

State of Connecticut



**Annual Progress and Services Report
2017**

**Submitted to:
Administration for Children and Families
of the
U. S. Department of Health and Human Services**

**By:
Department of Children and Families**

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Commissioner**

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A. Background

Introduction

The Department of Children and Families is responsible for the legislative mandates of prevention, child protective services, children's behavioral health and juvenile justice. With an annual operating budget of approximately \$795 million, the Department provides contracted as well as direct services through a central office, fourteen (14) area offices, and two (2) facilities. The Department also operates a Wilderness School that provides experiential educational opportunities; and is responsible for operating Unified School District II, which is a legislatively created local education agency for foster children with no other educational nexus or who are residents in one of the Department's facilities.

Mission and Vision

The Department's mission is: “working together with families and communities for children who are healthy, safe, smart and strong”. This mission is embodied in the Department’s strategic plan, which includes the following seven cross-cutting themes and nine overarching strategies:

Cross-cutting themes:

1. implementing strength-based family policy, practice and programs;
2. applying the neuroscience of early childhood and adolescent development;
3. expanding trauma-informed practice and culture;
4. addressing racial inequities in all areas of our practice;
5. building new community and agency partnerships;
6. improving leadership, management, supervision and accountability; and
7. becoming a learning organization.

Overarching Strategies:

1. Increase investment in prevention and health promotion
2. Apply strength-based, family-centered policy, practice and supports agency-wide

3. Develop or expand regional networks of in-home and community services
4. Ensure appropriate use of Congregate Care
5. Address the needs of specific populations
6. Support collaborative partnerships with communities and other state agencies
7. Support the public and private sector workforce
8. Increase the capacity of DCF to manage ongoing operations *and* change
9. Improve revenue maximization and develop reinvestment priorities and methods

This mission is grounded in a core set of beliefs that encompass the Department's vision for how to provide services to Connecticut's children and families. We believe 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 another family member who can provide a safe and nurturing home. If no family member can provide a suitably safe home that meets the child's needs, the child should receive care and services in an appropriate foster home until timely permanency can be achieved through reunification, transfer of guardianship or adoption. Foster care should only be used as a short-term intervention. While in foster care, regular and ongoing contact with parents and siblings is maintained. Finally, all youth are to exit the Department's care with legal and/or relational permanency.

Congregate care, such as group homes and residential treatment centers, should not be used for the vast majority of children. Young children should not be placed in congregate care settings. For older youth, treatment in congregate care is only used on a short-term basis, with extensive family involvement in the treatment process.

Services should be individualized and must be based on a full assessment of the strengths and needs of children and families. This assessment must be made together with family members and children, in an age appropriate manner. A full assessment is inclusive of safety, risk, domestic violence/intimate partner violence, substance use, criminogenic needs, medical, dental, educational and mental health needs. The goal of these individualized services is to enable the child to do well and thrive, living in the family home of a parent, family member or another permanent family.

Each year, the Agency leadership team identifies a series of agency-wide Performance Expectations with performance measures. The 2016 Performance Expectations remain the same as last year with some changes to the agency-wide performance measures.

B. 2016 PERFORMANCE EXPECTATIONS

The 2016 performance expectations are the third set of annual performance expectations issued by the Department of Children and Families. During the previous two years, regions, operating divisions, and facilities developed operational strategies designed to achieve departmental performance expectations. The 2016 performance expectations remain very similar to those issued in 2015, and management teams were advised to use 2015 performance data when assessing baseline performance, and determining the most promising strategies to turn the curve on their performance for 2016. Given the breadth and depth of measures, the agency believes it is essential to continue advancing these critical areas.

As with operational strategies developed for the previous two years, teams were instructed to review the desired outcomes for each strategy, the work that would need to be performed as part of the strategy, and how they would measure the quantity and quality of the work, the strategy outcome, and how the strategy helps to achieve one or more performance expectations.

Teams were encouraged to include the following three areas of concentration in the strategies developed for each of the five performance expectations:

- I. Achieving Racial Justice
- II. Specific inclusion of clients involved in the juvenile justice system
- III. Workforce stability/skills/support as they relate to achieving needs met

The five (5) performance expectations are as follows:

1. Exit from Juan F. Consent Decree

- a. Sustain outcome measures that are pre-certified
 - i. Continue meeting measure as reported through the outcome measures
- b. Achieve outcome measures not yet pre-certified
 - i. Measure: Percent improvement as identified through court monitor reviews
 1. OM 3: Case planning

- 2. OM 15: Needs met
- ii. Measure: Percent improvement as identified through automated reports
 - 1. OM 1: Commencement of investigation
 - 2. OM 2: Completion of investigation (ROM & QI PM reviews)
 - 3. OM 17. in-home visitation (ACRi Data)

2. Ensure that children reside safely with families whenever possible and appropriate

- a. Increase the proportion of children who are served in their homes; reduce the number of children in care
 - i. Measure: percent of all children served in home compared to out of home in CPS cases.
 - ii. Measure: percent of all children served in home compared to out of home in delinquency cases.
- b. Increase the use of preferred permanency goals
 - i. Measure: percent of children in care with a preferred permanency goal compared to OPPLA
 - ii. Measure: number of children exiting to permanency
 - iii. Measure: time for children to achieve permanency
- c. Increase the proportion of children in care who are in kinship care to 45%
 - i. Measure: percent of children in care placed with a relative or special study home
- d. Increase the proportion of children in care who are in family foster care settings to 90%
 - i. Measure: Percent of children in family placement, core, kinship, or therapeutic foster care homes
- e. Assure the community-based service system is effective and meets the needs of the community
 - i. Measure: number of clients served by program.
 - ii. Measure: utilization rate of contracted slots by program
 - iii. Measure: length of stay for target population clients
 - iv. Measure: percent of consumers satisfied with services
 - v. Measure: percent of clients completing services who are better off.
- f. Assure congregate care services are brief, family-engaged, connected to the community, and include discharge planning that begins at admission
 - i. Measure: average length of stay
 - ii. Measure: rates of readmission to the same, or higher, level of care

