Meeting. The resulting plan will guide the activities of the family, their community supports and DCF.

If additional case management services are required, the Service Plan will follow the family to the Community Partner Agency or to DCF Ongoing Services.

Supervisory Review

Prior to making a Family Assessment Response disposition, the Social Worker shall meet with the Social Work Supervisor to ensure that:

- efforts were made to commence and deliver Family Assessment Response services within the established time frames;
- sufficient information was collected during the course of the assessment process to address safety and risk concerns, including information gathered from collateral contacts;
- the SDM® Safety and Risk Assessments were completed;
- a Safety Plan was created to address safety factors where appropriate;
- efforts were made to effectively engage and collaborate with the family to:
    - determine the family's strengths, needs and resources;
    - identify family and community support systems;
    - ensure the family is linked to appropriate services; and
    - ensure a support network has been developed;

- mandatory background checks have been completed and assessed;
- efforts were made to interview and engage the required case contacts, documenting barriers (if appropriate); and
- all case-related activities, including the decision and rationale, have been documented in the Family Assessment Response protocol.

Note: A Program Supervisor shall approve all Family Assessment Response case transfers to Ongoing Services and to the Community Partner Agency.

Case Disposition

A Family Assessment Response disposition shall be made within 45 days of the acceptance of the Careline report.

Prior to making a Family Assessment Response disposition, the Social Work Supervisor shall discuss the case with the Social Worker, taking into consideration all facts and information collected during the Family Assessment process.

As part of the determination, the following shall be considered:

- results of the Safety and Risk Assessments;
- the family's strengths and level of need;
- connection to and engagement with family and community supports;
- case consultation recommendations; and
- family perception or preferred approach regarding continued DCF involvement or service provision.

Outcomes

Throughout the Family Assessment Response, SDM® Assessment tools shall be utilized to support decision-making. At the conclusion, several outcomes are possible in LINK. These outcomes include:

- assessment closed, new CPS report received;
- assessment closed, transferred to investigation;
- unable to complete assessment;
- voluntary services program recommended;
- report linked to incorrect family;
- referred to other state agency;
- no further agency involvement is necessary;
- services declined and no safety factors are present;
- referral to community services without further DCF case management;

- referred to the Community Partner Agency for service provision and case management; or
- transfer to DCF Ongoing Services.

Note: A referral to the Community Partner Agency shall be initiated prior to the approval of the Family Assessment Response protocol.

Community Partner Agency

The criteria for referral to the Community Partner Agency for community support will be based on the family's willingness to engage with the contracted agency.

Upon referral to the Community Partner Agency, services are coordinated and provided in collaboration with the family, DCF and the family's existing community partners. The content of the Service Plan will inform case management activities and service delivery based on the family's strengths, needs, resources and goals.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES - FAMILY PROTECTIVE FACTORS SOCIAL WORK GUIDE (DCF - 3011-G)

This guide is designed to engage the family in a discussion around their strengths and needs to help identify the supports, resources and services that may be needed to increase the health and well-being of the family.

Working with families to increase their protective factors will help them utilize and build upon their natural support networks within their own family and community.

Nurturing and Attachment: Building a close bond helps parents better understand, respond to, and communicate with their children.

Here are some additional questions to ask…

How much time are you able to spend with your child/teen? What do you like to do together? What does your child/teen do when he/she is tired, angry or sad? What happens when your child cries for a long time, has a tantrum, wets the bed or skips school? How do you comfort your child? How do you let your child/teen know you love him/her? What do you do when your child does something great? What are your child's greatest gifts and talents and how do you encourage them? What happens when there is a conflict in your house?

H*ere are some things to consider in your assessment:*

Is the parent responsive, involved and sensitive to the emotional and physical needs of their child(ren)? Do the child(ren) interact with parents in a way that indicates a positive relationship exists and the children feel nurtured and safe?

Knowledge of Parenting - Child and Youth Development: Knowing what to look out for at each age can help their children reach their full potential.

Here are some additional questions to ask…

What does your child do best and what do you like about your child? What do you like about parenting an Infant/toddler/teenager? What do you find challenging about parenting? What kinds of things make your child happy, sad, frustrated or angry and what do they do when they feel this way? How do you respond to these behaviors? How does your child respond? Are there things that worry you about your child? Have other expressed concern about your children? How do you encourage your child to communicate, explore surroundings, try new things, and be more independent?

Here are some things to consider in your assessment:

Do parents understand and encourage healthy development and are they able to respond and manage their child(ren's) behavior? Do they understand and demonstrate age-appropriate parenting skills in expectations, discipline, communication, protection, and supervision of their children? Are parents concerned about their child's behavior? Does the child respond positively to parent's approach? Does the child function at appropriate grade level? Are the children's physical and cognitive skills consistent with age? Are there indications of developmental delays for their children? Are parents involved in their children's education? Are parents aware of their children's academic and behavioral performance?

Parental Resilience: Recognizing the signs of stress and enhancing problem-solving skills can help build parents' capacity to cope.

Here are some additional questions to ask…

What helps you cope with everyday life? Where do you draw your strength? How does this help you in parenting? What are your dreams for yourself and family? What kind of worries and frustrations do you deal with during the day? How do you solve them? How are you able to meet your children's needs when you are stressed? How does your spouse or partner support you? When you are under stress, what is most helpful?

Here are some things to consider in your assessment:

Are parents able to cope and manage the stress of everyday life, handle an occasional crisis, and know when to seek help in times of trouble? Multiple life stressors, such as a family history of abuse or neglect, physical and mental health problems (caregivers and children), marital conflict, substance abuse (caregivers and children), domestic violence, community violence, unemployment, limited or insufficient financial resources or difficulty managing resources, and unstable housing may impact parents' capacity to cope effectively with the typical day-to-day stresses of raising their children. How do these stressors impact the family?

Social Connections: Developing strong connections to the community can help support the family in times of need.

Here are some additional questions to ask…

Do you have friends or family members that help you out once in a while? Are you a member of any group or organization? Who can you call for advice or just to talk? How often do you see them? What kind of support do you need?

Here are some things to consider in your assessment:

Do parents have supportive relationships with one or more persons (friends, family, neighbors, community, faith- based organizations, etc) who offer help? Are parents willing and able to accept assistance from others? Are the children connected with supports/activities in the community? Does the child demonstrate positive social skills and able to interact with peers?

Concrete Supports: Access to financial, housing, and other concrete resources and services that help meet the basic needs of your family can help you focus more on being a parent.

Here are some additional questions to ask…

What do you need to (stay in your house, keep your job, pay your heating bill etc.)? What have you done to handle the problem? Has this worked? Are there community groups or local services that have been or might be able to help you?

Here are some things to consider in your assessment:

Do you have the ability and willingness to access and utilize resources necessary to meet your family's needs? Needs include but are not limited to: food, clothing, housing, transportation, childcare, health care, mental health services, substance abuse treatment, and/or domestic violence counseling to address your family-specific needs.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES FAMILY PROTECTIVE FACTORS WORKSHEET (DCF -3011-WS)

Name: _____ **Assessment Date: __/__/__**
Worker: _____

We want to help you and your family. You know what makes your family strong and what you need to keep it strong, safe and healthy. We would like to talk with you about how your family is doing now because this will help us help you.

When you think about your family, what are you most proud of?

These areas have been shown to improve the health and well-being of families:

Nurturing and Attachment: Having a strong bond with your child/children
How much time are you able to spend with your child/children?
What do you like to do with your child/children?
How do you know what your child/children is feeling?
What do you do when your child/children does something great?
Discussion:

Knowledge of Parenting - Child and Youth Development: Being knowledgeable about parenting
We want to hear about your child/children.
Think about:
- What your child/children does best
- What you like about your child/children
- How he/she is doing in school
- How does he/she behave?
- Are there things that worry you about your child/children?

What do you hope for your child/children as he or she grows up?
Discussion:

Parental Resilience: Knowing how to bounce back and seek help when needed
What helps you cope with everyday life?
What worries you?
What do you do when…?
- Someone gets sick
- You are stressed
- You run into money problems
- You have a conflict with your partner or child/children

Discussion:

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES FAMILY PROTECTIVE FACTORS WORKSHEET (DCF -3011-WS)

Name: _____ **Assessment Date: __/__/__**
Worker: _____

Social Connections: Developing a strong connection to the community
Do you have people who can help you? Who has helped you in the past? Do your children have people besides you who they can turn to for help?

Think about:
- Family
- Neighbors
- Community providers
- People in church, school, or groups

Discussion:

Concrete Supports: Being able to meet the basic needs of your family

We will talk about:
- Childcare
- Housing
- Food
- Work or other financial support
- Health care
- Transportation

How have you handled these problems? Has this worked? Are there local services that might be able to help?

Discussion:

How can we make things better?

Discussion:

FAMILY ASSESSMENT RESPONSE PROTOCOL GUIDE (Computer generated)

CASE NAME: CASE NUMBER:

IDENTIFYING INFORMATION (Includes DOB, Race/Ethnicity/ Cultural Background)
Mother:
Father:
Children:
Preferred Language:
Native American:

DESCRIPTION OF THE FAMILY
(Brief synopsis of the family - include who lives in the home (immediate family members) and anything that would help the reader gain a better understanding of the family)

Other Household Members:
(Include others outside the immediate family and relationship. Assess whether these individuals present any risk to the children).

Significant Others Involved With Family:
(Include relationship with extended family members, kin, informal supports etc).

Presenting Concerns/Issues (Includes report information and context of when concerns are most/least likely to occur and their impact):
(Careline report -may add additional information obtained from reporter - include dates of contact with reporter)

Relevant History (Includes multigenerational history of substance abuse, domestic violence, abuse/neglect history as parent/child, criminal concerns, past CPS concerns, military/combat history):
(Include past DCF involvement - summary of concerns/issues, include whether family received prior treatment and/or voluntary services, etc., history of abuse/neglect of parent as a child, criminal and military history. Information obtained through the use of a Genogram would be included in this section).

FAMILY RESPONSE TO PRESENT CPS REPORT CONCERNS

Parental/Caregiver Interviews (response to concerns and their impact on self and family):
(Include commencement information, dates of contacts with parents (mother and father) and response to concerns in report. This section should also contain dates of home visits, and telephone calls and summary of issues discussed).

If father does not reside in the household, document in this section and respond to the following questions:

1. When was the last time the kids had contact with their father?
2. Does he help provide direct care to the children; does he support mother in her care of the children?
3. Do the kids have contact with paternal relatives?
4. What is father's relationship with the family? Does he present any safety concerns to mother and/or children?
5. Does the father have other children and do the kids have contact with their siblings?

Include father's response to concerns - include dates of contact and nature of contact (phone, face-to-face contact, etc.) Include attempts/efforts to engage father. Document the reasons/rationale for no contact with father.

Include parent's willingness to sign releases to obtain information from collateral contacts.

Child Interviews:
(Include dates of contact/interviews and summarize interview -children's response/reaction to concerns etc. If the child is too young to interview, identify how they presented during visits, appear bonded etc. If the child appeared reluctant and/or refused to respond to questions, include this information here).

SDM Safety Assessment: (If Conditionally Safe, Specify Planning)
(Results of Safety Assessment. Document the safety plan developed with the family of conditionally safe).

Track Change? (If Transferred To Investigations, provide summary here)
(Indicate whether there was a track change and explain reasons the case was transferred to intake).

STRENGTHS-BASED COMPREHENSIVE FAMILY ASSESSMENT (Staff's perception of their engagement and relationship with the family):
(Include worker's perception of their engagement and relationship with the family. Were they receptive to DCF intervention? Were they offered and willing to participate in a child and family team meeting? Did the family identify needs and participate in planning/help identify solutions to address their needs?

Basic Needs Assessment (Protective factors discussion around concrete supports)

A. Housing/Home/Living environment/Community:
   (Assessment of the home environment, stability of housing, assessment of their community, safety concerns within the home and their community)
B. Food:
   (Family's ability to maintain food in the home on a regular basis. Do they receive assistance?)
C. Clothing:

(Family's ability to maintain adequate clothing for their children. Are children dressed appropriately?)

D. Employment/Work Readiness/Education/Vocational:
(Parent's employment, educational history (highest grade completed), job skills, ability to secure employment)

E. Childcare:
(Childcare arrangements. Who provides it and are they appropriate caretakers?)

F. Transportation:
(Do they own a car, have access to transportation, or use public transportation?)

G. Insurance:
(Does the family have medical insurance? Does this preclude them from accessing the needed medical/mental health services?).

CHARACTERISTICS AND VIEWS OF THE HELPING SYSTEM (Includes information from the family and information obtained from collateral contacts).

Services Utilized by the Family (Past, Present and their view of the family problems/concerns):
(Description of services the family has been involved with in the past and present. Include whether these services benefited the family and were effective. Include perceptions by both provider and family. May also include support received by non-traditional services/supports (faith-based organizations).

Child(ren) Characteristics (Interests, Conflicts, Behaviors, Special Talents, Disabilities):
(For each child in the family describe their interests, special talents, behavioral health issues, whether the parents struggle with child's behavior in the home, and developmental concerns, emotional/physical disabilities, criminal involvement, substance abuse, medical issues/concerns etc.).

Educational Promise (Attendance, Grades, Parent Involvement, Needs):
(Educational information for each child - are children functioning at grade level? Any concerns regarding school attendance? Are children receiving special education services? Are parents involved in the child's education - do they attend parent/teacher conferences, are parents/teachers working together to support child?)

Parental Chemical Health (Includes History and Needs Re: Substance Use, Abuse, Treatment and benefits):
(Include current or past history of substance abuse of parents/guardians, current/past treatment interventions, benefit/effectiveness of prior treatment. If current concerns, assess impact on family functioning/care of children and how these concerns are being addressed? Include dates of contact with providers and summarize information).

Behavioral and Physical Health of the Parents (Includes History and Needs Re: Diagnosis and Treatment), Physical Disabilities, Cognitive Functioning, Suicide - ideation/gestures/attempts):
(Include mental health and medical information in this section for parents/guardians and assess for impact on family. Include use of prescription medication and whether they appear to be addressing concerns. Includes dates of contact with providers and summarize information).

Past Trauma (Include Parent/child - impact on self, others and how they believe others view them):
(Include trauma history for all family members. How did the family cope? Assess impact of trauma on current family functioning.)

Domestic Violence (Includes Past, Present and Safety):
(Include past/current domestic violence history, arrests, restraining/protective orders, current safety concerns for survivor/children, impact of domestic violence on children/family. Identify patterns of coercive control by the perpetrator and safety planning efforts of survivor to address behaviors).

CONCLUSION

SDM Risk Assessment:
(Final Risk Level)

Child and Family Team Meeting Outcomes:
(Document efforts to engage the family in this process and whether meeting(s) occurred. Document supports present and summarize plan to address needs/concerns).

Internal/External Consultations (RRG, Individual or Group Supervision, community):
(Document RRG, Legal, Managerial consults)

Summary, Recommendations and Continuing Service Needs:
(Summarize FAR activity which includes information around safety, risk, and needs of the family, services/supports currently involved with the family, referrals made on behalf of the family, the family's response to DCF intervention, unmet needs, recommendations and case disposition.

Be sure to document all barriers/rationale for decisions made throughout the Family Assessment Response in the protocol.

DCF-3013 State Of Connecticut (03/2012 New)

FAMILY ASSESSMENT RESPONSE SERVICE PLAN

Family Name: LINK Case: ###### Plan Approval:
Worker Name: Office: Worker Phone: ( )

What needs has the family identified?

What are the family strengths, resources and supports?

What do we want to happen (goals)?

What are the steps to make this happen and by when (Family, DCF, Community Provider)?

How will the goals and steps strengthen family well-being?

SIGNATURES

By signing, I understand and have helped develop this plan. I have been given a copy.

SIGNATURES	
Parent:	Date:
Parent:	Date:
Child/Youth	Date:
Social Work Supervisor:	Date:
Social Worker:	Date:
Other Interested Party:	Date:
Other Interested Party:	Date:

Structured Decision Making®
Policy and Procedures Manual

Manual Date:
March 2008
(Updated March 21, 2008)

Connecticut
Department of Children and Families

Children's Research Center
426 S. Yellowstone Drive, Suite 250
Madison, WI 53719
(608) 831-1180 fax (608) 831-6446
www.nccd-crc.org

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STRUCTURED DECISION MAKING® SYSTEM GOALS

Structured Decision Making® Goals

1. **Reduce subsequent maltreatment to children and families**.

    a. Reduce subsequent referrals
    b. Reduce subsequent substantiations
    c. Reduce subsequent injuries
    d. Reduce subsequent foster placements

2. **Expedite permanency for children**.

Structured Decision Making® Objectives

1. Identify **critical decision points**.

2. Increase **reliability** of decisions.

3. Increase **validity** of decisions.

4. **Target resources** to families at **highest risk**.

5. **Use case level data** to inform decisions throughout the agency.

Critical Characteristics of the Structured Decision Making® System

Reliability: Structured assessment tools and protocols systematically focus on the critical decision points in the life of a case, increasing worker consistency in assessment and case planning. Families are assessed more objectively, and decision making is guided by facts of the case, rather than by individual judgment.

Validity: Research repeatedly demonstrates the model's effectiveness at reducing subsequent abuse/neglect, as evidenced by reduced rates of subsequent referrals, substantiations, injuries to children, and placements in foster care. The cornerstone of the model is the actuarial research-based risk assessment that accurately classifies families according to the likelihood of subsequent maltreatment, enabling agencies to target services to families at highest risk.

Equity: Structured Decision Making® (SDM) assessment tools ensure that critical case characteristics, safety factors, and domains of family functioning are assessed for every family, every time, regardless of social differences. Detailed definitions for assessment items increase the likelihood that workers assess all families using a similar framework. Research demonstrates racial equity of the risk assessment tool in classifying families across risk levels. The reunification assessment tool has demonstrated expedited permanency for children, regardless of race.

Utility: The model and its tools are easy to use and understand. Assessment tools are designed to focus on critical characteristics that are necessary and relevant to a specific decision point in the life of a case. Use of the tools provides workers with a means to focus the information gathering and assessment process. By focusing on critical characteristics, workers are able to organize case narrative in a meaningful way. Additionally, the tools facilitate communication between worker and supervisor, and unit to unit, about each family and the status of the case. Aggregate data facilitates communication among community partners and stakeholders.