3. Achieve Racial Justice Across the DCF system

- a. Reduce disparities for children served by Child Welfare Services
 - i. Measure: The Disparity Index for alleged victims in DRS (intake and FAR)
 - ii. Measure: The Disparity Index for substantiated victims
 - iii. Measure: The Disparity Index for children in open cases
 - iv. Measure: The Disparity Index for children entering care
 - v. Measure: The Disparity Index for children in family care
 - vi. Measure: The Disparity Index for children in congregate care

- b. Reduce disparities for children served by the Juvenile Justice System
 - i. Measure: The Disparity Index for children placed in secure treatment on a pretrial basis
 - ii. Measure: The Disparity Index for children committed delinquent
 - iii. Measure: The Disparity Index for children committed delinquent and placed in a secure setting

 - iv. Measure: The Disparity Index for children committed delinquent and placed in a congregate setting
 - v. Measure: The Disparity Index for children committed delinquent and placed on parole services in the community

- c. Reduce disparities for children served by Behavioral Health Services
 - i. Measure-utilization rate by race and ethnicity of contracted services
 - ii. Measure-completion rate by race and ethnicity of contracted services.

- d. Reduce disparities for children served by Education Services
 - i. Measure: The disparity index for DCF-involved children relative to performing at grade level
 - ii. Measure: The disparity index for DCF-involved children who are chronically absent
 - iii. Measure: The disparity index for DCF-involved children with in-and out-of-school suspensions, expulsions, and disciplinary actions
 - iv. Measure: The disparity index for DCF-involved children graduating on time from high school

4. Prepare children and adolescents in care for success

- a. Ensure children and adolescents in care are safe and stable
 - i. Measure: rate of daily placement moves in a 12 month period for children in out of home care.

- ii. Measure: rate of daily maltreatment during a 12 month period for children in out of home care.
- iii. Measure: percent of 17 year old children in care with documented life-long family ties/connections.
- iv. Measure: reduction in the number of children with OPPLA by 50%.
- v. Measure: number and percent of 16 and 17 year olds with OPPLA goals approved by Regional Administrators.
- vi. Measure: number of permanency goals changed from OPPLA to a preferred goal.

b. Provide quality education and support services that lead to educational success
Provide quality education and support services that lead to educational success

- i. Measure: the percent of children in care who meet, or exceed, the achievement level based on SBAC test results for grades 3 – 8, and SAT for grade 11 (annual);
- ii. Measure: the percent of 9th graders in care who successfully promote (annual)
- iii. Measure: The average daily attendance rate for children in care, compared to all Connecticut students (quarterly);
- iv. Measure: The rate of suspensions for children in care, compared to all Connecticut students (quarterly);
- v. Measure: The number of children in care who earn high school credit through USD2 that is applied toward graduation requirements (quarterly)
- vi. Children served by the Child Justice Foundation by reason for referral and outcome

c. Provide formal and informal life skills

- i. Measure: The number and percent of committed adolescents, over 14 years old, who have been assessed using the approved DCF life skills program on an annual basis
- ii. Measure: The percent of adolescents aging out of care who score "advanced" on all relevant domains of the approved DCF life skills program

d. Ensure physical, mental, and dental health needs of children in care are met

- i. Measure-rates of obesity
- ii. Measure-% of children in care with asthma receiving appropriate care.
- iii. Measure-% of children in care with diabetes receiving appropriate care.
- iv. Measure-rate of up-to-date dental reviews.

5. Prepare and support the workforce to meet the needs of children and families

a. Create stability in the workforce

- i. Measure: rate of staff turnover
- ii. Measure: rate of lateral transfers

- iii. Measure: consistent and effective supervision
 - iv. Measure: percent of newly-hired social workers with MSWs or BSWs
 - v. Measure: establishment and functioning of staff support teams in each facility, office, and central office
 - vi. Measure: percent of DCF staff receiving 30 hours of training per year by position type
- b. Train managers and supervisors in supervisory and management skills
- i. Measure: percent of social work supervisors successfully completing the Leadership Academy for Supervisors
 - ii. Measure: percent of program managers and program directors successfully completing the Leadership Academy for Middle Managers
 - iii. Measure: percent of managers and directors completing the Data Academy.
- c. Support regions, facilities and communities in their work on behalf of children and families
- i. Measure: percent of wrap fund utilization compared to utilization of contracted provider services.
 - ii. Measure: percent of PDOC quarterly performance report card submission for contracted providers.
 - iii. Measure: length of time for fiscal to approve a spending request.
 - iv. Measure: length of time for OFAS to approve adoptions.
 - v. Measure: length of time for HR to fill vacancies
 - vi. Measure: amount of revenue generation from federal, state and private sources.

Each DCF regional management team, Central Office division management team, and facility management team has identified its role and contribution to the performance expectations, and has developed a set of operational strategies, with performance measures, to achieve the performance expectations. Performance data is presented to the Commissioner's team by each management team on a quarterly basis, and performance is reviewed, and recommendations for improvement are established.

[Strategic Plan and use of Results Based Accountability](#)

The Department continues its work on the ongoing strategic plan, through the annual Performance Expectations, and utilizing a Results Based Accountability (RBA) framework. The work continues to be aligned with the CTKids Report Card, as required by Public Act 11-109.

Result Statement: All Connecticut children grow up in stable environments, safe, healthy, and

ready for success.

Population-Level Headline Indicators of Child and Family Well-being

SAFE

- Child Fatalities
- Substantiated Reports of Abuse and Neglect
- Emergency Room Visits for Injuries
- Referrals to Juvenile Court for Delinquency
- High School Students missing school because they felt unsafe at school, or traveling to or from school

HEALTHY

- Low Birth Weight
- Childhood Obesity
- Children with Health Insurance
- Children with Thoughts of Suicide

STABLE

- Chronic Absenteeism
- Parents Without Full-time Jobs
- Families Spending more than 30% of Income on Housing
- Families Without Enough Money for Food

FUTURE SUCCESS

- Kindergarteners Needing Substantial Support
- Third Graders at or Above Grade Level in Reading
- On-Time High School Graduation Rate
- Children Living in Households Below the Federal Poverty Line

DCF's Contribution to the Results Statement: Working together with families and communities for children who are healthy, safe, smart and strong.

Since 2011, the Department of Children and Families has undergone a substantial transformation aimed at improving outcomes for the children and families we serve. This transformation was driven by the seven cross-cutting themes.

In addition, nine overarching strategies have been developed and continue to be utilized.

1. Increase investment in prevention and health promotion
2. Apply strength-based, family-centered policy, practice and supports agency-wide
3. Develop or expand regional networks of in-home and community services
4. Ensure appropriate use of Congregate Care
5. Address the needs of specific populations
6. Support collaborative partnerships with communities and other state agencies
7. Support the public and private sector workforce
8. Increase the capacity of DCF to manage ongoing operations *and* change
9. Improve revenue maximization and develop reinvestment priorities and methods

Section C. APSR Requirements

Stephanie Tubbs Jones Child Welfare Services – Subpart I- FFY2016

The figures provided below reflect anticipated expenditures. The services/activities that are described in this section are funded at levels that exceed the award amount. These programs are being supported through multiple year awards, including FFY 2015 and FFY 2016. Individuals occupying the positions supported by grant funding were selected through an interview process. The providers for Triple P and KJMB were selected through a procurement process. JRA Consulting, the Connection, CCMC, and UCONN were selected based on their level of expertise.

Services/Activities	Total Funding	Family Support	Prot Svcs	Family Preservation	Reun Svcs	Adopt	Group/Ins Care	Admin Costs
Solnit North Positions	\$1,013,007.00						\$1,013,007.00	
Office Assistant Positions	\$156,786		\$39,196	\$39,196	\$39,196	\$39,196		
JRA Consulting – Racism	\$90,000	\$22,500	\$22,500	\$22,500	\$22,500			
CCMC	220,500		\$110,250	\$110,250				
Central Office Contract Management	111,721							\$111,721
The Connection	200,000			\$100,000	\$100,000			
Triple P America	\$109,860	\$36,620	\$36,620	\$36,620				
Travel/Conferences	10,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000		
CCADV	\$108,000	\$27,000	\$27,000	\$27,000	\$27,000			
IPV-Fair Provider Training	\$49,364	12,341	12,341	12,341	12,341			
Parents with Cognitive Limitations	\$4,000	\$2,000	\$2,000					
KJMB Solutions	\$42,253	\$8,450	\$8,450	\$8,450	\$8,450	\$8,450		
CT-AIMH Membership	\$350	\$70	\$70	\$70	\$70	\$70		
Totals	\$2,115,841.00	\$110,981.00	\$260,427	\$358,427	\$211,557	\$49,716	\$1,013,007.00	\$111,721

SERVICE DESCRIPTION-STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM

Solnit North Positions: The Albert J. Solnit Psychiatric Centers’ North Campus is a facility run by the Connecticut Department of Children and Families. It provides brief treatment, residential care and educational instruction for abused and neglected children between the

ages of 10 and 18 from all across the state. It offers complete multidisciplinary medical and mental health assessments for those children under its care. Individual services are designed to meet the children's unique needs and to facilitate and support community placements when clinically indicated. The grant helps support multiple positions including Children's Services Assistants, Lead Children Services Workers and a secretarial position for a facility administrator.

Area Office – Office Assistant Positions: In an effort to enhance our service delivery to families and achieve more timely permanency for children, three part time Office Assistants were hired to provide support to the staff in the Meriden and Norwalk Area Offices to help coordinate our case planning efforts by conducting relative searches for children in care in order to identify and locate potential relative resources, and assure grandparent and relative notification as required.

JRA Consulting: After an extensive review of DCF racial disproportionality and disparate outcomes data on children of color in care, in February 2012 Commissioner Katz committed the Department to focus deeply on addressing racial inequities in all areas of our practice. A decision was made to contract with *JRA Consulting, Ltd* to guide the agency with this initiative. It was decided that this would be done by examining and addressing issues of racial injustice and disproportionality in the areas of racial, health, and educational disparities. It was also decided that to address this concern, the agency would need to develop a comprehensive approach to this work. The goal is to ensure that all of our agency policies and practices are reviewed with a racial/cultural justice lens, such that we can revise them as needed and the inequities in services and outcomes that currently exist begin to disappear. The Department is committed to keeping this an open and transparent process not only within the agency, but across the community as well.

Connecticut Children's Medical Center (CCMC): Funding supports additional staffing for child sexual abuse, physical abuse and psychosocial evaluations of children for whom abuse or neglect is suspected. CCMC provides the following array of services: DCF case consultations, training, medical evaluations, psychosocial assessments, family and professional interviews,

and ongoing participation in Multidisciplinary Team meetings. The contract is supported by both state and federal funding. The federal funding is used to increase capacity for case consultations when child abuse/neglect is suspected.

The Connecticut Children's Medical Center – Injury Prevention Center (IPC) was contracted by DCF to conduct an evaluation of the Department's procedures and policies around intimate partner violence. The scope of work would include developing a screening and assessment protocol for child safety and wellbeing; prevention efforts regarding child maltreatment and youth dating abuse prevention; and parent and child IPV service delivery and outcomes. They are also providing specialized training to DCF staff focused on IPV and to conduct qualitative and quantitative evaluation of changes in practice over time with a focus on recidivism, service utilization and child and family outcomes. The goal is to increase the effectiveness and efficacy of the response to IPV and the delivery of services offered by DCF through an evaluation.

Central Office Staff Position:

Funding was utilized to support a staff position within the Departments Fiscal Division. The staff works in the contracts division supporting the many initiatives on behalf of the department.

The Connection: The Supportive Housing for Families program provides permanent housing and intensive case management services to DCF families. The program began over 17 years ago, to help families recovering from substance use. In 2001, DCF received Federal Unification Program Vouchers and was able to expand eligibility to accept non-substance using clients into the program. The program was renamed Supportive Housing for Families (SHF). DCF contracts with the Connections, Inc. to provide intensive case management services to assist families to develop and utilize a network of services in the following areas: economic (financial support, employment assistance), social (housing, transportation, family support, parenting education, child care) and health (medical/mental health care for adult and child, relapse prevention, and domestic/child/substance abuse issues). The Connections, Inc. has nine sub-contracted agencies to provide these services statewide. Permanent housing is established through DCF's partnership with the Department of Social Services

(DSS). The DSS provides a Housing Choice Voucher (formally "Section 8" - federal program) or Rental Assistance Program (RAP-state program) Certificate. DCF's Supportive Housing for Families Model has been recognized as a promising model of housing assistance and family support by the Child Welfare League of America, The National Alliance to End Homelessness and the National Center for Social Research. This additional federal funding is used to develop a specialized unit to assess and serve the waitlisted reunification families who have children less than five years of age in order to expedite permanency. The program utilizes funding from this grant to provide housing and support services to families with children under the age 5. These funds help to alleviate homelessness or the risk of homelessness to the youngest children DCF serves. Services are also provided to families where housing is a barrier to the reunification process.