OVERVIEW OF STRUCTURED DECISION MAKING® POLICY AND PROCEDURES

ASSESSMENT TOOL/ DECISION GUIDELINE	WHICH CASES	BY WHOM	WHEN	DECISIONS
Screening Criteria	All reports of child abuse and neglect.	Hotline worker	No later than end of worker's shift.	Determines whether reports meet criteria for CPS investigation.
Response Priority	All CPS reports accepted for investigation, including new referrals on existing cases.	Hotline worker	Upon completion of the screening tool.	Determines how quickly an investigation must be initiated.
Safety Assessment Investigation	All CA/N investigations of parent(s), guardian(s), and other adult household member(s) including new investigations on existing cases.	Investigation worker	For investigations during the initial home visit – documented within five working days.	Identifies safety factors, interventions, and/or plans that guide the decision to remove or return a child.
Existing Cases	All existing CPS cases.	Treatment worker	For existing cases whenever safety factors are identified, documented within five working days.	Identifies safety factors, interventions, and/or plans that guide the decision to remove or return a child.
Risk Assessment	All CPS investigations of parent(s), guardian(s), and/or other adult household member(s) including new investigations on existing cases.	Investigation worker	At end of investigation.	Estimates the likelihood of future maltreatment and informs the transfer/close decision.
Case Decision Matrix	All initial CA/N investigations of parent(s), guardian(s), and/or other adult household member(s).	Investigation worker	At the completion of the risk assessment.	Guides the case open or close decision.
	All in-home CPS treatment cases.	Treatment worker	At the completion of risk reassessment.	Guides the case open or close decision.
Family Strengths and Needs Assessment Child Strengths and Needs Assessment	All CPS treatment cases.	Treatment worker	X Prior to the development of the initial treatment plan, which is within 45 days of investigation disposition for in-home cases. X Within 45 days following placement.	Guides treatment plan objectives and services.
Risk Reassessment	All CPS treatment cases where all children remain in or have been returned to the home.	Treatment worker	90 days following the initial treatment plan and every 90 days thereafter.	Guides the decision to close case or continue to serve.
Family Reunification Assessment Packet (i.e., risk, visitation, and safety assessment/reassessment)	All CPS treatment cases where any child is in out-of-home placement with a goal of "reunification."	Treatment worker	X 90 days following the initial treatment plan and every 90 days thereafter. X Whenever a child is being considered for reunification.	Guides the decision to reunify, maintain reunification services, or change the permanency plan goal.
Family Strengths and Needs Reassessment Child Strengths and Needs Reassessment	All CPS treatment cases.	Treatment worker	In conjunction with every risk reassessment or reunification assessment.	Assesses progress and informs further treatment planning decisions.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 03-08
SDM® CHILD ABUSE AND NEGLECT SCREENING CRITERIA

Case Name: _____ **LINK #:** _____ **Report Time:** ____:____ a.m./p.m.

Area Office: _____ **Worker:** _____ **Report Date:** ____/____/____

SECTION 1: MALTREATMENT TYPE

(Refer to definitions for additional examples of maltreatment.)

ABUSE

Physical Abuse

- ❑ Non-accidental physical injury.
- ❑ Injury at variance with history given.
- ❑ Medical abuse.
- ❑ Old, healed, or healing injuries that have gone untreated and appear suspicious as reported by a medical professional.
- ❑ Excessive or cruel punishment that is likely to cause serious physical injury.

Sexual Abuse and Exploitation

- ❑ Non-accidental incident of or exposure to sexual behavior.
- ❑ Sexual exploitation or online enticement.
- ❑ Grooming.
- ❑ Physical, behavioral, or suspicious indicators consistent with sexual abuse are reported regardless of disclosure.

Emotional Maltreatment/Abuse

- ❑ Act(s), statement(s), or threat(s) that have had or are likely to have an adverse impact on the child or interfere with a child's positive emotional development.

NEGLECT

Physical Neglect

- ❑ Abandonment.
- ❑ Action or inaction resulting in death.
- ❑ Action or inaction resulting in failure to thrive.
- ❑ Child is denied proper physical care and attention (mark all that apply).
  - ❑ Inadequate clothing or hygiene
  - ❑ Inadequate food/nutrition or malnutrition
  - ❑ Inadequate supervision
  - ❑ Inadequate shelter
- ❑ Erratic, deviant, or impaired behavior by the caregiver with adverse impact on the child.

Medical Neglect

- ❑ The unreasonable delay, refusal, or failure on the part of the caregiver to seek, obtain, and/or maintain necessary medical, dental, or mental health care.

Educational Neglect

- ❑ Caregiver fails to register for school a child five years of age and older and under 18 years of age who is not a high school graduate.
- ❑ Caregiver fails to allow the child to attend school or receive home instruction.
- ❑ Caregiver fails to take appropriate steps to ensure regular attendance at school if the child is registered.

Emotional Neglect

- ❑ The denial of proper care and attention, or failure to respond, to a child's affective needs that has an adverse impact on the child or seriously interferes with a child's positive emotional development.

- ❑ Child displays indicators of emotional distress related to living conditions, circumstances, or associations injurious to his/her well-being.

  - ❑ Substance abuse by caregiver
  - ❑ Psychiatric problem of caregiver
  - ❑ Exposure to family violence

Moral Neglect

- ❑ Exposing, allowing, or encouraging the child to engage in illegal or reprehensible activities by the caregiver.

SECTION 2: SCREENING DECISION

❑ Accepted as Child Abuse/Neglect (CA/N)

- ❑ Allegations against parent(s), guardian(s), and/or other adult household member(s).
- ❑ Allegations against other entrusted person or party, e.g., foster parent, daycare, residential, group home staff, etc. (Do not use SDM safety and risk assessment tools for these investigations.)

❑ Not accepted as CA/N.

❑ Accepted pended (i.e., Safe Haven Act).

Comments: _____

_____

_____

_____

_____

_____

Worker Signature: _____ **Date:** ___/___/____

If not accepted:

Supervisor Signature: _____ **Date:** ___/___/____

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® CHILD ABUSE AND NEGLECT SCREENING CRITERIA
DEFINITIONS

GENERAL DEFINITIONS

Child refers to any person under 18 years of age *or* under 21 years of age and in Department of Children and Families (DCF) care.

Only for purposes of completing the screening tool, a "caregiver" is considered to be any one of the following persons:

X A person responsible for a child's health, welfare, or care means the child's parent; guardian; foster parent; an employee of a public or private residential home, agency, or institution, or other person legally responsible under state law for the child's welfare in a residential setting; or any staff person providing out-of-home care, including center-based child daycare, family daycare, or group daycare;

X A person given access to a child is a person who is permitted to have personal interaction with a child by the person responsible for the child's health, welfare, or care or by a person entrusted with the care of a child.

X A person entrusted with the care of a child is a person who is given access to a child by a person responsible for the health, welfare, or care of a child for the purpose of providing education, child care, counseling, spiritual guidance, coaching, training, instruction, tutoring, or mentoring.

Serious injury is any significant impairment of a person's physical condition as determined by qualified medical personnel. This includes, but is not limited to, burns (rug/carpet burns are not considered serious injuries), lacerations, bone fractures, substantial hematomas (severe bruises), and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Only a child as defined above may be classified as a victim of abuse and/or neglect.

Only a person responsible, a person given access, or a person entrusted as defined above may be classified as a perpetrator of child abuse and/or neglect.

SECTION 1: MALTREATMENT TYPE

The following operational definitions are working definitions and examples of child abuse and neglect.

ABUSE

Physical Abuse

X A non-accidental physical injury to a child is one that, regardless of motive, is inflicted or allowed to be inflicted by the caregiver. If the reporter does not know how a reported injury was caused, consider the allegation to be a non-accidental injury. If the reporter does not know whether the caregiver's behavior resulted in an injury, do not mark as injury. Exclude injuries that result from a domestic violence incident (recorded under Physical Neglect) and injuries that result from sexual acts (recorded under Sexual Abuse). Injuries include but are not limited to the following:

- < Bruises, scratches, or lacerations;
- < Burns and/or scalds (reddening or blistering of the tissue through application of heat by fire, chemical substances, cigarettes, matches, electricity, scalding water, friction, etc.);
- < Injuries to bone, muscle, cartilage, ligaments (fractures, dislocations, sprains, strains, displacements, hematomas, etc.);
- < Head injuries;
- < Internal injuries; or
- < Death

X An injury at variance with history given includes situations that are inconsistent with the caregiver's explanation and/or those that are unlikely to have been caused by accident.

X Medical abuse includes circumstances in which medical treatments or therapies are misused, as diagnosed by a medical or mental health professional.

X Old, healed, or healing injuries that have gone untreated and appear suspicious as reported by a medical professional may include head injuries, bruises, scratches, lacerations, internal injuries, burns, scalds, fractures, dislocations, sprains, strains, displacements, and hematomas. Also include unrelated soft tissue bruises, lacerations, or scars that are in different stages of healing (so that they could not have occurred in the same incident).

X Excessive or cruel punishment that is likely to cause serious physical injury includes situations in which the caregiver is responding to and attempting to correct the behavior of the child but uses physical discipline that is age-inappropriate and/or bears

no resemblance to reasonable discipline. Examples include use of torture, suffocation, immersion in scalding water, tying up child, locking child in closet, or the use of dangerous objects (e.g., whips) to strike child.

Sexual Abuse and Exploitation

X Non-accidental incident of or exposure to sexual behavior includes but is not limited to the following, whether or not a specific offender is identified:

- < rape;
- < penetration (digital, penile, or foreign object);
- < oral/genital contact;
- < indecent exposure for the purpose of sexual gratification of the offender or for purposes of shaming, humiliating, shocking, or exerting control over the victim;
- < incest;
- < fondling, including kissing, for the purpose of sexual gratification of the offender or for purposes of shaming, humiliating, shocking, or exerting control over the victim;
- < coercing or forcing a child to participate in or be negligently exposed to pornography and/or sexual behavior.

X Sexual exploitation of a child includes possession, manufacture, or distribution of child pornography. Online enticement includes online solicitation of a child for sexual acts, child prostitution, or child-sex tourism; unsolicited obscene material sent to a child; or a misleading domain name likely to attract a child to an inappropriate website.

X Grooming includes verbal, written, or physical behavior not overtly sexual but likely designed to prepare a child for future sexual abuse. It includes a deliberate and escalating pattern of actions taken to lower a child's inhibitions in preparation for sexual abuse (e.g., treating the child as "more special" than other children, talking about sexual topics that are age-inappropriate, escalating touching from innocent to inappropriate, and "accidental" self-exposure by the caregiver).

X Physical, behavioral or suspicious indicators consistent with sexual abuse are reported regardless of disclosure. Evidence of such includes but is not limited to the following:

- < diagnosis of a child with a disease or condition that arises from sexual transmission; or

< sexual acting out by the child in age- and/or developmentally inappropriate ways.

Emotional Maltreatment/Abuse

X Act(s), statement(s), or threat(s) that have had or are likely to have an adverse impact on the child or interfere with a child's positive emotional development. The adverse impact may result from a single event or from a consistent pattern of behavior, and may be currently observed and/or predicted as supported by evidence-based practice. Types of emotional maltreatment/abuse include, but are not limited to the following:

< rejecting and/or degrading the child;

< isolating and/or victimizing the child by means of cruel, unusual, or excessive methods of discipline; or

< exposing the child to brutal or intimidating acts or statements, including exposure to family violence.

Whether or not the adverse impact has to be evident is a function of the child's age, cognitive abilities, verbal ability, and developmental level. Adverse impact is not required if the action/inaction is a single incident which demonstrates a **serious** disregard for the child's welfare.

Indicators of adverse impact of emotional abuse may include but are not limited to the following:

X depression;
X withdrawal;
X low self-esteem;
X anxiety;
X fear;
X aggression/passivity;
X emotional instability;
X sleep disturbances;
X somatic complaints with no medical basis;
X inappropriate behavior for age or development;
X suicidal ideations or attempts;
X extreme dependence;
X academic regression; or
X trust issues.

NEGLECT

Physical Neglect

Physical neglect is the failure, whether intentional or not, of the person responsible for the child's health, welfare, or care; of the person given access to the child; or of the person entrusted with the child's care to provide and maintain adequate food, clothing, supervision, and safety for the child.

X Abandonment. A child has been abandoned. Examples of abandonment include but are not limited to the following:

< The caregiver left a child unattended, the child is unable to identify him/herself, and, there is no evidence with which to identify the child's family.

< There is evidence that the parent will not assume further responsibility for the child and/or parent did not intend for the child to survive (e.g., infant left in a dumpster).

< The caregiver left a child in the full-time care of an adult, but the caregiver has failed to arrange for the child's financial support to meet his/her basic needs or has failed to provide the child with emotional support, including direct contact with the child and direct contact with the caregiver.

< It is not known where the caregiver is or approximately when the caregiver will return.

X Action or inaction resulting in death.

X Action or inaction resulting in failure to thrive.

X Child is denied proper physical care and attention. Child's living conditions, circumstances, or associations are injurious to his/her well-being because the child is denied proper physical care and attention as defined by any of the following:

< Inadequate clothing or hygiene: Caregiver has failed to meet a child's basic needs for clothing and/or hygiene to the extent the child's daily activities are adversely impacted, or there are medical consequences (e.g., sores, infection, physical illness, serious harm, hypothermia, or frostbite).

< Inadequate food/nutrition or malnutrition: Caregiver left a child without food for an unreasonable period of time, considering the child's age or physical needs, or the child is malnourished (as supported by medical opinion) as a result of acts of commission or omission by a caregiver.

< Inadequate supervision: Caregiver voluntarily and knowingly entrusts the care of a child to individuals who may be disqualified to provide safe care, (e.g., persons who are subject to active protection or restraining orders, persons with past history of violent/drug/sex crimes, persons appearing on the Central Registry, persons who do not/cannot respond to the child's need for supervision); and/or given the child's age and cognitive abilities, the caregiver fails to provide reasonable and proper supervision, allows a child to be alone for an excessive period of time, or holds the child responsible for the care of siblings or others.

< Inadequate shelter: Caregiver is unable or unwilling to provide basic shelter for the child, or the child's home environment contains hazards that could lead to injury or illness of the child if not resolved. Examples of such hazards include exposed heaters, gas fumes, faulty electrical wiring, no utilities (e.g.,

heat, water, electricity), no working toilet, broken windows or stairs, vermin, human or animal excrement, unguarded weapons, and accessible drugs or hazardous chemicals. Transience is also considered inadequate shelter.

Findings of inadequate food, clothing, or shelter or transience must be related to caregiver acts of omission or commission and not simply a function of poverty alone.

X Erratic, deviant, or impaired behavior by the caregiver with adverse impact on the child due to any of the following:

< Substance abuse by the caregiver: Caregiver's use of substances impairs his/her ability to meet the child's needs for safety and well-being OR substance abuse by the mother of a newborn child AND the newborn has a positive urine or meconium toxicology for drugs.

< Drug trafficking or illegal drug use: Caregiver exposes the child to drug trafficking in the home and/or individuals engaged in the active abuse of illegal substances.

< Psychiatric problem of the caregiver: Caregiver has a mental health issue that impairs his/her ability to meet the child's needs for safety and well-being.

< Exposure to family violence or violent events/situations/persons that would be reasonably judged to compromise a child's physical safety.

(Note: Whether or not the adverse impact has to be demonstrated is a function of the child's age, cognitive abilities, verbal ability, and developmental level. Adverse impact may not be required if the action/inaction is a single incident that demonstrates a **serious** disregard for the child's welfare.)

Medical Neglect

X The unreasonable delay, refusal, or failure on the part of the caregiver to seek, obtain, and/or maintain necessary medical, dental, or mental health care when caregiver knows, or should reasonably be expected to know, that such actions may have an adverse impact on the child. Such actions may include but are not limited to the following:

< Frequently missed appointments, therapies, or other necessary medical and/or mental health treatments.

< Withholding or failing to obtain or maintain medically necessary treatment for a child with life-threatening, acute, or chronic medical or mental health conditions.

< Withholding medically indicated treatment from disabled infants with life-threatening conditions.

(Note: Failure to provide the child with immunizations or routine well-child care in and of itself does not constitute medical neglect.)

Educational Neglect

Except as noted below, educational neglect occurs when, by action or inaction, the parent or person having control of a child five years of age and older and under 18 years of age who is not a high school graduate:

X Fails to register the child for school.

X Fails to allow the child to attend school or receive home instruction in accordance with Conn. Gen. Stat. §10-184.

X Fails to take appropriate steps to ensure regular attendance at school if the child is registered.

Exceptions (in accordance with Conn. Gen. Stat. §10-184):
A parent or person having control of a child may exercise the option of not sending the child to school at age five or age six years by personally appearing at the school district office and signing an option form. In these cases, educational neglect occurs if the parent or person having control of the child has registered the child at age five or age six years and then does not allow the child to attend school or receive home instruction.

Failure to sign a registration option form for such a child is not in and of itself educational neglect.

A parent or person having control of a child 16 or 17 years of age may consent to such child's withdrawal from school. Such parent or person shall personally appear at the school district office and sign a withdrawal form.

Emotional Neglect

X The denial of proper care and attention, or failure to respond, to a child's affective needs by the caregiver that has an adverse impact on the child or seriously interferes with a child's emotional development. Examples include but are not limited to the following:

- Having inappropriate expectations of the child given the child's developmental level.
- Failure to provide the child with appropriate support, attention, and affection.

X Child displays indicators of emotional distress related to living conditions, circumstances, or associations injurious to his/her well-being, including but not limited to the following:

- Substance abuse by caregiver that adversely impacts the child emotionally;
- Psychiatric problem of caregiver: The caregiver has a mental health issue that adversely impacts the child emotionally.

< Exposure to family violence that adversely impacts the child emotionally.

Whether or not the adverse impact has to be demonstrated is a function of the child's age, cognitive abilities, verbal ability, and developmental level. Adverse impact is not required if the action/inaction is a single incident that demonstrates a **serious** disregard for the child's welfare.

Indicators include but are not limited to the following:

X depression
X withdrawal
X low self-esteem
X anxiety
X fear
X aggression/passivity
X emotional instability
X sleep disturbances
X somatic complaints with no medical basis
X inappropriate behavior for age or development
X suicidal ideations or attempts
X extreme dependence
X academic regression
X trust issues

Moral Neglect

X Exposing, allowing, or encouraging the child to engage in illegal or reprehensible activities by the caregiver. Evidence of moral neglect includes but is not limited to the following:

< stealing;

< using drugs and/or alcohol;

< involving a child in the commission of a crime, directly or by caregiver indifference.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES SDM® CHILD ABUSE AND NEGLECT SCREENING CRITERIA POLICY AND PROCEDURES

The purpose of the child abuse and neglect screening tool is to assess whether a CPS report meets agency criteria for a child abuse or neglect (CA/N) investigation.

Which Cases: The child abuse/neglect screening criteria is completed on all reports of CA/N. This includes telephone and all other means of report; it also includes new reports of child abuse and neglect on open cases.

Who: The hotline worker.

When: The screening tool is completed as soon as possible, as part of processing the report, but no later than the end of the worker's shift. Non-accepted reports must be approved by a supervisor before the end of the hotline worker's shift.

Decisions: The child abuse and neglect screening criteria tool guides whether a report requires a child protective services (CPS) field investigation. (Note: The SDM screening and response priority tools are the only SDM tools to be used for CA/N referrals against "other persons or parties." SDM safety and risk assessment tools are ONLY used when investigating parent[s], guardian[s], and/or other adult household member[s] and not when investigating other persons or parties.)

Appropriate Completion: Mark all the criteria alleged for each maltreatment type. The hotline worker makes the screening decision. Reports that do not meet any of the screening criteria should not be accepted for CPS field investigation. Supervisors will review, approve, and/or revise all reports that are **NOT** accepted for a CPS investigation. These reviews will be completed by the end of the hotline worker's shift.