Triple P America:

Triple P is an evidenced-based model that provides in-home parent education curriculum along with support and guidance so that parents will become resourceful problem solvers and be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. It is being provided in English and Spanish. Federal funds were allocated to the Positive Parenting Program (Triple P) and were used to offer two week- Level 4 Standard long and Standard Teen Triple P trainings. This allocation supports ongoing training opportunities for provider staff to ensure no interruption in the provision of services. A total of 28 new Triple P staff members were trained and accredited.

Travel Conferences: The department understanding the importance of keeping current and informed of best practices in the field, utilized funding to support Area office and Central Office staff to attend and participate in several National and Regional conferences.

CCADV: Connecticut Coalition Against Domestic Violence (CCADV) is the state's leading voice for victims of domestic violence and those agencies that serve them. CCADV is a membership organization of Connecticut's 18 domestic violence service agencies that provide critical support to victims and their families including counseling, support groups, emergency shelter, court advocacy, safety planning, and lethality assessment, among other services.

Funding was utilized to bring all 18 of CT's Domestic Violence service agency's together and have designer instruct/teach the new IPV-Fair Model. Funding was also utilized for the purchase of materials and other needed incidentals for the Mothers Empowerment group. Moms Empowerment is a parenting program that provides support to mothers by empowering them to discuss the impact of the violence on their child's development; to build parenting competence; to provide a safe place to discuss parenting fears and worries; and to build connections for the mother in the context of a supportive group.

IPV-Fair Provider Training: Funding was utilized to provide several trainings. The Intimate Partner Violence – Family Assessment Intervention Response (IPV-FAIR) 5 day service training for newly awarded providers, as well as staff added to the initial provider group since the first training in June 2015. This provided the opportunity for a second training of the model to support statewide implementation. IPV-FAIR booster sessions: 2 ½ day (each offered x2) booster sessions for IPV-FAIR providers on emerging clinical treatment issues that providers identify as they begin to deliver IPV-FAIR services and to provide additional training support where there are gaps (e.g. Motivational Interviewing to increase engagement, supervision).

Intimate Partner Violence (IPV) & Substance Use (SU) – Cross-training – Design, implement and facilitate an IPV and SU intersection training to Child Protective Service staff, Court Services staff and adult providers. This area has been identified as a need for providers working with families with children involved in our court and adult treatment systems.

Parents with Cognitive Limitations: The Department of Children and Families and the Department of Developmental Services each contributed \$4,000 to support the “Identifying and Working with Parents with Cognitive Limitations trainings.” The trainings are delivered by a rotating team of trainers and are available at no cost to public and private providers who work with families. Through the Department’s Training Academy, CEUs are awarded to social workers. Two trainings have been held to date with an average of 30 participants attending each training and two additional trainings are scheduled to be completed by September 30, 2016.

KJMB Solutions: KJMB Solutions is a technology consulting firm specializing in web application development, database development, networking consultation, quality assurance services, and secure web application hosting. In June 2011, the Corporation for Standards and Outcomes disbanded and the staff involved in developing CT's data collection and reporting system established their own company called KJMB Solutions. Programs and Services Data Collection and Reporting System (rebranding to PIE - Provider Information Exchange), a web-based application that allows the Department, through its contracted community-based services providers, to gather and evaluate client and program level outcomes. Additional funding was allocated this year to provide enhancements and modifications that include:

- Adding federally required client level data elements and associated conditional logic to ensure data quality,
- Expanding the outcome measures collected and reported,
- Implementing and supporting additional programs/projects

CT Association of Infant Mental Health (CT-AIMH): Funding was used to sponsor a number of DCF staff's (Agency) membership costs that includes regional and central office staff. The memberships increase staff understanding and skills working with young children and their families. The Connecticut Association for Infant Mental Health (CT-AIMH) is a professional organization that offers expertise in infant and early childhood mental health, provide statewide opportunities to enhance knowledge and promote a positive influence on the social emotional health and development of infants, young children and their families/caregivers.

Promoting Safe and Stable Families – Subpart II – FFY 2016

The figures provided in the table below reflect anticipated expenditures. The programs are funded at levels that exceed the award amount. These programs are being supported through multiple year awards, including FFY 2015 and FFY 2016. The Community Collaboratives, FAVOR (Foster Care Consumer Advocate), The University of Connecticut's Adoption Assistance Program, Easter Seals Adoption Support Group, Adopt a Social Work

Program, and CT Association for Infant Mental Health were selected by the Department based on their expertise, the nature and scope of the work directly aligned with key areas of focus for the Department and their ability to provide the service as described below. Child First was an already established team that was developed as a result of a prior SAMHSA LAUNCH grant.

Services/Activities	Total Funding	Family Support	Family Preservation	Family Reunification	Adoption
Reunification & TFT Services	\$1,173,245	347,146	337,184	488,915	
Community Collaboratives	\$284,700				\$284,700
FAVOR	\$50,000	\$25,000	\$25,000		
UCONN -Adoption enhancements	\$300,000			27,163	\$272,837
Easter Seals Support Group	\$20,000	\$10,000			\$10,000
Adopt a SW program	\$95,275	\$31,758	\$31,758	\$31,758	
UCONN SSW PIC	\$232,787	\$116,393	\$116,394		
CT Association for Infant Mental Health	\$39,382		\$19,961	\$19,961	
Child First	\$75,000	\$37,500	\$37,500		
Totals	\$2,270,389	567,797	567,797	567,797	567537

SERVICE DESCRIPTIONS-PROMOTING SAFE AND STABLE FAMILIES -TITLE-IV-B, SUBPART II

Reunification & TFT Services: RTFT is a new service model that contains three distinct programs: Reunification Readiness, Reunification Services and Therapeutic Family Time.

Reunification Readiness (a 30 day assessment to determine a family’s readiness for reunification. The following is a brief summary of Readiness activities:

- Review/explore safety concerns and risk factors that may impact child safety with the family and DCF;
- Assess family functioning, skills, parental capabilities, and parent's motivation to change;
- Identify family strengths and needs;
- Implement the Visit Coaching Model
- Provide Family Time/Therapeutic Family Time services
- In collaboration with the family Identify family resources and informal/formal supports and how they may be used in safety planning;
- Observe family interactions;
- Provide a minimum of weekly visits with the parent and child.

- Identify problems and barriers that may be impacting reunification; and
- Complete initial (North Carolina Family Assessment Scale for General Services and Reunification (NCFAS- G+R) within 14 days of referral.

Reunification Services: A 4-6 month intervention focused on planning the safe return of children in out of home care through a staged process. The summary of the program is as follows:

- Utilizes the North Carolina Family Assessment Scale for General Services (NCFAS - G+R) to inform service delivery
- Delivers a Staged Model to support families throughout the reunification process
- Adopts a Wrap Model philosophy to engage the family and build their network of supports
- Employs Permanency Child and Family Teaming model to engage the family and their supports in case planning and decision-making
- Active engagement and involvement of father's (including non-custodial parent) in the reunification process
- Therapeutic Family Time interventions/treatment approaches including the Visit Coaching Model
- Flexibility in staff assignments based on presenting needs of the family
- Step-Down option if families require additional supports

Therapeutic Family Time: A 2-3 month intervention providing direct consultation with parents/guardians to assist them in maintaining or re-establishing relationships with children in out-of-home care. Key components include:

- Implement Visit Coaching Model
- Utilization of a Parent/Child Interaction tool (KIPS)
- Preserves and restores the parent/child attachment, and reduces the child's sense of abandonment and loss
- A family driven service that is, culturally and linguistically sensitive, individualized, and occurs in the least restrictive, most homelike setting possible.
- Facilitates permanency planning and emphasizes continuity of relationships.

Community Collaboratives:

The Department continues to support Community Collaboratives, designed to recruit, strengthen and support neighborhood-based culturally competent foster/adoptive resources for children for many years. They are responsible for engaging new partners to broaden

community ownership for planning and implementing activities that recruit and support foster and adoptive families. Funds are distributed through a fiduciary (Advanced Behavioral Health) and used to support meeting costs, planning efforts and activities implemented by the collaborative for the purpose of recruiting and retaining foster and adoptive families. These activities may include, but are not limited to: special family events, appreciation dinners, media/advertising, promotional items, brochure development and printing, program supplies and training. While Collaboratives have been established historically to serve all the Area Offices, some are no longer fully functional and will be further developed in the coming year.

FAVOR: The DCF Office for Community Mental Health has contracted with FAVOR, Inc., a statewide family advocacy organization. Family System Managers (FSM) are embedded statewide in DCF regional offices. Each Family System Manager works in partnership with the DCF Regional Systems Development Manager, DCF staff and the CT Behavioral Health Partnership (BHP), with formal reporting and supervision provided through the Contractor. They are required to promote family driven and youth guided practices throughout the local and regional service system and to support the identification, recruitment, and participation of families in behavioral health system analysis, planning and service provision. They provide leadership in the local and regional behavioral health system development from the family perspective while providing technical assistance and support to local systems of care including their governance.

Family System Managers conduct their work according to the following core values of the local system of care:

- family driven and youth guided;
- strength based;
- culturally and linguistically competent;
- individualized, flexible and community based approach to services and support;
- services and support provided in the least restrictive and most normative environment;
- adequate availability and access to broad array of effective services and support;
- evidence and science informed clinical interventions, services and supports;
- health and wellness promotion; and
- performance and outcome based services and support.

UConn Adoption Enhancements: The Department of Children and Families contracts with the University of Connecticut Health Center to provide post-adoption services to families who have adopted children from DCF's custody. It also provides service to relative families who have come from the state's subsidized guardianship program. Within available funding, services may be provided to families who have adopted privately or who have adopted internationally. This program is based on an employee assistance model, i.e., to provide limited interventions and/or make referrals to local services for families experiencing a variety of problems that may or may not be directly related to adoption. This service is free of charge to families. The AAP has four community case managers based in the four major cities in the state. The Community Case manager also provides in home assessment of the family's needs and assists in coordination of appropriate services. AAP also manages the post finalization services from a program that DCF offers for children following adoption and guardianship finalization. Within the context of the Permanency Placement and Services Program (PPSP) each child adopted from DCF's foster care system is eligible for a total of 132 hours of support services from 17 Connecticut Child Placing Agencies both pre and post legal permanency. This program is funded by both state and federal funds.

Easter Seals Adoption Support Group: This support group was established by several adoptive parents in Waterbury, CT who had adopted medically complex children through DCF. The focus was to create a network of support for families providing care to this population. Funding supports associated meeting costs.

Adopt a Social Work Program: This statewide program assists children and families (birth, foster and adoptive) that are DCF involved with supports and donations of goods to help families' secure needed resources.

UConn SSW PIC: The UConn School of Social Work has been functioning as the Performance Improvement Center for the Community Support for Families Program, a contracted service designed to provide support to families who received a Family Assessment Response from the Department. Last year, the Memorandum of Agreement between the Department and

UCONN was amended to expand their analysis to include all our Family Assessment Response dispositions to allow a more robust and comprehensive evaluation of our Family Assessment Response.

CT Association for Infant Mental Health: The Connecticut Association of Infant Mental Health was contracted to provide 8 full days of training focused on unresolved trauma, ***“Understanding Infant/Toddlers and Their Families and the Challenges of Unresolved Loss and Trauma: working towards deeper integration between DCF and Head Start.*** Presenters known nationally for their work in child welfare and Early Head Start offered their expertise on observations of young children and their families in child welfare, on integrating a trauma lens into work with very young children and their families, on making child welfare visitations a relationship-focused experience for parents and young children. Local presenters added their competencies in reflective practice, cultural sensitivity, and assessment/referral.