Area office investigative supervisors can request that an accepted CPS report be downgraded to "not accepted" status by contacting a hotline supervisor. Only a hotline supervisor can reverse an initial decision to accept a report for a CPS investigation. A request for a downgrade can only be made on the same day if the hotline accepts a report during regular business hours. If a report is accepted by the hotline after regular business hours or on a weekend, the area office can make its request for a downgrade the next business day. A hotline supervisor will make a final decision on the same day as the request.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 03-08
SDM® RESPONSE PRIORITY

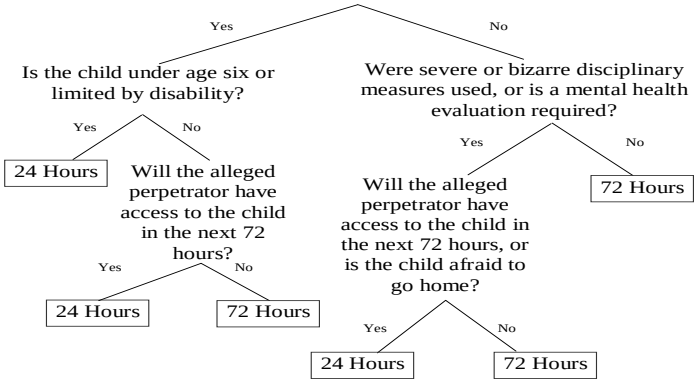
Case Name: _____ **LINK #:** _____ **Report Time:** ____:____ a.m./p.m.

Area Office: _____ **Worker:** _____ **Report Date:** ____/____/____

Current Report – Complete for each maltreatment type

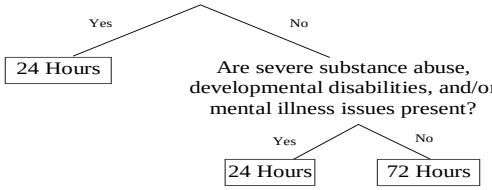
PHYSICAL/EMOTIONAL ABUSE

Are significant bruises, contusions, or burns evident, <u>or</u> is medical/mental health care required?



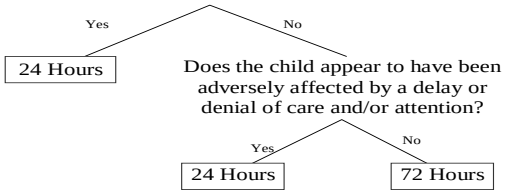
PHYSICAL NEGLECT

Is the living situation immediately dangerous and/or unhealthy, and/or is any child currently left unsupervised who is under age eight and/or limited by disability?



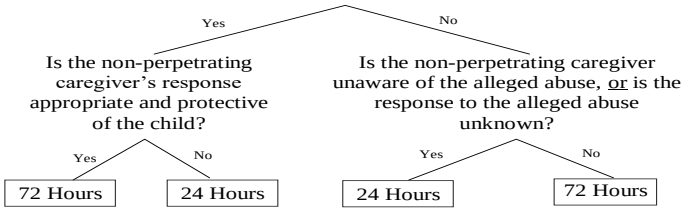
MEDICAL/EMOTIONAL/MORAL/EDUCATIONAL NEGLECT

Does the child appear seriously ill or injured, <u>or</u> is the child in need of immediate care or attention?



SEXUAL ABUSE

Does the alleged perpetrator have access to the child, <u>or</u> is the child afraid to go home?



Indicated Response (select one):
- ❑ 24 Hours
- ❑ 72 Hours

Policy Overrides:

Increase to Same Day whenever:
- ❑ Situations in which failure to respond immediately could result in death of, or serious injury to, a child
- ❑ Reports of abuse from a school when a child reports fear and/or has evidence of injury
- ❑ Law enforcement requires an immediate response

Increase to 24 Hours whenever:
- ❑ Forensic considerations would be compromised by slower response
- ❑ There is reason to believe that the family may flee

Decrease to 72 Hours whenever:
- ❑ Child safety requires a strategically slower response
- ❑ The child is in, and will likely remain in, an alternative safe environment for at least 72 hours
- ❑ The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period

Discretionary Override:
- ❑ Increase response level
- ❑ Decrease response level

Reason for Override: _____

Final Response (select one):
- ❑ Same Day
- ❑ 24 Hours
- ❑ 72 Hours

Hotline Worker: _____ Date: ____/____/____

Supervisor Approval: _____ Date: ____/____/____

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® RESPONSE PRIORITY
DEFINITIONS

PHYSICAL/EMOTIONAL ABUSE

Are significant bruises, contusions, or burns evident, *or* is medical/mental health care required?

X Are there visible signs of abuse apparent, such as bruises, welts, abrasions, lacerations, old scars/marks, including healing wounds?

X Are there possible internal injuries/broken bones/fractures?

X Significant injuries may include the presence of multiple bruises, contusions, or burns; swelling; or injuries to the torso, lower back, head, or other parts of the body not commonly prone to injuries of an accidental nature.

X Is there any physical evidence suggesting the child has been hit with an object or instrument (e.g., hammer, board, extension cord, etc.), placed in restraints, had chemicals put in the eyes, etc.?

X Are there apparent burns requiring medical treatment or evaluation? Is the child experiencing physical pain or serious discomfort due to suspected injuries? This does not include a child who has already received medical attention.

X Is there evidence of adverse impact or serious interference with a child's functioning due to an action(s) or threat(s) by the caregiver that would warrant immediate mental health treatment?

Is the child under age six *or* is the child limited by disability?
Is any child under age six, or does any child have a physical, mental, or cognitive disability that increases his/her vulnerability?

Will the alleged perpetrator have access to the child in the next 72 hours, *or* is the child afraid to go home?
Within the next 72 hours, is there reason to believe that the alleged offender will have unsupervised in-person contact, including visitation, with the child?

Is the child expressing fear of returning to the home at this time? The child exhibits behavioral indicators of fear.

Were severe or bizarre disciplinary measures used, *or* is a mental health evaluation required?
Examples include use of restraints, torture, or punishment that goes beyond the child's endurance.

Is there evidence of adverse impact or interference with the child's functioning due to an action(s) or threat(s) by a caregiver that would warrant an immediate mental health evaluation?

PHYSICAL NEGLECT

Is the living situation immediately dangerous and/or unhealthy, *and/or* is any child currently left unsupervised who is under age eight *and/or* is any child limited by disability?
Is any child under age eight? Is there any child limited by disability who is currently unsupervised? Based on the child's age and developmental status, is the home situation immediately dangerous or unhealthy? Examples include the following:

X Leaking gas from stove or heating unit.

X No food in the home or indications that the child is not being fed.

X Substances or objects accessible to the child that may endanger health/safety.

X Lack of water or utilities (heat, plumbing, electricity) and no alternate safe provisions made.

X Open/broken/missing windows/screens.

X Exposed electrical wires.

X Excessive garbage or rotted or spoiled food that threatens health.

X Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).

X Evidence of human or animal waste in the living quarters.

X Guns and other weapons are not locked.

Based on local community standards, the child is not receiving appropriate supervision from his/her caregiver and there is no appropriate alternative plan for supervision. Examples include the following:

X The child is currently alone (time period varies with age and developmental status).

X The caregiver does not attend to the child, so that care goes unnoticed or unmet (e.g., caregiver is present, but the child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards; a child with some suicidal ideation is not closely monitored; caregiver substance abuse impairs his/her ability to provide adequate supervision).

X The child is presently receiving inadequate and/or inappropriate childcare arrangements (e.g., a ten-year-old who supervises four children under the age of five all day).

Are severe substance abuse, developmental disabilities, and/or mental illness issues present?
Are issues related to alcohol or other drug abuse, developmental disabilities, and/or mental illness a factor in the current report and alleged to be an immediate concern related to the safety of the child?

MEDICAL/EMOTIONAL/MORAL/EDUCATIONAL NEGLECT

Does the child appear seriously ill or injured, *or* is the child in need of immediate care or attention?
Does the child require immediate medical treatment and/or hospitalization? This includes failure to thrive or caregiver refusal to treat a serious or significant injury/condition.

Is the child in need of mental health treatment or evaluation that the caregiver is unwilling to obtain, which may be indicated by the following: suicidal threats or attempts; severe emotional disorders, and/or exhibiting behavior dangerous to self or others?

Does the child appear to have been adversely affected by a delay or denial of care and/or attention, *or* has the child been encouraged to engage in illegal activity?
Does the child have a chronic illness or condition that does not pose a life-threatening safety concern at the present time, but the caregiver is unwilling to obtain/maintain treatment?

Does the child appear to have been adversely impacted by the denial of proper care and attention, or is there failure to respond to a child's affective needs by the caregiver?

Has the child been encouraged to engage in illegal activities such as but not limited to stealing, and/or using drugs and/or alcohol by the caregiver?

SEXUAL ABUSE

Does the alleged perpetrator have access to the child, *or* is the child afraid to go home?
Does the alleged offender live in the home or have immediate access to the child?

Is the child expressing fear of returning to the home at this time? The child exhibits behavioral indicators of fear.

Is the non-perpetrating caregiver's response appropriate and protective of the child?
Is the non-offending caregiver supporting the child's disclosure and demonstrating the ability to prevent the perpetrator from having access to the child? Will the non-offending caregiver not pressure the child to change his/her statement? Will the non-offending caregiver obtain medical treatment for the child if needed?

Is the non-perpetrating caregiver unaware of the alleged abuse, *or* is the response to the alleged abuse unknown?
Is the non-perpetrating caregiver not aware that sexual abuse has been alleged, or is the non-perpetrating caregiver's response to the alleged sexual abuse unknown?

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® RESPONSE PRIORITY
POLICY AND PROCEDURES

The purpose of the response priority decision trees is to assess how quickly a CPS investigation must be initiated. The decision trees structure this analysis to determine a response priority level.

Which Cases: The response priority decision trees are completed on every new CPS report that is assigned for investigation. This includes telephone and all other means of report; it also includes reports accepted for investigation on existing cases.

Who: The hotline worker.

When: The response priority process is completed immediately upon completion of the SDM screening tool for all reports accepted for a CPS investigation.

Decision: Response priority decision trees guide how quickly an investigation must be initiated. Response times are "24 Hours" and "72 Hours."

Hotline workers will continue the practice of notifying the area office of policy overrides to "Same Day" and/or "24 Hours" responses that require immediate review.

The time the report is accepted for investigation is used as the start time for monitoring compliance with the required response time.

Appropriate Completion: Until further notice, complete the four decision trees for every report accepted for investigation whether an allegation has been made related to that maltreatment type or not. There is only one exception: whenever you reach a decision of 24 Hours, you do not need to answer any further questions or complete any further trees.

Start by answering the first question asked at the top of the alleged maltreatment decision tree. Each answer will lead to a follow-up question or an indicated response time. Continue with any other trees where an allegation exists.

Whenever you complete decision trees where there is no reported allegation, answer no to the first two questions until you get a 72 Hours response. **You should never have a decision of 24 Hours for an allegation type that was not alleged by the reporter and documented at the time of screening.**

Select the indicated response time by marking the highest priority response time recommended by the decision trees.

Overrides

The decision trees are designed to guide decisions, not to replace worker judgment. If, after consultation with the supervisor, it is agreed that appropriate completion of the trees leads to a decision that does not apply to a particular case due to unique circumstances not captured by the tool, or because critical information is unknown, an alternate decision using policy or discretionary overrides may be made.

Policy Overrides

Certain conditions have been determined to require an immediate response regardless of the maltreatment type. If any such circumstances exist, the hotline worker should mark the appropriate policy override reason.

Increase to Same Day whenever:

X A situation exists in which failure to respond immediately could result in death of, or serious injury to, a child.

X There are reports of abuse from a school when a child reports fear and/or has evidence of injury.

X Law enforcement requires an immediate response.

Increase to 24 Hours whenever:

X Forensic considerations would be compromised by slower response.

X There is reason to believe that the family may flee.

Decrease to 72 Hours whenever:

X Child safety requires a strategically slower response.

X The child is in, and will likely remain in, an alternative safe environment for at least 72 hours.

X The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period.

Discretionary Overrides

Occasionally there will be unique circumstances not captured within the questions and definitions of the decision trees. The hotline worker may select a response priority different from that indicated by the decision trees to provide a higher or lower response priority. Note that an override may be necessary when critical information needed to assess the case is unknown. **The worker should respond in the most protective way.** The hotline

worker should check "Increase response level" or "Decrease response level" and indicate the reason a discretionary override has been exercised.

All overrides must be approved by a supervisor. Supervisors approve and document the reason for the override.

Indicate the final response by marking one answer. If an override was exercised, the final response will differ from the indicated response. If no override was used, the indicated and the final response will be the same.

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CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 1/07
SDM® SAFETY ASSESSMENT

Case Name: _____ **LINK #:** _____ **Household Assessed:** _____

Area Office: _____ **Worker:** _____ **Assessment Date:** ____/____/____

Assessment Type: ❑ Initial ❑ Subsequent

SECTION 1: SAFETY FACTORS

The following factors are behaviors or conditions that may be associated with a child being in immediate danger of serious harm. Identify the presence or absence of each factor by checking either "yes" or "no." **Note: The vulnerability of each child needs to be considered throughout the assessment. Children ages zero through six cannot protect themselves. For older children, inability to protect themselves could result from diminished mental or physical capacity or repeated victimization.**

Yes	No		
❑	❑	1.	Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation indicated by: ❑ Serious injury or abuse to the child other than accidental. ❑ Caregiver fears he/she will maltreat the child. ❑ Threat to cause harm or retaliate against the child. ❑ Excessive discipline or physical force. ❑ Drug-exposed infant. ❑ Death of a child due to abuse/neglect.
❑	❑	2.	Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern.
❑	❑	3.	Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
❑	❑	4.	Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.
❑	❑	5.	The family refuses access to the child, or there is reason to believe that the family is about to flee.
❑	❑	6.	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
❑	❑	7.	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
❑	❑	8.	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
❑	❑	9.	Domestic violence exists in the home and poses a risk of serious physical and/or emotional harm to the child.
❑	❑	10.	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
❑	❑	11.	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
❑	❑	12.	There is a pattern of prior investigations or behavior AND current circumstances are near the threshold for any other safety factor.
❑	❑	13.	Other (specify): _____

IF NO SAFETY FACTORS ARE OBSERVED, PROCEED TO SECTION 3.

SECTION 2: SAFETY INTERVENTIONS

If no safety factors are present, go to Section 3. If one or more safety factors are present, consider whether safety interventions 1-8 will allow the child to remain in the home for the present time. Check the item number for all safety interventions that will be implemented. If there are no available safety interventions that would **allow the child to remain in the home**, indicate by checking item nine if the caregiver arranges for the care of the child outside of the home or intervention 10 if the child will be taken into protective custody.

Check all that apply:

Interventions that will enable the children to remain in the home for the present time:

- ❑ 1. Intervention or direct services by worker as part of a safety plan.
- ❑ 2. Use of family, neighbors, or other individuals in the community as safety resources.
- ❑ 3. Use of community agencies or services as safety resources.
- ❑ 4. Have the non-offending caregiver appropriately protect the victim from the alleged perpetrator.
- ❑ 5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
- ❑ 6. Have the non-offending caregiver move to a safe environment with the child.
- ❑ 7. Legal action planned or initiated—child remains in the home.
  - ❑ The family has initiated a legal action (e.g., restraining/protective orders, change in custody/visitation, mental health commitments) that mitigates identified safety factors.
  - ❑ The Department may have or will be filing neglect petitions in Juvenile Court based on identified safety factors. The decision to file petitions in and of itself is not an appropriate intervention to ensure the child's safety in the home.
- ❑ 8. Other (specify): _____

Intervention caregiver makes for the child to be cared for outside of the home:

- ❑ 9. Caregiver arranges for care of the child outside the home.

Intervention to remove a child from the home:

- ❑ 10. Child placed in protective custody because no interventions are available to adequately ensure the child's safety.

SECTION 3: SAFETY DECISION

Identify the safety decision by checking the appropriate box below. This decision should be based on the assessment of all safety factors, safety interventions, and any other information known about the case. Check one box only.

- ❑ 1. **Safe.** No safety factors were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- ❑ 2. **Conditionally Safe.** It has been determined that this child is at imminent risk of removal from the home and that reasonable efforts are being made to prevent the removal and that absent effective pre-placement preventive services, the plan is to place the child in foster care. One or more safety factors are present, and protecting safety interventions have been planned or taken. Based on protecting interventions, the child will remain in the home at this time or the caregiver has arranged for care of the child outside of his/her home as a protective intervention.
- ❑ 3. **Unsafe.** One or more safety factors are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in immediate danger of serious harm.
  - ❑ All children placed.
  - ❑ One or more children will be placed in protective custody, but others remain in the home.

Worker: _____ **Date:** ____/____/____

Supervisor: _____ **Date:** ____/____/____

SECTION 4: SAFETY PLAN

If any safety factors were identified on the safety assessment AND if any children will remain in the home, identify each safety factor and describe the safety plan which will be implemented to specifically address each identified safety factor(s). Describe who will do what and by when. Select one review date for the most acute activity, then update as needed.

Review Date: ____/____/____

Safety factor: _____

Parent/Guardian will do the following: _____

_____

_____

DCF will do the following: _____

_____

_____

Safety factor: _____

Parent/Guardian will do the following: _____

_____

_____

DCF will do the following: _____

_____

_____

Safety factor: _____

Parent/Guardian will do the following: _____

_____

_____

DCF will do the following: _____

_____

_____

Caregiver: _____ **Date:** ____/____/____

Caregiver: _____ **Date:** ____/____/____

Worker: _____ **Date:** ____/____/____

Supervisor: _____ **Date:** ____/____/____

Indicate date when a copy of the signed safety plan was or will be placed in the hard copy record. ____/____/____

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® SAFETY ASSESSMENT
DEFINITIONS

SECTION 1: SAFETY FACTORS

1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation indicated by:

X Serious injury or abuse to the child other than accidental – Caregiver caused serious injury defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child (e.g., poisoning, suffocating, shooting, serious bruises/welts, bite marks, choke marks) and requires medical treatment.

X Caregiver fears he/she will maltreat the child – and/or requests placement.

X Threat to cause harm or retaliate against the child – Threat of action that would result in serious harm; or household member plans to retaliate against child for CPS investigation.

X Excessive discipline or physical force – Caregiver has used torture, physical force, or acted in a way that bears no resemblance to reasonable discipline.

X Drug-exposed infant – E.g., drugs found in the child's system; infant is medically fragile as result of drug exposure; infant suffers adverse effects from introduction of drugs during pregnancy.

X Death of a child due to abuse/neglect – Caregiver caused or is suspected of causing death of a child due to abuse/neglect.

2. Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern.

Suspicion of sexual abuse may be based on indicators such as:

X The child discloses sexual abuse either verbally or behaviorally (e.g., age-inappropriate, sexualized behavior toward self or others).

X Medical findings consistent with sexual abuse.