Child First Child First is a two-generation, intensive, home-based, early childhood intervention serving the most vulnerable young children and families, prenatal through age five years. Health and Human Services (HHS) has designated Child First one of the 17 national, approved, evidence-based home visiting models. The New Britain team was initially funded via a SAMHSA grant. Funding was used to support the team through June 2016 until permanent funding could be secured.

[Monthly Caseworker Visitation Funds](#) **(See Section 7)**

[Adoption and Legal Guardianship Incentive Payments](#) **(See Section 8)**

[Child Welfare Waiver Demonstrations](#) **(See Section 9)**

[CHAFEE FOSTER CARE INDEPENDENCE PROGRAM - FFY 2016](#)

The figures provided in the table below reflect anticipated expenditures. Personnel positions were supported through grant funding that were identified through an interview process. The providers who deliver Community Based Life Skills were selected through a

procurement process. Our Work to Learn programs were selected through a procurement process. Many of the providers delivering One on One Mentoring have done so for over 12 years through a sole source contract. The most recent Contractors were selected through a procurement process.

Service Description	Funding
Personnel Expenses	\$ 38,450
One on One Mentoring	\$289,513
Community Based Life Skills	\$398,430
Work to Learn	\$532,866
Youth Advisory Board Stipends	\$50,000
Total	\$1,309,809

SERVICE DESCRIPTIONS - CHAFEE FOSTER CARE INDEPENDENCE PROGRAM

Personnel Expenses: The grant supports one Pupil Services Position established to assist youth in their transition from high school to vocational programming or college. Other responsibilities include the administration of the state's Education and Training Vouchers program (ETV). The specialists routinely meet with youth, social workers, program staff, Job Corps staff and educational personnel to review, coordinate and develop an appropriate educational plan for our youth.

One on One Mentoring: DCF continues to provide mentoring services to youth statewide, ages 14 -21, who are committed to the Department and residing in foster care. DCF funds 11 community based providers to deliver mentoring services to 321 adolescents in out of home care. These providers are under contract with the Department to recruit, train and provide support for prospective mentors and mentor/mentee matches.

Community-Based Life Skills: The Department currently contracts with 10 community agencies to provide community based life skills in 14 Area Offices, to DCF committed youth placed in community settings. Currently the Department is using the LIST (Assessment Tool and Curricula) for the provision of life skills. It provides youth age 14 and older who are in foster care with the life skills necessary to successfully transition to adulthood.

Work to Learn: The Department continues to support Connecticut's Work to Learn model for the five (5) work to learn sites in the state. The Jim Casey Youth Opportunities Initiative work to learn model was designed to ensure that youth aging out of foster care have increased opportunities for a successful transition to adulthood in the following areas: youth leadership, youth engagement, employment, housing and improved physical and mental health functioning. The grant funds three of the five sites.

- *Our Piece of the Pie (OPP):* A comprehensive work/learn model located in Hartford that helps youth access and attain a combination of educational, employment and personal development opportunities that promote success. OPP is also operating a second Work/Learn site in Norwich.
- *Boys and Girls Village:* This Bridgeport program partners youth with technical experts and role models in a youth-centered small business. They develop transferable skills, identify goals and reinforce the personal skills needed for successful employment.
- *Marrakech Inc:* Located in New Haven and Waterbury, these sites offer a comprehensive work/learn model that helps youth access and attain a combination of educational, employment and personal development opportunities that promote success.

Youth Advisory Boards: In order to encourage and facilitate youth participation in Youth Advisory Boards, stipends are distributed to youth who serve on the YABs. Each region/Area Office has established a YAB.

ETV

The Department continues to make available vouchers for Education and Training program and expenses to youth who have aged out of the foster care system or who after attaining the age of 16 have left the foster care system due to being legally adopted or who are in kinship subsidized transfer of guardianship care. See Section G3.

Child Welfare Demonstration Grants

Connecticut has not been awarded a Child Welfare Demonstration Grant.

Trainings in Support of CFSP Goals

DCF is committed to data-informed and strategy-driven management and has implemented annual performance expectations, with all regions, facilities, and central office divisions. All are required to develop detailed operational strategies to achieve the performance expectations. DCF is committed to workforce development opportunities and the importance of providing managerial trainings on strategy development, the development of outcome-focused strategies, use of data to manage performance, and strategy modification based on performance data. The trainings provided include:

- a. Using a results oriented approach to strategy development
- b. Identification of performance measures, with a focus on outcomes
- c. Using data to manage performance
- d. Using performance data to analyze effectiveness of strategies and to inform strategy modification

GENERAL INFORMATION

Collaboration

The Department continues to recognize the value and importance of collaboration and consultation with the community to improve outcomes for children, youth and families. Therefore, the Department has established and participates in a variety of opportunities to

partner with key stakeholders.

The Department receives community input from a number of statewide and local advisory councils. At the statewide level, the State Advisory Council (SAC) is a 17-member council appointed by the Governor to advise the Commissioner on all matters pertaining to services for children and families. The Department also receives significant input from a statewide Children's Behavioral Health Advisory Council (CBHAC), local Regional Advisory Councils (RACs) affiliated with each of our six regions, advisory councils at each of our facilities and Youth Advisory Boards (YAB). In addition the department works with the Children's Behavioral Health Plan Implementation Advisory Board, which meets quarterly with subcommittees meeting in between. The focus is on advising the agency and the states on the efforts to advance the recommendations set forth in the 2014 plan submission. The department has quarterly meetings held between agency Program Leads, providers and regional partners to review and analyze service types.

DCF has been working very hard in helping and assisting youth aging out of the foster care system. Towards this goal DCF has been utilizing the expertise of the SAC and our partnership/ collaboration with the Department of Mental Health and Addiction services. DDS Regional Office staff meet with DCF local Area Office and Central Office staff to review and track youth transitioning from DCF to DDS utilizing a DDS/DCF shared client list; the purpose of the meeting is to identify who is transitioning, the transition plan and timing and any barriers that need to be addressed systemically or on an individual basis.