X Caregiver or others given access to the child have been convicted, investigated, or accused of rape or sodomy or have had other sexual contact with the child.

X Caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing the child to observe sexual performances or activities).

3. Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.

X Caregiver fails to protect the child from serious harm or threatened harm as a result of physical abuse, neglect, or sexual abuse by other family members, other household members, or others having regular access to the child. Caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage.

X An individual with known violent criminal behavior/history resides in the home, or caregiver allows access to the child.

X An individual with known CPS history of substantiated abuse, sexual abuse, or prior children removed from his/her care resides in the home, or caregiver allows access to the child.

4. Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.

The injury requires medical evaluation AND:

X medical evaluation indicates injury is a result of abuse; caregiver denies or attributes injury to accidental causes; OR

X caregiver's explanation for the observed injury is inconsistent with the type of injury; OR

X caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child.

5. The family refuses access to the child, or there is reason to believe that the family is about to flee.

X Family currently refuses access to the child or cannot or will not provide the child's location.

X Family has removed the child from a hospital against medical advice to avoid investigation.

X Family has previously fled in response to a CPS investigation.

X Family has a history of keeping the child at home, away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.

X Caregiver intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

6. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

Supervision:

X Caregiver does not attend to the child to the extent that need for care goes unmet (e.g., caregiver is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).

X Caregiver leaves the child alone (time period varies with age and developmental stage).

X Caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).

X Caregiver makes inadequate and/or inappropriate baby-sitting or childcare arrangements or demonstrates very poor planning for the child's care.

Food:

X Nutritional needs of the child are not met, resulting in immediate danger to the child's health and/or safety.

X The child appears severely malnourished and in need of medical attention.

Clothing:

X Caregiver does not provide the child with adequate/appropriate clothing, compromising his/her health.

Medical Care:

X Caregiver does not seek treatment for the child's immediate, chronic, and/or life-threatening medical condition or does not follow prescribed treatment for such conditions.

X The child has exceptional needs, such as being medically complex, and caregiver does not or cannot meet these needs.

Mental Health Care:

X Caregiver is aware that the child has suicidal ideations and caregiver will not/cannot take protective action.

X The child exhibits serious emotional, behavioral, or physical symptoms that the caregiver fails to address.

7. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening including, but not limited to:

X Leaking gas from stove or heating unit.

X Substances or objects accessible to the child that may endanger his/her health and/or safety.

X Lack of water or utilities (heat, plumbing, electricity), and no alternate or safe provisions are made.

X Open/broken/missing windows/screens.

X Exposed electrical wires.

X Excessive garbage or rotted or spoiled food that threatens health.

X Serious illness or significant injury has occurred due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites).

X Evidence of human or animal waste throughout living quarters.

X Guns and other weapons are not locked.

X Sleeping arrangements and/or conditions that pose an immediate threat to the health or safety of the child.

X An insufficient, inaccessible, and/or hazardous means of egress (per CT. Building Code 1010.3).

8. Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.

X Caregiver has recently abused legal or illegal substances or alcoholic beverage or is likely to do so in the immediate future; AND

X Caregiver's use is to the extent that control of his/her actions is significantly impaired; AND

X As a result, the caregiver is unable, or will likely be unable, to care for the child, has harmed the child, or is likely to harm the child.

9. Domestic violence exists in the home and poses a risk of serious physical and/or emotional harm to the child.

X The child was previously injured or exposed to a domestic violence incident.
X The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations associated with domestic violence.

X The child cries, cowers, cringes, trembles, or otherwise exhibits fear and/or aggression as a result of domestic violence in the home.

X The child is at potential risk of physical injury.

X The child's behavior increases risk of injury (e.g., attempting to intervene during violent dispute, participating in the violent dispute).

X Use of guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.

X Evidence of property damage resulting from domestic violence.

10. Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.

Examples of caregiver actions include:

X Caregiver describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).

X Caregiver curses at the child and/or repeatedly puts the child down publicly and/or privately.

X Caregiver scapegoats a particular child in the family.

X Caregiver blames the child for a particular incident or family problems.

X Caregiver intentionally places the child in middle of custody battle.

11. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.

X Caregiver's unmet mental health needs impede his/her ability to parent the child.

X Caregiver expects the child to perform or act in a way that is unrealistic for the child's age or developmental stage (e.g., babies and young children expected not to cry, expected to be still for extended periods, be toilet trained, eat neatly, expected to care for younger siblings or expected to stay alone).

X Due to cognitive delay(s), the caregiver lacks the basic knowledge related to parenting skills given the child's age and developmental needs.

12. There is a pattern of prior investigations or behavior AND current circumstances are near the threshold for any other safety factor,

X Prior death of a child as a result of maltreatment.

X Prior serious harm to the child – Previous maltreatment by caregiver that was serious enough to cause severe injury (e.g., fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, and/or physical findings consistent with sexual abuse based on medical exam).

X Termination of parental rights – Caregiver had parental rights terminated as a result of a prior CPS investigation.

X Prior removal of the child – Removal/placement of the child by CPS or other responsible agency or concerned party was necessary for the safety of the child.

X Prior CPS substantiation – Prior CPS investigation substantiated for maltreatment.

X A pattern of unsubstantiated CPS investigations.

X Prior threat of serious harm to child – Previous maltreatment that could have caused severe injury, retaliation, or threatened retaliation against the child for previous incidents; or prior domestic violence that resulted in serious harm or threatened harm to a child.

X Prior service failure – Failure to successfully complete court-ordered or previously recommended services.

13. Other

If, after careful review of the definitions for the other 12 safety factors, you feel there is something so unique in this family that it was not captured in any other safety factor, then you would select "Other" and document the identified unique safety factor that if not resolved immediately would lead to removal of a child(ren) in this home.

SECTION 2: SAFETY INTERVENTION DEFINITIONS

1. Intervention or direct services by worker as part of a safety plan.
Actions taken or planned by the investigating worker, or other CPS staff, that specifically address one or more safety factors. Examples include providing information about non-violent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; planned return visits to the home to check on progress; information on obtaining restraining orders; or providing definition of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. Use of family, neighbors, or other individuals in the community as safety resources.
Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbors, or other individuals to mitigate safety concerns. Examples include: family's agreement to use non-violent means of discipline, engaging a grandparent to assist with childcare, agreement by a neighbor to serve as a safety net for an older child, commitment by 12-step sponsor to meet with caregiver daily and call worker if caregiver has used or missed meeting.

3. Use of community agencies or services as safety resources.
Involving community-based organization, faith-related organization, local law enforcement, or other agency in activities to immediately address safety concerns. An example is using a local food pantry. DOES NOT INCLUDE long-term therapy or treatment or being put on a waiting list for services.

4. Have the non-offending caregiver appropriately protect the victim from the alleged perpetrator.
A non-offending caregiver has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator. Examples include: agreeing that the child will not be left alone with the alleged perpetrator or preventing the alleged perpetrator from physically disciplining the child.

5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
Temporary removal from the home pending further assessment or permanent removal of the alleged perpetrator. Examples include: arrest of alleged perpetrator and/or court orders, non-perpetrating caregiver removing alleged perpetrator from the home who has no legal right to residence; perpetrator agrees to leave.

6. Have the non-offending caregiver move to a safe environment with the child.
A non-offending caregiver has taken or plans to take the child to an alternate location where there will be no access to suspected perpetrator. Examples include: domestic violence shelter, home of friend or relative, hotel.

7. Legal action planned or initiated–child remains in the home.
The family has initiated a legal action (e.g., restraining/protective orders, change in custody/visitation, mental health commitments) that mitigates identified safety factors. The

Department may have filed or will be filing neglect petitions in Juvenile Court based on identified safety factors. The decision to file petitions in and of itself is not an appropriate intervention to ensure the child's safety in the home.

8. Other.

The family or worker identified a unique intervention for an identified safety concern that does not fit within items 1-7.

9. Caregiver arranges for care of the child outside the home.

A caregiver arranges for the child to be cared for outside of his/her home by a relative or friend as a protective intervention. (That arrangement is with someone who has no criminal or CPS history that would preclude that person from being a caretaker.)

10. Child placed in protective custody because no interventions are available to adequately ensure the child's safety.

One or more children are protectively placed pursuant to a 96-hour hold or order of temporary custody (Chapter 319a – 17a-101c).

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® SAFETY ASSESSMENT
POLICY AND PROCEDURES

The purpose of the safety assessment is to: 1) help assess whether any children are currently in *immediate* danger of serious harm that may require a protecting intervention; and 2) to determine what interventions should be maintained or initiated to provide appropriate protection.

Safety versus Risk Assessment: It is important to keep in mind the difference between safety and risk when completing this tool. Safety assessment differs from risk assessment in that it assesses the child's present danger and the interventions currently needed to protect the child. In contrast, risk assessment looks at the likelihood of future maltreatment.

Which Cases: All CA/N investigations of parent(s), guardian(s), or other adult household member(s), including new investigations on existing cases. In addition, a safety assessment will be completed on any open investigation or any treatment case where new information becomes available that indicates a threat to the safety of a child.

Who: The investigative worker during any investigation involving parent(s), guardian(s), or other adult household member(s). The treatment worker for an open case whenever new information becomes available that indicates a threat to the safety of a child.

When: The safety assessment is completed:

X Prior to the removal of any child from the home, before the caregiver arranges for the child to be cared for outside of his/her home, or before leaving a child in the home at the time of the first face-to-face contact for each new investigation. The assessment will be documented within five working days.

Note: During an investigation, if parents live separate and apart, complete the safety assessment for the children in the household where the abuse/neglect occurred. If the alleged abuse/neglect did not occur in the child's primary household, also complete a safety assessment for the children in the household where the child primarily lives. Be sure to identify in the heading which household each assessments is on.

X Prior to returning a child to the home during the investigation whether protectively placed by the agency or prior to the end of the arrangement the caregiver made for care outside of the home with a friend or family as a protective intervention.

X Throughout the investigation period or on existing cases whenever new information becomes available that indicates a threat to the safety of a child (see next section on reassessing safety).

Decisions: The safety assessment is used to guide decisions about the removal and return of a child to his/her family. It also guides decisions on whether or not the child may remain in the home, the need for interventions to eliminate any threat of immediate harm (e.g., caregiver and child go to a domestic violence shelter, the caregiver arranges for care of the child outside of his/her home), or if the child must be removed.

A safety plan is required for any child remaining in his/her home or if the caregiver has made arrangements for care by another outside of his/her home when any safety factor has been identified. The safety plan must be signed by the caregiver(s), the worker, and conferenced with a supervisor. One copy of the safety plan is to be left with the caregiver and one must be kept in the hard copy record.

The safety plan is a discrete document that outlines the current and immediate safety factors identified, the protective interventions in place to eliminate the threat of immediate harm, and descriptions of who will be responsible for which interventions and when those interventions will be reviewed. A service agreement will no longer be used as a safety plan and a safety plan is not to be used in place of a service agreement.

Appropriate Completion: The safety factors should be reviewed/referenced during the safety assessment process and any safety plan agreed upon with the family must be completed **immediately.** The safety assessment has four sections:

Section 1:	Safety Factors
Section 2:	Safety Interventions
Section 3:	Safety Decision
Section 4:	Safety Plan

The vulnerability of each child is considered throughout the assessment. Young children cannot protect themselves. For older children, inability to protect themselves could result from diminished mental or physical capacity or repeated victimization.

Section 1: Safety Factors requires that the worker consider each of the 13 behaviors and/or conditions listed and identify the presence or absence of each factor by checking "yes" or "no." **Answer each item as it relates to the most vulnerable child**.

Section 2: Safety Interventions is completed by the worker whenever one or more safety factors have been identified in Section 1. For each factor identified, the worker considers the resources available in the family and the community that might help to keep the child safe. This section is intended to assist the worker in exploring the alternatives to removing the child and to document upon completion, per state and federal requirements, that the

agency made reasonable efforts to safely maintain a child at home whenever possible.

Section 3: Safety Decision is the result of careful consideration of the safety factors present and any available safety interventions taken or immediately planned by the agency, family, or community resources to protect the child.

Consideration of these factors will affect any decision regarding removal or return of the child. When safety factors are present, the worker may put safety interventions in place designed to protect the child in the home, the caregiver may arrange for care of the child outside of his/her home, or the worker may seek emergency temporary physical custody.

If a child is removed during the investigation, the safety assessment is used to guide decision making on return of the child. A child must be safe or conditionally safe prior to being returned home.

The safety assessment is reviewed and approved by a supervisor no later than at the close of an investigation or within 45 days of receipt of new information on an active case.

The worker makes a determination of unsafe, conditionally safe, or safe based on whether safety interventions can mitigate any unsafe factor(s) identified. Answer **unsafe** if <u>any</u> child was removed from the home. Answer **conditionally safe** if all children remain in the family home while services are provided by the worker, family, and/or community resources, or if the caregiver has arranged for care of the child outside of his/her home as a protective intervention. Answer **safe** only if <u>no</u> safety factors were identified in Section 1.

When situations require protective placement of one child, and another child or children remain in the home, the decision will be "unsafe" due to the removal. There may also be in-home interventions and a safety plan required for the child(ren) remaining in the home. There would be **only one decision**, i.e., "unsafe," whenever any child is protectively placed.

Note: For ongoing cases where a child is in out-of-home placement, the reunification safety reassessment is completed to guide decisions about returning the child to the removal home.

Section 4: Safety Plan. This section is completed whenever any safety factor has been identified and any child will remain in the home or if the caregiver has arranged for care of the child outside of his/her home. The safety plan must document the specific interventions that will be taken immediately to ensure the child's safety in the home while the investigation continues, who is responsible for monitoring compliance with the safety plan, and the anticipated next review date. The caregiver(s), worker, and supervisor must all sign and date the agreed-upon safety plan. A copy of the safety plan is to be left with the caregiver and one must be maintained in the hard copy record.

At the bottom of the safety assessment tool, indicate the date that a copy of the signed safety plan was or will be placed in the hard copy record. If any other workers have children in the home, send them a copy of the safety plan.

Reassessing Safety: Assessing child safety is a critical consideration throughout the agency's involvement with the family. Consideration of safety factors should be incorporated as part of each contact with the family. After the initial safety assessment is completed, subsequent safety assessments should be completed whenever a change in the family's circumstances poses a safety concern(s) and the need for possible protective interventions.

If the investigation will be closed and no CPS services will be provided, case documentation should specify how all identified safety factors were resolved.

If the investigation will be opened for CPS services, case documentation should indicate whether the safety plan and interventions are still applicable at the time that the case is transferred to a treatment worker.

X If safety factors still exist or new factors have emerged, a new safety plan is required until the interventions can be incorporated into the treatment plan.

X If protective interventions successfully mitigated initial safety factors, and no current safety factors exist, case documentation should specify how they were resolved.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 07/06

SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT

Case Name: _____ **LINK #:** _____ **Household Assessed:** _____

Area Office: _____ **Worker :** _____ **Assessment Date:** ___/___/___

NEGLECT	**Score**
N1. Current Complaint Is for Neglect a. No ....0 b. Yes 1	
N2. Prior Investigations (assign highest score that applies) a. None....0 b. One or more, abuse only....1 c. One or two for neglect....2 d. Three or more for neglect....3	
N3. Household Has Previously Received CPS (voluntary/court-ordered) a. No ....0 b. Yes 1	
N4. Number of Children Involved in the CA/N Incident a. One, two, or three....0 b. Four or more....1	
N5. Age of Youngest Child in Household a. Two or older....0 b. Under two....1	
N6. Primary Caregiver Provides Physical Care Inconsistent with Child Needs a. No ....0 b. Yes 1	
N7. Primary Caregiver Has a Past or Current Mental Health Problem a. No ....0 b. Yes, check if applicable....1 ❑ during the last 12 months ❑ prior to the last 12 months	
N8. Primary Caregiver Has Historic or Current Alcohol or Drug Problem (check applicable items and add for score) a. Not applicable ....0 b. Alcohol....1 ❑ during the last 12 months ❑ prior to the last 12 months c. Drug ....1 ❑ during the last 12 months ❑ prior to the last 12 months	
N9. Characteristics of Children in Household (check applicable items and add for score) a. Not applicable ....0 b. ❑ Medically fragile/failure to thrive ....1 c. ❑ Developmental or physical disability ....1 d. ❑ Positive toxicology screen at birth 1	
N10. Housing (check applicable items and add for score) a. Not applicable ....0 b. ❑ Current housing is physically unsafe....1 c. ❑ Homeless at time of investigation 2	
TOTAL NEGLECT RISK SCORE	

ABUSE	**Score**
A1. Current Complaint Is for Abuse a. No....0 b. Yes....1	
A2. Number of Prior Abuse Investigations (number: ____) a. None....0 b. One or more....1	
A3. Household Has Previously Received CPS (voluntary/court-ordered) a. No....0 b. Yes....1	
A4. Prior Injury to a Child Resulting from CA/N a. No....0 b. Yes....1	
A5. Primary Caregiver's Assessment of Incident (check applicable items and add for score) a. Not applicable....0 b. ❑ Blames child....1 c. ❑ Justifies maltreatment of a child....2	
A6. Two or More Domestic Violence Incidents in the Household in the Past Year a. No....0 b. Yes....2	
A7. Primary Caregiver Characteristics (check applicable items and add for score) a. Not applicable....0 b. ❑ Provides insufficient emotional/psychological support ...1 c. ❑ Employs excessive/inappropriate discipline ....1 d. ❑ Domineering caregiver 1	
A8. Primary Caregiver Has a History of Abuse or Neglect as a Child a. No....0 b. Yes....1	
A9. Secondary Caregiver Has Historic or Current Alcohol or Drug Problem a. No....0 b. Yes, alcohol and/or drug (check all applicable) ....1 ❑ Alcohol ❑ during the last 12 months ❑ prior to the last 12 months ❑ Drug ❑ during the last 12 months ❑ prior to the last 12 months	
A10. Characteristics of Children in Household (check appropriate items and add for score) a. Not applicable....0 b. ❑ Delinquency history ....1 c. ❑ Developmental disability....1 d. ❑ Mental health/behavioral problem 1	
TOTAL ABUSE RISK SCORE	

INITIAL RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
❑ 0 – 1	❑ 0 – 1	❑ Very Low
❑ 2 – 4	❑ 2 – 4	❑ Low
❑ 5 – 8	❑ 5 – 7	❑ Moderate
❑ 9 +	❑ 8 +	❑ High

POLICY OVERRIDES. Check box if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to high.

❑ 1. Sexual abuse cases AND the perpetrator is likely to have access to the child victim.
❑ 2. Cases with non-accidental physical injury to a child under age six.
❑ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
❑ 4. Positive toxicology screen (alcohol or drugs) of mother or newborn at time of birth.
❑ 5. Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).
❑ 6. Household member had prior Termination of Parental Rights.

DISCRETIONARY OVERRIDE. If a discretionary override is used, check box, mark override risk level, and indicate reason. Risk level may be overridden one level higher.