During the development of the Department's strategic plan, the SAC, CBHAC, RACs and other stakeholder groups were consulted for their input and feedback. The input of stakeholders helped inform the Department's assessment of its performance and identify goals and objectives for the plan. The strategic plan goals and objectives that were developed with collaboration from our stakeholders have been integrated into the 2015-2019 CFSP.

In addition to consulting with our advisory groups, the Department also receives

considerable input from our service providers. We hold twice-yearly statewide provider meetings to share the Department's progress toward our goals and to get input on further expansion of the service array. The Department's senior leadership team also meets quarterly with the provider trade associations and monthly with our credentialed providers to gather input of the effectiveness of our service array and quality improvement system.

During the development of the CFSP, the various stakeholder groups were consulted for their feedback on how the Title IV-B services in the plan can be best aligned to meet our goals and objectives for the upcoming five year period. We will continue to consult with our advisory councils, the courts and other stakeholders during the five-year implementation of the CFSP.

Community Collaboratives

The Department has been supporting Community Collaboratives designed to recruit, strengthen and support neighborhood-based culturally competent foster/adoptive resources for children for many years. Collaboratives have been established to serve all the Area Offices and are responsible for engaging new partners to broaden community ownership for planning and implementing activities that recruit and support foster and adoptive families. Funds are distributed through a fiduciary (Advanced Behavioral Health) and used to support meeting costs, planning efforts and activities implemented by the collaborative for the purpose of recruiting and retaining foster and adoptive families. These activities may include, but are not limited to: special family events, appreciation dinners, media/advertising, promotional items, brochure development and printing, program supplies and training.

Each Collaborative has an executive board that provides support and direction to the collaborative. A staff person from the Department's Area Office foster care unit leads the Community Collaboratives and meets with the coordinators bi-weekly and approves all financial reimbursements. The coordinator from each collaborative maintains contact with families from the date of inquiry up to licensing or withdrawal and gathers information about their decision to withdraw.

DCF Interface with DMHAS and DDS

DCF collaborates closely with both the Department of Mental Health and Addiction Services (DMHAS) and the Department of Developmental Services (DDS). In conjunction with DMHAS and DDS, a number of protocols and processes have been implemented which support transition planning and collaboration. These apply to youth aging out of foster care as well as those involved in other parts of the DCF system (Voluntary Services, Juvenile Justice, In-home services, etc.).

DMHAS offers a specialized Young Adult Services program (YAS) for 18-25 year olds aging out of the DCF system who have significant psychiatric disabilities and who will need services and supports when they leave the children's system. DMHAS also has an array of adult mental health services, but most of the DCF-involved youth who meet the program criteria go directly to this specialized YAS program. DCF has referred an average of 306 youth to DMHAS YAS each year (between FY 2007 and 2015). These referrals are made at age 16 unless the youth enters care later. DMHAS cannot start services until age 18; DCF transitions an average of 105 youth to DMHAS each year between the ages of 18 and 21.

DDS works with individuals who have developmental disabilities and are likely to need support and services throughout their lifetime. DDS has an array of services and has been able to target resources not available to the general public specifically for youth aging out of DCF. As of May 2015, DCF has identified 215 children/adolescents who have been referred to and made eligible for DDS and who will eventually transition to adult services, typically at age 21. DCF and DDS maintain a "shared client list" which is updated regularly to assure that DCF involved youth are identified, referred and transitioned. DCF has been tracking transitions to DDS since SFY 2011, and an average of 70 youth per year have transitioned to DDS through FY 2015.

DDS also has a program for children and adults on the autism spectrum (ASD) but who do not have intellectual disabilities (ID). The program has a limited number of slots with only 50 set aside for children. From the beginning of this program in FY 13 through the present, DCF transitioned 37 youth from the DCF Voluntary Program to the DDS Autism Spectrum Division

(a Medicaid Waiver supported program). However, due to several years of DDS budget cuts with more anticipated, the transfers were put on hold. DCF continues to maintain a list of eligible youth in the hopes that transfers will be possible at some point in the future. In the meantime, DCF has been able to refer some of these children to the ASD behavioral services for children with HUSKY A, C or D up to age 21. For families who are not HUSKY eligible but have private insurance, DCF has an initiative with the Connecticut Office of the HealthCare Advocate to assure families are getting the most out of private insurance coverage for children with ASD.

The specific protocols and activities that support both DMHAS and DDS screening, referral, and transition include:

1. Agency specific Memorandum of Agreements which formally define coordination and collaboration;
2. Statewide screening process utilizing standardized criteria to identify youth starting at age 15 who need referral to DMHAS or DDS (DCF has screened an average of 861 youth annually between FY 2007 and 2015);
3. Centralized process to track and monitor referral timeliness and completion and provide regular feedback to Regional and Central Office administrators and staff;
4. Centralized referral processing for DMHAS and centralized monitoring of referrals sent to DDS;
5. Identification of a liaison to DMHAS and DDS in each DCF Region and an Office of Interagency Client Planning located in DCF Central Office which specifically manages DMHAS and DDS related activities and supports local collaboration; and
6. Formal mechanisms which focus on the coordination of referral, eligibility and transition:
 - At the local level, DCF Area Offices have monthly, bimonthly or quarterly meetings with DMHAS and DDS staff:
 - DMHAS Young Adult Services staff plus representatives from their local YAS Programs meet with DCF Area Office staff to discuss individuals who have been referred to DMHAS and are in need of or already in the

process of transitioning; they address any issues that impact transition and identify problems or resource needs that impede smooth and timely transitions.