❑ 7. If yes, override risk level (check one): ❑ Low ❑ Moderate ❑ High

Discretionary Override Reason: _____

FINAL RISK LEVEL (check final level assigned): ❑ Very Low ❑ Low ❑ Moderate ❑ High

Supervisor Approval: _____ **Date:** ___/___/___

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT
DEFINITIONS

The risk assessment tool is composed of two indices: the neglect assessment index and the abuse assessment index. Only one household can be assessed on a risk assessment tool. If two households are involved in the alleged incident(s), separate risk assessment tools are completed for each household.

The household includes all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home.

The primary caregiver is the legally responsible adult living in the household where the allegation occurs who assumes the most childcare responsibility. When two adult caregivers are present and the social worker is in doubt which one assumes the most childcare responsibility, the adult with legal responsibility for the child involved in the incident should be selected as the primary caregiver. For example, when a mother and her boyfriend reside in the same household and appear to equally share caregiving responsibilities for the child, the mother is selected. If this does not resolve the question, the legally responsible adult who was a perpetrator or alleged perpetrator should be selected. For example, when a mother and a father reside in the same household and appear to equally share caregiving responsibilities for the child and the mother is the perpetrator (or the alleged perpetrator), the mother is selected. In circumstances where both parents are in the household, equally sharing caregiving responsibilities, and both have been identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior is selected. Only one primary caregiver can be identified.

When parents live separate and apart, they are considered to be in separate households. Each parent would be considered the primary caregiver since he/she is the legally responsible adult in his/her household. He/She cannot be the secondary caregiver in the other parent's home.

The secondary caregiver is defined as an adult living in the household who has routine responsibility for childcare, but less responsibility than the primary caregiver. A partner may be a secondary caregiver even though he/she has minimal responsibility for care of the child.

NEGLECT INDEX

N1. Current Complaint Is for Neglect

Score 1 if the current allegation is for any type of neglect. This includes:

X severe and general neglect;
X exploitation (excluding sexual exploitation); and
X caregiver absent/incapacitated.

This includes referred allegations as well as allegations made during the course of the investigation.

N2. Prior Investigations

a. Score 0 if there were no investigations prior to the current investigation (do not include referrals that were not accepted for investigation).

b. Score 1 if there were one or more investigations (do not include referrals that were not accepted for investigation), substantiated or not, for any type of abuse prior to the current investigation. Abuse includes physical, emotional, or sexual abuse/sexual exploitation.

c. Score 2 if there were one or two investigations (do not include referrals that were not accepted for investigation), substantiated or not, for any type of neglect prior to the current investigation, with or without abuse investigations.

d. Score 3 if there were three or more investigations (do not include referrals that were not accepted investigation), substantiated or not, for any type of neglect prior to the current investigation, with or without abuse investigations.

See N1 for the definition of neglect.

Where possible, history from other county or state jurisdictions should be checked. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

N3. Household Has Previously Received CPS (voluntary/court-ordered)

Score 1 if household has previously received ongoing child protective services or is currently receiving ongoing services as a result of a prior investigation.

N4. Number of Children Involved in the CA/N Incident

Score the appropriate amount given the number of children under 18 years of age for whom abuse or neglect was alleged and/or substantiated in the current investigation.

N5. Age of Youngest Child in Household

Score the appropriate amount given the current age of the youngest child presently in the household where the maltreatment incident reportedly occurred. If a child is removed as a result of the current investigation, count the child as residing in the home.

N6. Primary Caregiver Provides Physical Care Inconsistent with Child Needs
Score 1 if physical care of the child (age-appropriate feeding, clothing, shelter, hygiene, and medical care of the child) threatens the child's well-being or results in harm to the child. Examples include:

X failure to obtain medical care for severe or chronic illness;

X repeated failure to provide the child with weather-appropriate clothing;

X persistent rat or roach infestations;

X inadequate or inoperative plumbing or heating;

X poisonous substance or dangerous objects lying within reach of a small child;

X the child is wearing filthy clothes for extended periods of time; or

X the child is not being bathed on a regular basis, resulting in dirt caked on skin and hair and a strong odor.

N7. Primary Caregiver Has a Past or Current Mental Health Problem
Score 1 if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver:

X has been diagnosed with a Diagnostic and Statistical Manual (DSM) condition by a mental health clinician;

X had repeated referrals for mental health/psychological evaluations; or

X was recommended for treatment/hospitalization or treated/hospitalized for emotional problems at any time.

N8. Primary Caregiver Has Historic or Current Alcohol or Drug Problem
The primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Such interference is evidenced by:

X substance use that affects or affected:

< employment;
< criminal involvement;
< marital or family relationships; or
< ability to provide protection, supervision, and care for the child.

X an arrest in the past two years for driving under the influence or refusing breathalyzer testing;

X self report of a problem;

X treatment received currently or in the past;

X multiple positive urine samples;

X health/medical problems resulting from substance use; or

X the child was diagnosed with Fetal Alcohol Syndrome or Exposure (FAS or FAE), or the child had a positive toxicology screen at birth and primary caregiver was the birthing parent.

Score the following characteristics and record the sum as the item score.

a. Score 0 if no past or current substance abuse problems.
b. Score 1 if past or current alcohol abuse.
c. Score 1 if past or current drug abuse.

Legal, non-abusive prescription drug use should not be scored.

N9. Characteristics of Children in the Household

Score the appropriate amount for each characteristic present and record the sum as the item score.

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child in the household is medically complex, defined as having a long-term (six months or more) physical condition requiring medical intervention or diagnosed as failure to thrive.

c. Score 1 if any child is developmentally or physically disabled, including any of the following: mental retardation, learning disability, other developmental delays, or significant physical handicap.

d. Score 1 if any child had a positive toxicology report for alcohol or another drug at birth.

N10. Housing

Score the appropriate amount for each characteristic present and record the sum as the item score.

a. Score 0 if the family has physically safe housing.

b. Score 1 if the family has housing but the current housing situation is physically unsafe such that it does not meet the health or safety needs of the child (e.g., exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, or rotting food).

c. Score 2 if the family is/was homeless or is/was about to be evicted.

ABUSE INDEX

A1. Current Complaint Is for Abuse

Score 1 if the current complaint is for any type of abuse. This includes:

X physical abuse;
X emotional abuse; or
X sexual abuse/sexual exploitation.

This includes referred allegations as well as allegations made during the course of the investigation.

A2. Number of Prior Abuse Investigations

Score the appropriate amount given the count of all investigations, substantiated or not, that were accepted for CPS investigation for any type of abuse (physical, emotional, or sexual abuse/sexual exploitation) prior to the complaint resulting in the current investigation. Where possible, abuse history from other county or state jurisdictions should be checked. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

A3. Household Has Previously Received CPS (voluntary/court-ordered)

Score 1 if household has previously received ongoing child protective services or is currently receiving ongoing services as a result of a prior investigation.

A4. Prior Injury to a Child Resulting from CA/N

Score 1 if a child sustained an injury resulting from abuse and/or neglect prior to the allegation that resulted in the current investigation. Injury sustained as a result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn.

A5. Primary Caregiver's Assessment of Incident

Score the appropriate amount for each characteristic and record the sum as the item score.

a. Score 0 if none of the characteristics below are applicable.

b. Score 1 if the primary caregiver blames the child for incident. Blaming refers to caregiver's statement that maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced him/her, or the child deserved beating because he/she misbehaved).

c. Score 2 if the primary caregiver justifies maltreatment of the child. Justifying refers to caregiver's statement that his/her action or inaction, which resulted in harm to the child, was appropriate (e.g., claiming that this form of discipline was how he/she was raised, so it is acceptable).

A6. Two or More Domestic Violence Incidents in the Household in the Past Year
Score 2 if, in the previous year, there have been two or more physical assaults or multiple periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult.

A7. Primary Caregiver Characteristics
Score the appropriate amount for each characteristic present and record the sum as the item score.

a. Score 0 if the primary caregiver does not exhibit the characteristics listed below.

b. Score 1 if the primary caregiver provides insufficient emotional/psychological support to the child, such as persistently berating/belittling/demeaning the child or depriving the child of affection or emotional support.

c. Score 1 if the caregiver's disciplinary practices caused or threatened harm to the child because they were excessively harsh physically or emotionally and/or inappropriate to the child's age or development. Examples include:

X locking the child in closet or basement;

X holding the child's hand over fire;

X hitting the child with dangerous instruments; or

X depriving a young child of physical and/or social activity for extended periods.

d. Score 1 if the primary caregiver is domineering, indicated by controlling, abusive, overly-restrictive, or unfair behavior or over-reactive rules.

A8. Primary Caregiver Has a History of Abuse or Neglect as a Child
Score 1 if credible statements by the primary caregiver or others indicate that the primary caregiver was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

A9. Secondary Caregiver Has Historic or Current Alcohol or Drug Problem
The secondary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Such interference is evidenced by:

X substance use that affects or affected:

< employment;
< criminal involvement;
< marital or family relationships; or
< ability to provide protection, supervision, and care for the child.

X an arrest in the past two years for driving under the influence or refusing breathalyzer testing;

X self-report of a problem;

X received or is receiving treatment;

X multiple positive urine samples;

X health/medical problems resulting from substance use; or

X the child was diagnosed with Fetal Alcohol Syndrome (FAS or FAE), or the child had a positive toxicology screen at birth and secondary caregiver was the birth parent.

Score the following:

a. Score 0 if no past or current substance abuse problems.
b. Score 1 if past or current substance abuse.

Legal, non-abusive prescription drug use should not be scored.

A10. Characteristics of Children in Household

Score the appropriate amount for each characteristic present and record the sum as the item score.

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child in the household has ever been referred to juvenile court for delinquent or Family with Service Needs (FWSN) behavior. Other behavior that is not brought to court attention but creates stress within the household should also be scored, such as children who run away or are habitually truant.

c. Score 1 if any child is developmentally disabled, including any of the following: mental retardation, learning disability, or other developmental delays.

d. Score 1 if any child in the household has mental health or behavioral problems not related to a physical or developmental disability (includes ADHD/ADD). This could be indicated by:

X a DSM diagnosis;
X receiving mental health treatment;
X attendance in a special classroom because of behavioral problems; or
X currently taking psychoactive medication.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT
POLICY AND PROCEDURES

Risk assessment identifies families who have high, moderate, low, or very low probabilities of abusing or neglecting their children in the future. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 12 to 18 months. The difference between the risk levels is substantial. High risk families have significantly higher rates than low risk families of subsequent referral and substantiation and are more often involved in serious abuse or neglect incidents.

When risk is clearly defined, the choice between serving one family and another family is simplified: agency resources are targeted to higher risk families because of the greater potential to reduce subsequent maltreatment.

The risk instrument is based on research of abuse/neglect cases that examined the relationships between family characteristics and the outcomes of subsequent confirmed abuse and neglect. The instrument does not predict recurrence but simply assesses whether a family is more or less likely to have another abuse/neglect incident without intervention by the agency. One important result of the research is that a single scale should not be used to assess the risk of both abuse and neglect. Different family dynamics are present in abuse and neglect situations. Hence, separate scales are used to assess the future probability of abuse or neglect, although both scales are completed for every family under investigation for child maltreatment.

The risk level is determined by scoring each of the scales, totaling the score, and taking the highest level from the abuse and neglect scales.

Which Cases: All initial CPS investigations, whether substantiated or unsubstantiated, including new investigations on existing cases.

If additional reports are accepted for a CPS investigation for completion by a single investigator during the course of an open investigation, only one risk assessment shall be completed at the disposition of the final CPS investigation on the family. The risk assessment items shall be completed based on the facts known to the investigator at the time of conclusion of the most recently accepted report for investigation. For example, items N1 and A1 should be based on the allegation(s) contained in the last accepted report; N2 and A2 should include as prior investigations all of the investigations, except for the most recently accepted report for investigation. For N2 and A2, when an investigator is concluding three reports/investigations at the same time, this item would reflect the facts from the two prior reports being investigated at this time, as well as any other prior investigations.

Who: The investigation worker.

When: The risk assessment is completed at the end of the investigation. The assessment is completed based on conditions that existed at the time of the

reported incident and on additional information obtained during the investigation.

Decisions:

The risk level is used to determine if the case should be transferred for treatment services or be closed. This determination is made by consulting the "case decision matrix" described in this manual.

For cases opened for treatment services following the investigation, the risk level should be considered by workers and supervisors when prioritizing case work activities, targeting more time and services to high risk cases.

Appropriate Completion:

1. Complete both scales and determine the risk level based on the highest level on either scale.

2. Review policy overrides to see if any apply.

3. Consider a discretionary override.

4. Indicate the final risk level. If an override has been exercised, the final risk level should differ from the initial risk level. If an override has not been used, the final risk level will be the same as the initial risk level.

Only one household can be assessed on the risk assessment tool. If the child resides in two households, select the household in which the CA/N incident occurred.

Each scale (abuse and neglect) is completed regardless of the type of allegation(s) reported or investigated. All items on the risk assessment scales are completed. The investigator must make every effort throughout the investigation to obtain the information needed to answer each assessment question. If information cannot be obtained to answer a specific item, the item must be scored as "0."

Score all items on each scale and total the score. Using the chart in the initial risk level section, identify the corresponding risk level for the score on each scale. Indicate the overall risk level by placing a check next to the higher of the two levels.

Note: Connecticut statute states that a child who has been abused is a neglected child. For scoring purposes, if the current allegation is for abuse only, then answer yes **only** to the abuse indices.

Note how items N8, N9, N10, A5, A7, and A10 require that the investigator check each characteristic of the primary caregiver and/or children in the household and **total** the score.

The item definitions must be used when answering each risk question.

Policy Overrides

After completing the risk scales, the worker then determines if any of the policy override reasons exist. Policy overrides reflect incident seriousness and child vulnerability concerns and have been determined by the agency to be cases that warrant the highest level of service regardless of the risk scale scores. If any policy override reasons exist, check the appropriate policy override reason. The risk level is then increased to high. Do not check a policy override if the risk level is already high.

Discretionary Override

A discretionary override is applied by the worker to increase the risk level in any case where the worker believes the risk level set by the scales is too low. Discretionary overrides may only increase the risk level by one unit (e.g., from very low to low, low to moderate, or moderate to high, but NOT very low to high). Indicate the override reason.

Place a check next to the appropriate final risk level. If an override has been exercised, the final risk level will differ from the initial risk level. If an override has not been used, the final risk level will be the same as the initial risk level.

The risk assessment tool, including any policy or discretionary overrides, is approved by a supervisor no later than the close of the investigation.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® RISK-BASED CASE DECISION MATRIX

Risk-Based Case Open/Close Matrix	
Risk Level	**Recommendation**
High	Open for treatment services
Moderate	Open for treatment services
Low*	Close
Very Low*	Close

*Very low and low risk cases with unresolved safety issues should always be transferred for treatment services. These cases should be considered for closure whenever safety issues are no longer present.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® RISK-BASED CASE DECISION MATRIX
POLICY AND PROCEDURES

The risk-based case decision matrix is used to guide decisions about which cases should be transferred for treatment services. Two primary criteria are used to structure the transfer or close decision: 1) the family's risk level; and 2) continued presence of unresolved safety issues.

The matrix shows that all cases assessed as moderate or high risk would be transferred, regardless of the investigation finding.

All very low and low risk cases may be recommended for closure unless there continue to be unresolved safety issues. All cases with existing safety concerns should be transferred for treatment services.

Which Cases: All new CA/N investigations will have the transfer/close decision structured by the matrix except cases currently open for treatment services.

Who: The investigation worker.

When: After determination of the investigation disposition and completion of the risk assessment.

Decisions: Whether to close the case or transfer to treatment services. **The program supervisor must approve an opening/closing decision that does not coincide with a recommendation on the decision matrix**. For example: If a child lives primarily with the mother but is abused/neglected while with the father, a safety assessment would be completed on both households and a risk assessment would be completed on the father's household. If the mother is willing/able to protect, you may decide to close the case even though the father's risk score may be moderate or high. The reason for this decision must be documented in LINK.

Appropriate Use: Find the column that corresponds to the assessed risk level. This cell in the matrix contains the recommended decision.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 12/06

SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT/REASSESSMENT

Case Name: _____ **LINK #:** _____ **Household Assessed:** _____

Area Office: _____ **Worker:** _____ **Assessment Date:** ____/____/____

Assessment Type (check one): ❑ Initial ❑ Reassessment #: 1 2 3 4 5 _____

A. CAREGIVERS – For each item, record the score for both the primary and secondary caregivers in the household of each parent you assess.

		Primary Caregiver	Secondary Caregiver
SN1.	**Substance Abuse/Use**		
	(Substances: alcohol, illegal drugs, inhalants, prescription/over-the-counter drugs)		
	a. Teaches and demonstrates healthy understanding of alcohol and drug use ..... +3		
	b. No use or abuse of alcohol or drugs 0		
	c. Alcohol or drug abuse ..... -3		
	d. Alcohol or drug dependency ..... -5	_____	_____
SN2.	**Household Relationships (applies to relationships among adults in household)**		
	a. Supportive ..... +3		
	b. Minor/occasional discord 0		
	c. Frequent discord ..... -3		
	d. Chronic and/or violent discord ..... -5	_____	_____
SN3.	**Social Support System**		
	a. Strong support system ..... +2		
	b. Adequate support system 0		
	c. Limited support system ..... -2		
	d. No support system ..... -4	_____	_____
SN4.	**Parenting Skills**		
	a. Strong skills ..... +2		
	b. Adequately parents and protects child 0		
	c. Inadequately parents and protects child ..... -2		
	d. Destructive/abusive parenting ..... -4	_____	_____
SN5.	**Coping Skills**		
	a. Strong coping skills ..... +2		
	b. Adequate coping skills 0		
	c. Limited coping skills ..... -2		
	d. Severely impaired coping skills ..... -4	_____	_____
SN6.	**History of Child Abuse and Neglect (documented and/or self report)**		
	a. Draws skills and strengths from childhood experiences ..... +1		
	b. No child maltreatment history 0		
	c. Maltreated as child, none to minor current negative effects ..... -1		
	d. Maltreated as child, major current negative effects ..... -3	_____	_____
SN7.	**Resource Management/Basic Needs**		
	a. Resources sufficient to meet basic needs and are adequately managed ..... +1		
	b. Resources adequate or limited but are adequately managed 0		
	c. Resources are insufficient or not well-managed ..... -1		
	d. No resources, or resources severely limited and/or mismanaged ..... -3	_____	_____
SN8.	**Physical Health**		
	a. Preventive health care is practiced ..... +1		
	b. Health issues do not affect family functioning 0		
	c. Health concerns/disabilities affect family functioning ..... -1		
	d. Serious health concerns/disabilities result in inability to provide care ..... -3	_____	_____

Does the family identify areas of needs or strengths that are not included in the above areas?

____ No ____ Yes, describe: _____

_____

Identifying Priority Needs and Strengths: List all assessed needs/strengths for both caregivers, then identify **up to three priority needs/strengths** to guide initial services.

Caregiver Needs				
Item	**Domain**	**Score**	**Caregiver**	**Priority**
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑

Caregiver Strengths				
Item	**Domain**	**Score**	**Caregiver**	**Priority**
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑
_____	_____	_____	[ ] Primary [ ] Secondary	❑

B. CHILDREN – Rate each child according to his/her current level of functioning. For each item, if not applicable due to child's age, score as "0."

	Child 1:	Child 2:	Child 3:	Child 4:

CSN1. Physical Health

Is the child medically complex? ❑ Yes ❑ No

Answer yes or no for each child:

a. Good health ..... +3
b. Adequate health 0
c. Minor health needs ..... -3
d. Serious health needs ..... -5

CSN2. Emotional/Behavioral

a. Strong coping skills ..... +3
b. Age-appropriate coping skills 0
c. Limited coping skills ..... -3
d. Severely impaired coping skills ..... -5

CSN3. Education/Development

Does the child have an Individualized Education Plan (IEP)? ❑ Yes ❑ No

Answer yes or no for each child:

a. Advanced achievement/development ..... +3
b. Satisfactory achievement/development 0
c. Some educational difficulty/development issues ..... -3
d. Severe educational difficulty/development issues ..... -5

CSN4. Substance Abuse

(Substances: alcohol, tobacco, illegal drugs, and/or prescribed drugs)

a. Conscious decision to avoid use ..... +2
b. No use/minor experimentation 0
c. Alcohol or other drug use ..... -2
d. Abuse/dependency ..... -4

CSN5. Social Support

a. Positive support network ..... +2
b. Adequate support network 0
c. Limited support network ..... -2
d. Lacks support network .....

For each child, list the assessed needs and strengths in the correct column according to score.

Child	Priority Needs*	Additional Needs	Strengths
	Domains with scores of -3, -4, or -5	Domains with scores of -2	Domains with scores of 0, +2, or +3
Child 1:			
Child 2:			
Child 3:			
Child 4:			

*All child needs with scores of -3, -4, or -5 MUST be addressed on the treatment plan. If less than three priority needs are identified, select from any additional child needs (up to three total) to incorporate into the treatment plan.

Worker: _____ **Date:** ____/____/____

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT/REASSESSMENT DEFINITIONS

CAREGIVERS—For each item, record the score for both the primary and secondary caregivers.

SN1. Substance Abuse/Use
(Substances: alcohol, illegal drugs, inhalants, prescription/over-the-counter drugs)

a. Teaches and demonstrates healthy understanding of alcohol and drug use.

- Caregiver does not use alcohol or illegal drugs; OR
- Caregiver may use alcohol or prescribed drugs; however, use does not negatively affect parenting skills and functioning; AND
- Caregiver teaches and demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behavior and society.

b. No use or abuse of alcohol or drugs.

- Caregiver does not use alcohol or illegal drugs; OR
- Caregiver may use alcohol or prescribed drugs; however, use does not negatively affect parenting skills and functioning; OR
- Caregiver has a history of substance abuse; however, he/she has been clean and sober for at least the last 90 days, and past abuse does not negatively affect parenting skills and functioning.

c. Alcohol or drug abuse.

- Caregiver continues to use despite negative consequences in some areas such as family, social, health, legal, or financial.
- Caregiver needs help to achieve and/or maintain abstinence from alcohol or drugs.
- Caregiver uses illegal drugs.

d. Alcohol or drug dependency.

- Caregiver's use of alcohol or drugs results in behaviors that impede ability to meet his/her own and/or his/her child's basic needs.

- Caregiver experiences some degree of impairment in most areas including family, social, health, legal, and financial.
- Needs intensive structure and support to achieve abstinence from alcohol or drugs.

SN2. Household Relationships (applies to relationships among adults in the household)

a. Supportive.

- No physical or verbal altercations; AND
- Adult members demonstrate effective coping skills by showing respect, mutual affection, empathy, and open communication; AND
- Responsibilities are shared and mutually agreed upon by household members; AND
- There may be an internal/external stressor present, i.e., divorce, illness, loss of employment, financial difficulty, death or loss, special needs, custody and visitation that doesn't affect functioning.

b. Minor/occasional discord.

- No physical altercations; AND
- Internal/external stressors are present.
- Adult members are coping with some disruption of positive interactions (i.e., verbal discussions or disagreement that do not become threatening in nature).

c. Frequent discord.

- There may be physical altercations such as pushing, shoving, throwing objects; however, there are no injuries sustained and the police do not get involved.
- In the presence of a stressor, the household members become increasingly argumentative, resulting in frequent arguments and/or verbal and emotional abuse.
- Due to the conflict between the adult household members, there is a negative change in the child's overall functioning at home or school.

d. Chronic and/or violent discord
Physical altercations occur frequently and/or may result in injuries or police involvement.

- Limited to no positive interactions among household members.

- Internal/external stressors cause severe conflict.

- Custody and visitation issues result in malicious referrals to police and/or CPS.

- Behaviors of adult household members place the child at risk for maltreatment and/or the behavior contributes to severe emotional distress to the child (i.e., overall functioning of the child is affected in multiple arenas).

SN3. Social Support System

a. Strong support system. Family regularly has positive interactions with extended family, friends, cultural, religious, and/or community support or services that provide a wide range of resources.

b. Adequate support system. Family utilizes extended family, friends, cultural, religious, and community resources to provide support and/or services such as child care, transportation, supervision, role-modeling for parent and child, guidance, etc. on an as-needed basis.

c. Limited support system. Some extended family, friends, or community resources, or family is reluctant to utilize resources available to them (i.e., do not want to feel like a burden, do not want others to know personal information).

d. No support system. No supports available (family is isolated). If supports are available, family refuses to utilize them.

SN4. Parenting Skills

a. Strong skills. Caregiver demonstrates good knowledge and understanding of age-appropriate parenting skills and integrates use on a daily basis. Caregiver expresses hope for and recognizes the child's abilities and strengths and encourages participation in family and community. Caregiver advocates for family and responds to changing needs.

b. Adequately parents and protects child. Caregiver demonstrates adequate parenting patterns that are age-appropriate for the child in areas of expectations, discipline, communication, protection, supervision, and nurturing. Caregiver has basic knowledge and skills to parent.

c. Inadequately parents and protects child. Improvement of basic parenting skills is needed by caregiver. Caregiver has some unrealistic expectations, demonstrates poor knowledge of age-appropriate disciplinary methods, and/or lacks knowledge of child development that interferes with effective parenting. Utilizes poor judgment regarding supervision and protection of the child.

d. Destructive/abusive parenting. Caregiver demonstrates destructive/abusive parenting patterns and/or gross negligence in supervision, and/or protection that results in significant physical/emotional harm to the child.

SN5. Coping Skills

a. Strong coping skills. Caregiver demonstrates the ability to deal with adversity, crises, and long-term problems in a constructive manner. Demonstrates realistic/logical thinking and judgment. Displays resiliency; has a positive, hopeful attitude. Recognizes impact of crisis on the child's emotional health and takes steps to safeguard his/her emotional well-being.

b. Adequate coping skills. Caregiver demonstrates emotional responses that are consistent with circumstances; displays no apparent inability to cope with adversity, crises, or long-term problems.

c. Limited coping skills. Caregiver displays periodic mental health issues including, but not limited to, depression, low self-esteem, or apathy (lack of interest/concern). Caregiver has occasional difficulty dealing with situational stress, crises, or problems. These impairments negatively impact the caregiver's ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.

d. Severely impaired coping skills. Caregiver displays chronic, severe mental health problems including, but not limited to, depression, anxiety, or loss of touch with reality. These impairments have a severe negative impact on the caregiver's ability to perform in most areas of parental functioning, employment, education, or provision of food and shelter.

SN6. History of Child Abuse and Neglect (documented and/or self report)

a. Draws skills and strengths from childhood experiences.

- Experienced positive childhood without instances of maltreatment, and as a result has positive current parenting experience and substantial skills; OR
- May have experienced maltreatment in childhood but has completed formal or informal work to resolve issues and translate past maltreatment into positive skills and strengths in his/her current role as a parent.

b. No child maltreatment history.

No history of child maltreatment.

c. Maltreated as child, none to minor current negative effects.

- Experienced maltreatment as a child; AND
- Occasionally struggles with effects of maltreatment but this has no or minor impact on his/her current parenting role.

d. Maltreated as a child, major current negative effects.

- Experienced maltreatment as a child; AND
- Struggles with effects of maltreatment to the extent that he/she is unable to fully or appropriately engage in his/her current parenting role. For example, he/she is unable to form a close relationship with his/her child or becomes enmeshed and overprotective; unable to discipline without causing harm or unable to discipline at all; OR
- Performing parenting role but is experiencing severe emotional disturbance in relation to recollection of his/her own childhood experiences.

SN7. Resource Management/Basic Needs

a. Resources sufficient to meet basic needs and are adequately managed. Caregiver has a history of consistently providing safe, healthy, and stable housing; nutritional food; clothing; and basic care needs. The family has sufficient financial resources and those resources are used appropriately.

b. Resources adequate or limited but are adequately managed. Caregiver provides adequate housing, food, clothing, and resources to meet basic care needs. The family has adequate financial resources, or resources may be limited, but they are managed in such a way that basic needs for health and safety are adequately met.

c. Resources are insufficient or not well-managed. Caregiver provides housing but it does not meet the basic needs of the child due to such things as inadequate plumbing, heating, wiring, or housekeeping. Food and/or clothing do not meet basic needs of the child. Family may be homeless; however, there is no evidence of harm or threat of harm to the child. Family has insufficient financial resources or has difficulty managing financial resources in a manner that adequately provides for basic care needs related to health and safety.

d. No resources, or resources severely limited and/or mismanaged. Conditions exist in the household that have caused illness or injury to family members such as inadequate plumbing, heating, wiring, and housekeeping; there is no food; food is spoiled; or family members are malnourished. The child chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair. Family is homeless, which results in harm or threat of harm to child. Family has no financial resources or mismanages resources to the extent that the child is deprived of minimal basic care needs for health and safety.

SN8. Physical Health

a. Preventive health care is practiced. Caregiver teaches and promotes good health.

b. Health issues do not affect family functioning. Caregiver may or may not have current health issues, but if he/she does, those issues do not adversely affect family

functioning. Caregiver accesses regular health resources for him/herself (e.g., medical/dental).

c. Health concerns/disabilities affect family functioning. Caregiver has health concerns or conditions that adversely affect family functioning.

d. Serious health concerns/disabilities result in inability to provide care. Caregiver has a serious/chronic health problem or condition that adversely affects his/her ability to care for and/or protect the child.

CHILDREN – Rate each child according to his/her current level of functioning.
For each item, if not applicable due to child's age, score as "0."

CSN1. Physical Health

Is the child medically complex? Check the yes or no box on the tool for each child.

a. Good health. Demonstrates good health and hygiene care involving awareness of nutrition and exercise. The child has no known health care needs. The child receives routine preventive and medical/dental/vision care and immunization.

b. Adequate health. The child has no health care needs or may have sporadic health issues that can be addressed with minimal intervention that typically requires no formal training, e.g., oral medications. Age-appropriate immunizations are current.

c. Minor health needs. The child has health care needs that require ongoing interventions that are typically provided by lay (non-professional) persons after minimal instruction, e.g., glucose testing and insulin, cast care.

d. Serious health needs. The child has serious health/ problems that require interventions that are typically provided by professionals or caregivers who have received substantial instruction, e.g., central line feeding, trach-vent care, wound dressing changes.

CSN2. Emotional/Behavioral

a. Strong coping skills. The child displays strong coping skills in dealing with disappointment, anger, grief, stress, and daily challenges in home, school, and community. The child is able to develop and maintain trusting relationships. The child is also able to identify the need for, seek, and accept guidance. He/she has the ability to adjust to new situations.

b. Age-appropriate coping skills. The child displays age-appropriate emotional coping responses. May demonstrate some symptoms of depression, anxiety, or isolation that are situationally related (such as in home, school, or community) and usually maintains appropriate emotional control.

c. Limited coping skills. The child has occasional difficulty coping with situational stress, crises, or problems, which impairs functioning in home, school, or community. The child displays periodic problem behaviors or exhibits emotional instability including, but not limited to, depression, psychosomatic (physical or emotional) complaints, running away, hostility, truancy, or apathy (lack of concern/interest).

d. Severely impaired coping skills. The child severely impaired coping skills and/or extreme emotional responses, which prohibit or severely limit adequate functioning in home, school, or community. The child exhibits serious emotional instability or chronic/severe problem behaviors such as violence towards self, others, animals, or property.

CSN3. Education/Development

Does the child have an Individualized Education Plan (IEP)? Check the yes or no box on the tool for each child.

a. Advanced achievement/development. The child consistently functions above appropriate grade level and/or is exceeding the expectations of his/her IEP. The child's physical and cognitive skills are above chronological age level; the child meets all or most developmental milestones and there is no indication of developmental delay.

b. Satisfactory achievement/development. The child consistently functions at appropriate grade level and/or meets expectations of his/her IEP. The child's physical and cognitive skills are consistent with chronological age level; the child meets most developmental milestones, and there is no indication of developmental delay.

c. Some educational difficulty/development issues. The child inconsistently functions at the appropriate grade level and/or struggles to meet the goals of his/her IEP. The child has some delays in meeting developmental milestones and/or has some developmental delay that requires standard services (e.g., Early Intervention or Birth-to-Three).

d. Severe educational difficulty/development issues. The child functions significantly below grade level and/or is not meeting the goals of his/her IEP. The child has significant delays in meeting developmental milestones requiring formalized structured intervention and/or specialized services.

CSN4. Substance Abuse

(Substances: alcohol, tobacco, illegal drugs and/or prescribed drugs)

a. Conscious decision to avoid use. The child has not used substances and is aware of consequences of use. The child avoids peer relations/social activities involving substances and/or chooses not to use despite peer pressure/opportunities to use.

b. No use/minor experimentation. No demonstrated history or current problems related to substance use. Child may have experimented with substances, but there is no indication of sustained use.

c. Alcohol or other drug use. The child's current substance use results in disruptive behavior, legal problems, and/or discord in relationships in school/community/family/work. Use may include multiple drugs or inappropriate use of prescribed drugs and/or alcohol.

d. Abuse/dependency. The child's chronic abuse and/or dependency results in severe disruption of functioning such as loss of relationships, job, school suspension, expulsion, drop-out, problems with the law, and/or physical harm to self or others. May require medical intervention to detoxify.

CSN5. Social Support

a. Positive support network. Routinely interacts with social groups, having positive support and influence. Models responsible behavior. Participates in age-appropriate social activities. Uses leisure time constructively. Has good support network. The child has at least one supportive caring adult in his/her life.

b. Adequate support network. Engages in positive leisure time activities or extra-curricular activities, respects and interacts with others, and has adequate support network and age-appropriate peers. The child has stable relationship with others and has developed good conflict resolution skills.

c. Limited support network. Interacts and relates to others, but conflicts may be more frequent and serious and the child may be unable to resolve them. The child lacks social skills, has non-productive use of leisure time, and has a limited support network with limited involvement with age-appropriate peers. The child engages in some high risk and/or illegal activities.

d. Lacks support network. The child has poor social skills as demonstrated by frequent conflicted relationships, is isolated, has no support network available, and consistently seeks out age-inappropriate peers or exclusively interacts with negative or exploitive peers. The child engages in chronic high risk and/or illegal activities within the community. The child is isolated and lacks support system.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT
POLICY AND PROCEDURES

The family strengths and needs assessment (FSNA) is used to evaluate the presenting strengths and needs of the primary and, if applicable, secondary caregiver in the household of each parent you assess in preparation for the development of a treatment plan. If you are considering reunification to a family where both parents live together, then one would be the primary and one would be the secondary caregiver on that household's FSNA. If you were considering reunification to either parent and they live separate and apart, you would assess each household separately on an FSNA and he/she would be the primary caregiver in his/her respective households. This tool is used to systematically identify critical family needs, and it helps plan effective service interventions. The strengths and needs assessment serves several purposes:

- It ensures that all social workers consistently consider each family's strengths and needs in an objective format when assessing need for services.

- It provides an important treatment planning reference for workers and supervisors.

- The initial strengths and needs assessment, when followed by periodic reassessments, permits social workers, their supervisors, and families to easily assess changes in family functioning and thus assess the impact of services on the treatment/permanency plan.

- In the aggregate, needs assessment data provide management with information on the problems families require services to improve. These profiles can then be used to develop resources to meet family needs.

Which Cases: All CPS treatment cases.

(The child assessment portion is completed for each child in the home or placed as a result of a CPS issue.)

Note: For existing open cases at the time of initial SDM implementation, an FSNA is required prior to the development of the next treatment plan.

Who: The treatment worker who is responsible for developing the initial treatment plan in conjunction with the family.

When: Prior to the development of the treatment plan. For in-home cases, within 45 days of the investigation disposition. For placement cases, within 45 days from the date of removal. If you are considering reunification to either parent and they live separate and apart, you would continue to include the strengths and needs of each in one treatment plan and redact appropriately at review.

Decisions: Identifies the three highest priority needs of caregivers and all needs of children that must be addressed in the treatment plan. Goals, objectives, and interventions in a treatment plan should relate to one or more of the priority needs.

Identifies a family's priority areas of strengths that should be incorporated into the treatment plan to the greatest extent possible, as a means to address identified needs.

Appropriate Completion:

Workers should familiarize themselves with the eight caregiver categories and the five child categories of the FSNA and definitions. Workers will notice that the items are areas they are probably already assessing. What distinguishes the SDM model is that it ensures that every worker assesses the same categories in each case, and that the responses to these items lead to specific treatment planning. Once a worker is familiar with the items that must be assessed to complete the FSNA, the worker should conduct his/her family assessment as he/she normally would—using good social work practice and/or a family team conferencing model to collect information from the child, caregiver, and/or collateral sources. The SDM model ensures that a specific set of categories are addressed at some time during the assessment.

For each category, there are four possible responses:

a. This is a strength response. A caregiver/child with a response of "a" has exceptional skills or resources in this area.

b. This is an "average" or adequate functioning response. This response is also used to score children who are too young to assess in some categories. A caregiver/child with a response of "b" has not achieved the exceptional skills or resources reflected by a response of "a" and may experience a degree of stress or struggle common to daily functioning, but he/she is generally functioning well in the area. These responses are considered as potential strengths, with the exception of children who are scored "b" in some categories because they are too young to assess.

c. A caregiver/child is experiencing increased need in the category's domain.

d. A caregiver/child is experiencing extraordinary need in the category's domain.

When scoring, consider the entire scope of available information, including the family's perspective, information from collateral sources, existing records and documents, and worker observations. Often, different sources will suggest different responses (e.g., father states he has no problem with alcohol but has two DUIs in the last year; mother states she believes he is an alcoholic; a court-ordered AOD assessment suggests alcohol dependency; father's brother states father has no problem with alcohol). The worker must make a determination based on social work assessment skills, taking into account the merits of each perspective. The household is assessed by

completing all items. If there are two caregivers, each is assessed and scored separately.

Items SN1 to SN8 and CSN1 to CSN5
Determine the appropriate response for each item and enter the corresponding score on the line provided. Be aware of negative and positive values.

Items CSN1 to CSN5 relate to children in the family/household. Use one column for each child who will be assessed.

Priority Needs and Strengths for Caregivers
To identify priority needs and strengths for caregivers, consider scores for items SN1 through SN8 in Section A (caregiver) of the FSNA. All identified child needs must be considered in the family treatment plan.

For priority needs, enter the item number and title that corresponds with the three LOWEST scores. Only items with negative scores may be included as priority needs. Look across both caregivers to search for lowest score. Up to three domains should be selected for priority needs. A domain may be a priority need for one or both caregivers. In the column labeled "Caregiver," make an X to indicate whether one or both caregivers have the need.

For priority strengths, enter the item number and title that corresponds with the three HIGHEST scores. Only items with "0" or positive scores may be included as priority strengths. Look across both caregivers to search for the highest score. No more than three domains should be selected for priority strengths. A domain may be a priority strength for one or both caregivers. In the column labeled "Caregiver," make an X to indicate whether one or both caregivers have the strength.

For both needs and strengths, ties are resolved by worker judgment as to which of the tied items are most critical.

Note: A domain may be a priority need for one caregiver and a priority strength for another caregiver.

Treatment Plan
A family treatment plan is to be written with goals and objectives that consider and incorporate the caregiver's priority strengths in addressing the caregiver's priority needs. The family treatment plan is also to include service referrals that address the child's needs and take into consideration the child's strengths. The goals should be clearly connected to the reason for DCF involvement and what needs to be accomplished in order for DCF to close the case. It is the caregiver's responsibility to ensure that the child's needs are met through appropriate service provision. If a child is in protective placement and the caregiver is unable to meet the child's needs, the agency must meet the child's needs. Goals should be prioritized, as too

many goals may overwhelm the family; remember each plan addresses a six-month period.

When the supervisor reviews and approves the treatment plan, he/she is expected to have reviewed the completed SDM FSNA and/or reassessments to ensure: 1) that the SDM assessments have been completed in a reliable and valid manner, and 2) that the identified needs of the caregivers and children have been appropriately addressed in the treatment plan. The supervisor's approval of the treatment plan includes an approval of the FSNA and/or reassessments that were completed to guide the formulation of the treatment plan.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY STRENGTHS AND NEEDS REASSESSMENT
POLICY AND PROCEDURES

The family strengths and needs reassessment provides an opportunity to evaluate a family's progress toward reducing needs. In the aggregate, reassessments also provide a continuing profile of case characteristics for agency planning and program development. The FSNA and definitions used for initial assessments are also used for reassessments.

Which Cases: All CPS cases that will remain open for in-home or placement services.

Who: The treatment worker.

When: At minimum, in conjunction with each risk reassessment for in-home cases and reunification assessments for placement cases. This tool guides the process for reviewing progress on and updating the treatment plan.

Note: If you are still considering reunification to either parent and the parents live separate and apart, you would complete an FSNA for each household, and each parent would be the primary caregiver in his/her respective household.

The first reassessment is required within 90 days from the initial treatment plan and every 90 days thereafter. At the interim 90-day reviews, the FSNA is used to review the family's progress and to begin preparing for the development of the new treatment plan that will occur every six months.

For placement cases, the first reassessment will occur within 90 days of the first treatment plan and every 90 days thereafter until reunification or there is a change in the permanency plan goal.

Decisions: For cases that will remain open, the priority caregiver needs and all identified child needs established as a result of the initial assessment should be addressed in the treatment plan and updated as required. Similarly, any updated treatment plan should draw upon the updated family strengths in addressing updated areas of priority need.

Appropriate Completion: At reassessment, the FSNA is completed in exactly the same manner as it is completed at the time of the initial assessment except for the following:

- Indicate that this is a reassessment and indicate which reassessment is being completed (first, second, etc.).
- Consider **ONLY** the period of time since the most recent assessment/reassessment.

When the supervisor reviews and approves the treatment plan, he/she is expected to have reviewed the completed FSNA and/or reassessments to

ensure: 1) that the SDM assessments have been completed in a reliable and valid manner, and 2) that the identified needs of the caregivers and children have been appropriately addressed in the treatment plan. The supervisor's approval of the treatment plan includes an approval of the FSNA and/or reassessments that were completed to guide the formulation of the treatment plan.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 12/06
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES

Case Name: _____ **LINK #:** _____
Area Office: _____ **Worker:** _____ **Assessment Date:** ___/___/___

		Score
R1.	**Number of Prior Neglect or Abuse CPS Investigations**	
	a. None 0	
	b. One 1	
	c. Two or more 2	_____
R2.	**Household Has Previously Received CPS (voluntary/court ordered)**	
	a. No 0	
	b. Yes 1	_____
R3.	**Primary Caregiver Has a History of Abuse or Neglect as a Child**	
	a. No 0	
	b. Yes 1	_____
R4.	**Child Characteristics** (mark applicable items and add for score)	
	a. ❑ No child has any of the characteristics below 0	
	b. ❑ One or more children in household are developmentally or physically disabled 1	
	c. ❑ One or more children in household are medically fragile or diagnosed with failure to thrive 1	_____

The following case observations pertain to the period since the initial risk assessment or last reassessment.

R5.	**New Investigation of Abuse or Neglect since the Initial Risk Assessment or the Last Reassessment**	
	a. No 0	
	b. Yes 2	_____
R6.	**Caregiver Has Not Addressed Alcohol or Drug Abuse Problem since the Last Assessment/Reassessment** (mark one)	
	a. ❑ No history of alcohol or drug abuse problem 0	
	b. ❑ No current alcohol or drug abuse problem; no intervention needed 0	
	c. ❑ Yes, alcohol or drug abuse problem; problem is being addressed 0	
	d. ❑ Yes, alcohol or drug abuse problem; problem is <u>not</u> being addressed 1	_____
R7.	**Problems with Adult Relationships**	
	a. None applicable 0	
	b. Yes, harmful/tumultuous relationships with adults 1	
	c. Yes, domestic violence 2	_____
R8.	**Primary Caregiver Provides Physical Care Inconsistent with Child Needs**	
	a. No problems 0	
	b. Yes, problems 1	_____
R9.	**Caregiver's Progress with Treatment Plan** (mark one, based on the caregiver demonstrating the least progress)	
	a. ❑ Not applicable; all services unavailable 0	
	b. ❑ Successfully completed all services recommended or actively participating in services; demonstrating behaviors that are consistent with objectives in the treatment plan. 0	
	c. ❑ Participating in services but not fully demonstrating behaviors consistent with objectives in treatment plan. 2	
	d. ❑ Refuses services; failed to participate and/or is not demonstrating behavior consistent with objectives in treatment plan as required 4	_____
	TOTAL SCORE	_____

SCORED RISK LEVEL. Assign the family's risk level based on the following chart:

Score	Risk Level
❑ 0 – 2	❑ Very Low
❑ 3 – 5	❑ Low
❑ 6 – 8	❑ Moderate
❑ 9 – 16	❑ High

POLICY OVERRIDES TO HIGH. Check box if condition in 1, 2, 3, or 4 is applicable in the current review period. If condition 5 exists, the risk level will always remain high. If <u>any</u> condition is applicable, override final risk level to high.

❑ 1. Sexual abuse cases AND the perpetrator is likely to have access to the child victim.
❑ 2. Cases with non-accidental physical injury to a child under age six.
❑ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
❑ 4. Positive toxicology screen (alcohol or drugs) of mother or newborn at time of birth.
❑ 5. Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. If a discretionary override is made, check box, mark override risk level, and indicate reason. Risk level may be overridden one level higher or lower. Discretionary override cannot be used to reduce a policy override.

❑ 6. If <u>yes</u>, override risk level (mark one): ❑ Very Low ❑ Low ❑ Moderate ❑ High
Discretionary override reason: _____

Supervisor Review/Approval of Discretionary Override: _____ **Date:** ___/___/___

FINAL RISK LEVEL (mark final level assigned): ❑ Very Low ❑ Low ❑ Moderate ❑ High

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES
DEFINITIONS

R1. Number of Prior Neglect or Abuse CPS Investigations

Score the item based on the count of all investigations, substantiated or not, that were assigned for CPS investigation for any type of abuse or neglect prior to the investigation resulting in the current case. Where possible, history from other county or state jurisdictions should be marked. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

R2. Household Has Previously Received CPS (voluntary/court ordered)

Score 1 if household has received CPS prior to the investigation resulting in the current case. Service history includes voluntary or court-ordered treatment services or Family Preservation Services but does not include delinquency services.

R3. Primary Caregiver Has a History of Abuse or Neglect as a Child

Score 1 if credible statements by the primary caregiver or others indicate that the primary caregiver was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

R4. Child Characteristics

Score the appropriate amount for each characteristic present and record the sum (0, 1, or 2) as the item score.

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child has a developmental or physical disability, including any of the following: mental retardation, learning disability, other developmental problem, or significant physical handicap.

c. Score 1 if any child in the household is medically fragile, which is defined as having a long-term (six months or more) physical condition requiring medical intervention, or is diagnosed as failure to thrive.

The following case observations pertain to the period since the initial risk assessment or last reassessment.

R5. New Investigation of Abuse or Neglect since the Initial Risk Assessment or Last Reassessment

Score 2 if at least one investigation has been initiated **since the initial risk assessment or last reassessment**. This includes open or completed investigations, regardless of investigation conclusion, that have been initiated since the initial assessment or last reassessment.

R6. Caregiver Has Not Addressed Alcohol or Drug Abuse Problem since the Initial Risk Assessment or the Last Reassessment

Indicate whether or not the primary and/or secondary caregiver has a current alcohol/drug abuse problem and he/she is not addressing the problem. If both caregivers have a substance abuse problem, rate the more negative behavior of the two caregivers. Not addressing the problem is evidenced by:

- substance use that affects or affected the caregiver's employment; criminal involvement; marital or family relationships; or his/her ability to provide protection, supervision, and care for the child;
- an arrest since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing;
- self report of a problem;
- multiple positive urine or hair samples;
- health/medical problems resulting from substance use;
- the child's diagnosis with Fetal Alcohol Syndrome or Exposure (FAS or FAE) or the child had positive toxicology screen at birth and the primary or secondary caregiver was the birth parent.

Score as follows:

a. Score 0 if there is no history of an alcohol or drug abuse problem.

b. Score 0 if there is no current alcohol or drug abuse problem that requires intervention.

c. Score 0 if there is an alcohol or drug abuse problem, and the problem is being addressed.

d. Score 1 if there is an alcohol or drug abuse problem, and the problem is not being addressed.

Legal, non-abusive prescription drug use should not be scored.

R7. Problems with Adult Relationships

Score this item based upon current status of adult relationships in the household.

a. Score 0 if not applicable or there are no problems observed.

b. Score 1 if yes, there are harmful/tumultuous adult relationships that interfere with domestic functioning or the care the child receives (but not at the level of domestic violence).

c. Score 2 if yes, domestic violence is present, i.e., the household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/ harassment between caregivers or between a caregiver and another adult.

R8. Primary Caregiver Provides Physical Care Inconsistent with Child Needs

Score 1 if physical care of the child (age-appropriate feeding, clothing, shelter, hygiene, and medical care of the child) threatens the child's well-being or results in harm to the child. Examples include:

- repeated failure to obtain required immunizations;
- failure to obtain medical care for severe or chronic illness;
- repeated failure to provide the child with weather-appropriate clothing;
- persistent rat or roach infestations;
- inadequate or inoperative plumbing or heating;
- poisonous substances or dangerous objects lying within reach of small child;
- the child is wearing filthy clothes for extended periods of time; or
- the child is not being bathed on a regular basis, resulting in dirt caked on skin and hair and a strong odor.

R9. Caregiver's Progress with Treatment Plan

Score this item based on whether a caregiver has demonstrated or is beginning to demonstrate skills learned from participation in services. If there are two caregivers and progress differs, score based on the least amount of participation/progress.

a. Score 0 if not applicable. All desired services were unavailable during the last assessment period.

b. Score 0 if the caregiver successfully completed all recommended services or is actively participating in services and demonstrating behaviors that are consistent with objectives in the treatment plan. Observation demonstrates the caregiver's application of learned skills in interaction(s) between child/caregiver, caregiver to caregiver, caregiver to other significant adult(s), self care, home maintenance, financial management, or demonstration of skills toward reaching the behavioral objectives agreed upon in the treatment plan.

c. Score 2 if caregiver has participated in services and made some progress but is not fully demonstrating behaviors that are consistent with the objectives in the treatment plan.

d. Score 4 if the caregiver refuses services, sporadically follows the treatment plan, or has not demonstrated the necessary skills due to a failure or inability to participate.

Also score this item if the caregiver has participated in services, but he/she is not demonstrating behaviors consistent with objectives in the treatment plan.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES
POLICY AND PROCEDURES

The initial assessments of risk and strengths and needs represent the first phase of the SDM process. Reassessments are performed at established intervals as long as the case is open. Case reassessment ensures that risk of maltreatment and family service needs will be considered in later stages of the service delivery process and that case decisions will be made accordingly. At each reassessment, social workers reevaluate the family using instruments that help them systematically assess changes in risk and needs. Case progress will determine if a case should remain open or if the case can be closed.

Periodic reassessment also provides for ongoing monitoring of important case outcomes such as: 1) new abuse or neglect incidents; 2) changes in each family's service utilization pattern and/or observations of family behavior changes resulting from service provision; and 3) changes in the severity of previously identified problems. The routine reassessment of each family at fixed intervals provides case managers and their supervisors with an efficient mechanism for collecting and evaluating information necessary to effectively manage their cases. The family risk reassessment combines items from the original risk assessment with additional items that evaluate a family's progress toward case plan goals.

Research has demonstrated that for the reassessment, a single index best categorizes risk for future maltreatment. Unlike the initial risk assessment that contains separate indices for risk of neglect and risk of abuse, the risk reassessment is comprised of a single index.

Which Cases: All open cases in which all children remain in the home, or cases in which all children have been returned home and CPS treatment services will continue to be provided.

Note: For existing open cases at the time of initial SDM implementation, a risk reassessment for in-home cases will be completed at the next scheduled review. Since there will be no SDM initial risk assessment to guide your answers, R1 through R4 answers must be based on information at the time of the most recent case opening, unless additional information has become available. Answers for R5 through R9 will be based on information available since the last treatment plan.

Who: The treatment worker.

When:

- The first reassessment is required within 90 days after the initial treatment plan and every 90 days thereafter.
- At the time of any required ad hoc reviews, i.e., court or central office review.
- Prior to closing a case, if the last reassessment occurred more than 30 days ago.

- As directed by supervisor.

If a new report is received while a case is open, an initial risk assessment (not a risk reassessment) will be completed during the investigation, according to risk assessment policy and procedures in Section IV of this manual.

- The original reassessment schedule will remain in effect.

- If the case was an in-home case and the NEW report results in a placement or a treatment worker's safety assessment results in a placement, the reunification assessment/reassessment will start based on the date of the child's post-removal treatment plan.

Decisions: The risk reassessment guides the decision to keep a case open or close a case.

Risk-Based Case Open/Close Matrix	
Risk Level	**Recommendation**
Very Low	Close if there are no unresolved safety factors
Low	Close if there are no unresolved safety factors
Moderate	Case remains open
High	Case remains open

For cases that remain open, workers and supervisors should consider the new risk level when prioritizing case work activities, targeting more time to high risk cases.

Appropriate Completion:

Items R1-R4

Using the definitions, determine the appropriate response for each item and enter the corresponding score. Items R1 and R2 refer to the time period PRIOR to the investigation that led to the opening of the current case. Scores for these items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

Item R3 may change if new information is available or if there has been a change in who is primary caregiver.

Item R4 may change if a child's condition has changed, or if a child with a described condition is no longer part of the household (children in out-of-home placement with a plan to return home are considered part of the household, and the family should be reassessed using the reunification assessment/reassessment).

Items R5-R9

These items are scored based ONLY on observations since the most recent assessment or reassessment. Using the definitions, determine the appropriate response for each item and enter the corresponding score. After entering the

score for each individual item, enter the total score and indicate the corresponding risk level.

Policy Overrides

The worker determines if any of the policy override reasons exist. Policy overrides have been determined by the agency as case situations that warrant the highest level of service from the agency regardless of the risk scale score at reassessment. If any policy override reasons exist, check the applicable reason and increase the final risk level to high. Note that the conditions associated with all but one of the policy overrides must have taken place as a result of a new referral **during the reassessment period**. A policy override is only used at reassessment if the event has occurred in relation to a new referral since the last assessment/reassessment, except in cases where the death of a sibling has occurred due to abuse or neglect. These cases always remain high risk cases.

Discretionary Override

A discretionary override is used by the treatment worker whenever the worker believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment in which the worker could only *increase* the risk level, the risk reassessment permits the worker to increase or *decrease* the risk level by one step. Discretionary overrides cannot be used to reduce a policy override. The reason a worker may now decrease the risk level is that after a minimum of three months, the worker has acquired significant knowledge of the family. If a discretionary override applies, mark yes, indicate the reason, and mark the override risk level. The worker then indicates the final risk level.

A supervisor's approval is required for all risk reassessments. A program supervisor's approval and documentation in LINK is required whenever a decision is made that is not consistent with the opening/closing recommendation in the Case Decision Matrix.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 04/07
SDM® FAMILY REUNIFICATION ASSESSMENT/REASSESSMENT

Case Name: _____ **LINK #:** _____ **Household Assessed:** _____

Area Office: _____ **Worker:** _____ **Assessment/Reassessment Date:** ____/____/____

Assessment/Reassessment #: 1 2 3 4 ____ **Removal Household (circle one)?** Yes No

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A. FAMILY REUNIFICATION RISK ASSESSMENT/REASSESSMENT

		Score
R1. Risk Level from Most Recent Investigation (after overrides)		
a.	Very Low 0	
b.	Low 3	
c.	Moderate 4	
d.	High 5	
e.	No initial SDM risk level 4	_____
R2. Household's Progress Toward Treatment Goals		
a.	Successfully met all current treatment plan objectives ..... -2	
b.	Pursuing all objectives detailed in treatment plan ..... -1	
c.	Pursuing the majority of the objectives in treatment plan 0	
d.	Pursuing less than the majority of the objectives in treatment plan 2	
e.	Refuses involvement in programs, or fails to participate 4	_____
R3. Has There Been a New Substantiation (in this household) since the Last Assessment/Reassessment?		
a.	No 0	
b.	Yes 6	_____
	Total Score:	_____

SCORED RISK LEVEL:
Assign the family's risk level based on the following chart.

Score	Risk Level
❑ -2 – 1	❑ Very Low
❑ 2 – 3	❑ Low
❑ 4 – 5	❑ Moderate
❑ 6 +	❑ High

POLICY OVERRIDES TO HIGH. Check box if condition in 1, 2, 3, or 4 is applicable in the current review period. If condition 5 exists, the risk level will always remain high. If any condition is applicable, override final risk level to high.

❑ 1. Sexual abuse cases AND the perpetrator is likely to have access to the child victim.
❑ 2. Cases with non-accidental physical injury to a child under age six.
❑ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
❑ 4. Positive toxicology screen (alcohol or drugs) of mother or newborn at time of birth.
❑ 5. Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. Override up or down one level.
❑ 6. Reason: _____

FINAL RISK LEVEL: ❑ Very Low ❑ Low ❑ Moderate ❑ High

B. VISITATION PLAN EVALUATION

Evaluate caregiver visitation with each child.

	Child #___	Child #___	Child #___	Child #___
1. Evaluation of Visitation Plan				
a. No visitation. State the reason: 1) Court order prohibits 2) Unable to locate 3) Other, specify: _____ **STOP. GO TO SECTION D.**				
b. Excellent—Unsupervised extended and/or overnight visits, positive caregiver-child interactions.				
c. Good—Unsupervised visits, caregiver-child interaction is appropriate.				
d. Fair—Supervised visits, caregiver-child interaction may have improved, but more improvement is necessary.				
e. Poor—Supervised visits, poor caregiver-child interactions.				
f. None—Caregiver has failed to visit or visits have been suspended due to parental behavior.				

C. REUNIFICATION SAFETY REASSESSMENT

SECTION 1: SAFETY FACTORS

1. Are any safety factors that were identified on the SDM safety assessment that resulted in the child's removal still present?

❑ Yes: Describe safety factor(s) as they currently exist: _____

❑ No: Describe how the initial safety factors were ameliorated or mitigated after the child's removal: _____

1a. If yes, were interventions incorporated into the treatment plan and did they mitigate the safety factors?

❑ Yes: Describe: _____

❑ No Explain: _____

2. Have any new safety factors emerged since the child's removal or are there any other circumstances or conditions present in the reunification household that, if the child were to be returned home, would present an immediate danger of serious harm?

❑ Yes: Describe: _____

❑ No: Explain: _____

2a. If yes, are these interventions being incorporated into the treatment plan to mitigate these safety concerns?

❑ Yes: Describe: _____

❑ No Explain: _____

SECTION 2: SAFETY DECISION

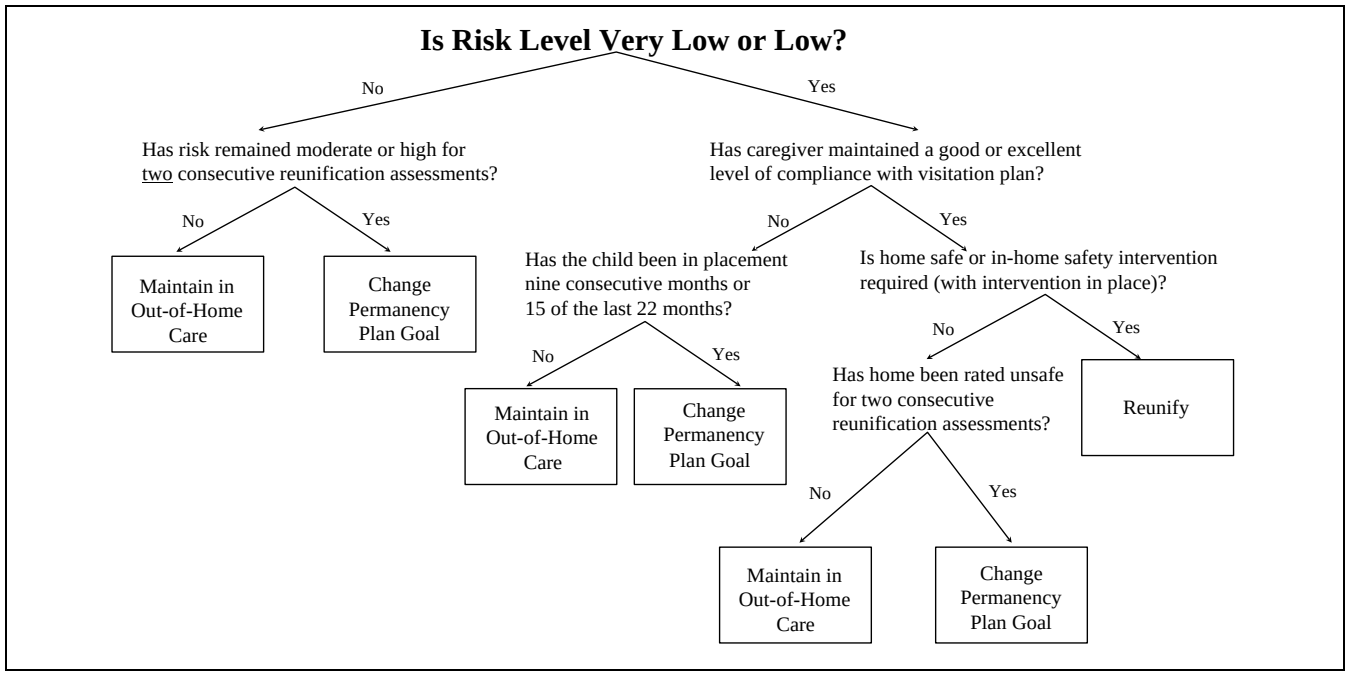
❑ A. **Safe.** Safety factors that resulted in the child's removal (as documented on the initial safety assessment) are no longer present, and no additional safety factors were identified. **Specific services to support successful reunification are described in the treatment plan.**

❑ B. **In-Home Safety Interventions Required.** One or more safety factors are present, as identified by a "yes" answer in question 1 and/or 2 above. **Specific services that will be put in place to mitigate safety factors are described in the treatment plan.**

❑ C. **Unsafe.** One or more safety factors are present, as described above, and interventions are not available or possible to ensure child safety in the home; one or more children remain in custody.

D. PLACEMENT/PERMANENCY PLAN GUIDELINES

Complete for each child in out-of-home care and enter results below in Section E.



E. PERMANENCY PLAN RECOMMENDATION SUMMARY

Record recommendation for each child. The child listed as #1 must be the same child listed first in Section B.

Child Name	Child #	Guideline Recommendation				Override Y/N	Worker's Final Permanency Plan Recommendation (Maintain OHP, Change Goal, Reunify)
		Reunify	Maintain OHP with Goal of Reunification	Change Permanency Plan*	New Goal		
1.							
2.							
3.							
4.							
5.							
6.							

*****If "Change Permanency Plan" is marked, you must enter the new goal using the codes below:

New Permanency Plan Goal Codes:

A = Reunification
B = Adoption
C = Guardianship
D = Permanent and Legal Placement with a Relative
E = APPLA (Another Planned Permanent Living Arrangement may be used only with a documented and approved compelling reason)

Override Reason: _____

Worker: _____ **Date:** ____/____/____

Supervisor/Program Supervisor: _____ **Date:** ____/____/____

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY REUNIFICATION ASSESSMENT/REASSESSMENT
DEFINITIONS

A. FAMILY REUNIFICATION RISK ASSESSMENT/REASSESSMENT

R1. Risk Level from Most Recent Investigation (after overrides)
The risk level from the most recent investigation is used to score this item. Score "e" if no SDM initial risk assessment was completed for this household.

R2. Household's Progress Toward Treatment Goals
Rate this item based on whether the members of the household have mastered or are mastering skills learned from participation in services.

a. Successfully met all current treatment plan objectives. Continuing cooperation with ongoing programs; demonstrating behaviors that are consistent with objectives in the treatment plan. The family has successfully met *all* current treatment plan objectives. After meeting these objectives, they continue to cooperate with ongoing services.

b. Pursuing all objectives detailed in treatment plan. The family is actively participating in all of the services and demonstrates an effort in pursuing the objectives detailed in treatment plan. They continue to demonstrate behaviors that are consistent with objectives in the treatment plan.

c. Pursuing the majority of the objectives in treatment plan. The family is participating in the majority of the services. They are demonstrating improved functioning in the majority of the behaviors consistent with objectives in the treatment plan.

d. Pursuing less than the majority of the objectives in treatment plan. The family is minimally participating in services; there is little or no demonstrated improvement in behaviors consistent with objectives in the treatment plan.

e. Refuses involvement in programs, or fails to participate. The family refuses services or has not mastered the necessary skills due to a failure or inability to participate. There have been no demonstrated behavior changes consistent with objectives in the treatment plan.

R3. Has There Been a New Substantiation (in this household) since the Last Assessment/Reassessment?
Rate this item based on whether a report(s) has been received (for this household) **since the last assessment (if done at case opening) or reassessment.**

a. No, a report was not substantiated—report may have been made, but it was not substantiated.

b. Yes, a report was received and substantiated.

B. VISITATION PLAN EVALUATION

Note: When assessing visitation, the need to supervise a visit due to safety concerns is evaluated. If a visit is being supervised because of a legal status (i.e., OTC), but you would not supervise or be concerned for the child's safety were it not for the legal status, then consider the visit unsupervised when evaluating the quality of visitation.

a. No visitation. Caregiver is unable to visit the child.

b. Excellent. Unsupervised (or supervised, but not because of safety concerns) visits, extended and/or overnight visits; positive caregiver-child interactions. There have been no missed visits. During visits, caregiver has demonstrated nurturing, feeding, appropriate supervision, age-appropriate interaction, etc.

c. Good. Unsupervised (or supervised, but not because of safety concerns) visits, caregiver-child interaction is appropriate. Visits may have been rescheduled but arrangements were made in advance.

d. Fair. Supervised (due to safety concerns) visits, caregiver-child interaction may have improved, but more improvement is necessary. Visits are supervised but may have been extended in length due to improved parental behavior. No more than one missed visit without legitimate explanation or advance notice.

e. Poor. Supervised (due to safety concerns) visits, poor caregiver-child interaction. More than one missed visit without legitimate explanation and/or advance notice, and/or caregiver has demonstrated poor parenting techniques or poor caregiver-child interaction during visitation. Unsupervised visits may have been rescinded due to poor parental behavior.

f. None. Caregiver has failed to visit or visits have been suspended due to parental behavior.

C. REUNIFICATION SAFETY REASSESSMENT

Whenever reunification for any child is being considered, a safety reassessment must be completed on the household to which the child would be returned. The worker must address the safety factors identified at the time of removal and any new or emerging safety factors. Documentation as to how the initial safety factors were resolved is required. A child may be reunified if a safety factor exists as long as a protective intervention is in place (and documented) to ensure the child's safety.

D. PLACEMENT/PERMANENCY PLAN GUIDELINES

Maintain in Out-of-Home Care

Do not place the child home. Continue reunification efforts with the household.

Change Permanency Plan Goal
Change the permanency plan goal from reunification to adoption, guardianship, or other. Stop efforts to place the child in the home under assessment.

Reunify
The child is eligible to be reunified with the household being assessed.

E. PERMANENCY PLAN RECOMMENDATION SUMMARY

Reunify
Based on the reunification assessment results, the child is eligible to be reunified with the household being assessed.

Maintain OHP with Goal of Reunification
Based on the reunification assessment results, keep the child in out-of-home care and continue reunification efforts with household under assessment.

Change Permanency Plan
Change the permanency plan goal from reunification to adoption, guardianship, long-term foster care (with identified, licensed relative) or APPLA (Another Planned Permanent Living Arrangement) (may be used only with a documented and approved compelling reason). Stop efforts to place the child in the home under assessment.

Override
Mark "Y" for yes or "N" for no to indicate whether the worker is overriding the permanency plan recommendation guided by the decision tree for each child.

Worker's Final Permanency Plan Recommendation
If an override is used, indicate the final permanency plan recommendation: Maintain OHP, Change Goal, Reunify. If "Change Goal" is selected, use new permanency plan goal codes to indicate the new goal.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY REUNIFICATION ASSESSMENT/REASSESSMENT
POLICY AND PROCEDURES

The family reunification assessment/reassessment consists of five parts that are used to evaluate risk, visitation compliance, and safety issues; describe permanency plan guidelines; and record the permanency plan goal. Results are used to reach a permanency placement recommendation and to guide decisions about whether or not to reunify a child. This assessment/reassessment is only to be used with households being considered as a reunification resource. This is not to be used to assess potential relative caregivers or other potential permanent placements. The family reunification assessment/reassessment is completed in conjunction with the FSNA and individual child strengths and needs assessment(s).

Which Cases: Any CPS treatment case in which at least one child is in out-of-home placement with a goal of "reunification." When parents live separately and each has treatment objectives to achieve for reunification, separate reunification assessments/reassessments are required.

During the period between the filing of a Termination of Parental Rights Petition and a determination of same, if there is a judicial order that reunification efforts are no longer required by the Department, the reunification assessment/reassessment is no longer used.

Note: For existing open cases at the time of initial SDM implementation, a reunification assessment will be completed at the next scheduled review using the answer (e) for R1 (no initial risk assessment) for reunification cases. Workers would also look to the reasons for the most recent removal when they complete the safety reassessment.

Note: When parents live separate and apart and you are considering reunification to a parent who did not have an initial risk assessment, you would also answer (e) for R1. If the parent you are considering for reunification was not involved and did not live in the home where the abuse/neglect occurred that led to the removal, you would state that on your safety reassessment.

Note: Occasionally there are cases where a child may be in out-of-home care with a goal of reunification, and there are children at home with parents and two workers are assigned. The worker assigned to the child in out-of-home care with a goal of reunification would complete the reunification assessment for the family. That worker would, of course, work closely with the worker assigned to the in-home case, and each would share vital information as to the risk, safety, visitation, and treatment plan objectives.

Who: The treatment worker

When:

- The first assessment needs to be completed within 90 days of the initial treatment plan, and reassessments are required every 90 days

thereafter until the goal on the treatment plan is no longer reunification or all children had been reunified.

- At any time a child is being considered for immediate reunification.

Note: If a child is removed from the home while the case is opened for treatment services, the family reunification assessment schedule will start based on the date of the child's post removal treatment plan.

Decisions:

The reunification risk reassessment results, the visitation plan evaluation results, and the reunification safety reassessment results determine if a child is eligible for reunification or if the permanency plan goal should be changed. The permanency plan guidelines and recommendation section guide decisions to reunify a child, continue reunification efforts with this household, or change the permanency goal.

Note: When the decision is made to reunify a child with their family, services to the family should continue for a period of time immediately after reunification.

Appropriate Completion:

Circle the assessment/reassessment number that represents how many reassessments have been conducted for this household (including regular CPS in-home reassessments). Under "Household Assessed," enter the name of the primary caregiver who resides in the household. If this is the household from which the child had been removed, circle "yes." If this is a household under consideration for reunification other than the household from which the child was removed, circle "no."

SECTION A. FAMILY REUNIFICATION RISK ASSESSMENT/ REASSESSMENT

Complete the family reunification risk assessment/reassessment and indicate the final risk level.

Policy Overrides

The worker determines if any of the policy override reasons exist. Policy overrides have been determined by the agency as case situations that warrant the highest level of service from the agency regardless of the risk scale score at reassessment. If any policy override reasons exist, check the applicable reason and increase the final risk level to high. Note that the conditions associated with all but one of the policy overrides must have taken place as a result of a new referral **during the reassessment period**. A policy override is only used at reassessment if the event has occurred in relation to a new referral since the last assessment/reassessment, except in cases where the death of a sibling has occurred due to abuse or neglect. These cases always remain high risk cases.

Discretionary Override

The worker determines if there is a discretionary override reason. At assessment/reassessment, a discretionary override may be applied to **increase or decrease the risk level** by one level in any case where the worker feels the risk level set by the scale is too low or too high.

SECTION B. VISITATION PLAN EVALUATION

For each child, indicate the level at which the caregiver has participated in the visitation plan. If the visitation plan calls for no visitation, supply a reason in 1a. Proceed to Section D.

If 1a does not apply, evaluate the caregiver participation in visitation. Visitation evaluation choices range from none to excellent. Rate caregiver(s) compliance with the plan for each child.

SECTION C. REUNIFICATION SAFETY REASSESSMENT

Complete a reunification safety reassessment. Review the safety issues at the time of the child's removal and how they are being addressed and or have been resolved. Indicate whether new safety issues have arisen and how they are being resolved and/or addressed.

1. Safety Factors

   Answer questions 1 and 2 in this section based on current information. The worker must review the initial safety assessment that was completed at the time of the child's removal to ensure that all conditions that resulted in the child's removal are no longer present. For existing open cases at the time of SDM implementation, review the safety concerns at the time of that removal.

2. Safety Decision

   A. If no safety factors are present, as indicated by a "no" answer to both questions 1 and 2 in Section C1, mark "A. Safe" to indicate that the child can be recommended for reunification.

   B. If one or more safety factors are present, as indicated by a "yes" answer to either question 1 and/or 2 in Section C1, **and** interventions are available, documented, and appropriate to mitigate safety concerns, mark "B. In-Home Safety Interventions Required" to indicate that the child may be recommended for reunification with safety interventions in place.

   C. If one or more safety factors are present, as indicated by a "yes" answer to either question 1 and/or 2 in Section C1, and no interventions can be put in place to mitigate safety concerns, mark "C. Unsafe" to indicate that the child will remain in placement. The child must not be recommended to be reunified to a home rated "unsafe."

SECTION D. PLACEMENT/PERMANENCY PLAN GUIDELINES

The decision tree provided in Section D is used to determine if a child is to be reunified, maintained in out-of-home care while reunification efforts continue, or if a recommendation for a change in the permanency plan is warranted. Follow the tree to conclusion.

SECTION E. PERMANENCY PLAN RECOMMENDATION SUMMARY

Complete Section E for all reunification assessments/reassessments. Enter the name and case number of each child in placement and check the recommended permanency goal. If "Change Permanency Plan" is checked, you MUST enter the new permanency plan using the codes provided on the form.

Indicate "Y" in the override column if an override will be used to change the permanency plan recommendation for any child and indicate the final permanency plan recommendation (Maintain OHP, Change Goal, or Reunify) in the next column. If "Change Goal" is selected, write in the new goal using the codes provided.

If an override is being used, indicate the reason in the space provided. Note that if an override is being used to reunify, a reunification safety assessment must be completed if not already completed for the reunification home.

A supervisor's approval is required for all reunification assessments/reassessments. A program supervisor's approval is required when an override has been determined.

Appendix

SDM® Distinctions between Safety, Risk, and Needs

SDM® Distinctions between Safety, Risk, and Needs

Safety Assessment – an assessment of whether any child is in immediate danger of serious harm.

Risk Assessment – an assessment of a caregiver's likelihood of subsequent maltreatment.

Family Strengths and Needs Assessment – an assessment of the underlying issues and/or conditions that contributed to maltreatment that serves as a guide to individualized treatment planning.

While safety, risk, and needs are related, they also lead to distinctly different measurements and decisions in the life of a case.

	Safety vs.	Risk vs.	Needs
When	Immediate	Future (i.e., next 18-24 months)	Future (i.e., next three to six months)
Who or Whom	Child-focused	Caregiver-focused	Family-focused
What	Immediate danger of serious harm	Likelihood of subsequent maltreatment. Any harm regardless of seriousness.	Identify underlying issues leading to abuse/neglect
Why	Informs "removal of child" decision	Informs case open/close decision	Inform and prioritize treatment plan service(s)
How	Evidence-based	Research	Evidence-based