- DDS Regional Office staff meet with DCF local Area Office and Central Office staff to review and track youth transitioning from DCF to DDS utilizing a DDS/DCF shared client list; the purpose of the meeting is to identify who is transitioning, the transition plan and timing and any barriers that need to be addressed.
- DMHAS holds monthly meetings with the Albert J. Solnit Children's Center and the Connecticut Juvenile Training School to assure coordination when youth are in DCF operated inpatient or psychiatric residential treatment facilities; staff from the Office of Interagency Client Planning in DCF Central Office also participate in these meetings.
- The Office of Interagency Client Planning also participates in a monthly meeting at the Department of Corrections facility that houses 18-21 year old offenders to assure those who are involved with DCF are identified if they need to be referred to DMHAS or DDS.
- Case-specific transition planning is done between the Social Worker at the DCF Area Office and the DMHAS or DDS Case Manager.
- To address administrative and systems issues that cannot otherwise be resolved at the local level, DCF convenes interagency meetings to provide a forum to discuss and address these issues:
 - One meeting is held between DCF and DMHAS Central Office administrators.
 - A separate meeting is held between DCF and DDS Central Office administrators.
 - As needed, a larger inter-departmental meeting can be convened including DCF, DMHAS, DDS, along with the Office of Policy and Management (the Governor's budget office), Court Support Services Division (Juvenile and Adult Probation) and the Department of Social Services.

7. Informal mechanisms are also available to assure case-specific issues are addressed when they arise including:
- If individual clinical, resource or system issues are identified as impeding a transition, an individual case conference may be convened. This brings a larger group of stakeholders together to discuss a particular situation and come up with solutions.
 - Staff of the DCF Office of Interagency Client Planning is available to provide training, technical assistance and consultation on client specific, administrative and/or systems issues related to screening, referral, eligibility, transition and interagency coordination. This consultation is available to both staff in the DCF system and to DMHAS and DDS. General in-service training on DCF/DMHAS/DDS interface is also available for other agencies and community groups. This past year has included several presentations at DCF's Regional and Statewide Advisory Council meetings regarding DMHAS referral and transition issues.
 - The Office of Interagency Client Planning also provides training as part of the Department's Adolescent Services and Voluntary Services Certification program.
8. Provision of data and reports regarding DDS and DMHAS processes is another element that supports collaboration and helps to ensure better compliance with MOA requirements and DCF Outcome Measures. This includes but is not limited to:
- Number of individuals screened;
 - Timeliness of referrals;
 - Number of referrals;
 - Number of youth transitioned;
 - Tracking the completion of SSI applications (which is required for transition to both DMHAS and DDS) and
 - Tracking the completion of Transition Action Plans which are a DMHAS document used to guide the transition process.
9. Participation in a number of interagency committees/workgroups by the DCF Office of Interagency Client Planning including:

- Statewide TBI Advisory Committee;
- DDS Autism Spectrum Division Advisory Council;
- DDS Children's Services Committee;
- The Connecticut Family Support Council;
- Connecticut Strong (SAMHSA Now is the Time – Health Transitions Grant) initiative; and
- DCF Unique Service Expenditure Team.

10. The capacity to develop child-specific agreements with DMHAS and DDS to access services - which are not available within DCF - earlier than usual. This allows a young adult to a move to a more permanent community setting when they are ready, prevents multiple moves, and can even avoid a youth prematurely signing out of DCF care.

11. Budget permitting, special transition initiatives between DCF and DDS for transfer of:

- DCF Voluntary cases to the DDS Voluntary Program; and
- Children on the autism spectrum to the DDS Autism Division Medicaid Waiver program.

In FY 2017, the DDS ASD program is transitioning from DDS to the state's Medicaid agency – the Department of Social Services - which will require a new set of collaborative relationships be developed specifically around this population and related issues.

Special Collaboration Project – Life Skills preparation

DCF and DMHAS have been working together for a number of years to identify ways to better prepare youth for adult roles and responsibilities. DMHAS provided feedback that many of the youth, coming from both foster care and congregate care settings, had few, if any practical skills to prepare them for community living.

DCF and DMHAS began a pilot project in one DCF Area Office (New Britain) around both better transition planning and improving life skills. The collaboration brought together DCF, DMHAS, community provider staff as well as youth who had already transitioned to DMHAS

and could provide feedback on what did/did not work. To look at the area of life skills, DMHAS also included Occupational Therapists with special training in assessing and teaching skills to young adults with psychiatric disabilities. A specific assessment tool (Learning Inventory of Skills Training – LIST) was developed and piloted originally just in New Britain but is now being used by DCF statewide for all adolescents age 14 and over regardless of their DMHAS status. This makes it possible to move forward with statewide implementation of LIST inclusion as a requirement in all DMHAS referrals.

Future Planning

With the mechanisms described previously, interagency collaboration between DCF and DMHAS/DDS has been built into the core of the work and will continue to be a priority. In addition to maintaining the existing coordination protocols and processes, it is critical to identify those areas for improvement and expansion. This is an ongoing process supported by more extensive review and analysis of data.

Progress toward goals established for the next 5 years are reported below. Each of these, unless otherwise identified, will continue to be a priority for the Office of Interagency Client Planning in DCF Central Office:

1. Expand the Life Skills pilot to additional Regions (beyond the New Britain Office) so that all youth leaving DCF care for DMHAS (and elsewhere) are prepared – *Addition of annual reassessment in the New Britain Office was completed so that each client who has a baseline LIST also has an annual update to allow for comparison of the two scores to determine if any progress has been made. The plan is to expand the inclusion of LIST in all DMHAS referrals across the state in FY 17. Because DCF now requires an annual update, these can also be provided to DMHAS.*
2. Enhance coordination and communication between DCF and DMHAS throughout the transition process by formally tracking and reporting on the use of the DMHAS Transition Action Plan (TAP) and providing feedback to DCF and DMHAS staff –

ongoing tracking of the completion of TAP's was fully implemented; DCF and DMHAS are sharing and reviewing data to assure accuracy and refine the process.

3. Update the Memorandum of Agreements to assure they reflect current practice – *DMHAS MOA finalization was delayed due to a decision made between the agencies to change the format. The actual MOA document will be shorter and simpler and the more extensive practice details will be kept in an accompanying document. This will allow for ease of revision when protocols and processes need to be updated but the essence of the agreement for the two agencies to collaborate will not change. The new format is anticipated to be ready for review and finalization by the end of FY 16 or early in FY 17. Revision of the DDS MOA is awaiting the completion of state agency reorganization (ASD services from DDS to DSS) which significantly impacts content and protocols; a separate MOA may be needed between DCF and DSS.*
4. Enhance transition from DCF to DDS through coordination of benefits transfer, particularly around Medicaid and SSI related issues; this has been identified as a barrier to timely and smooth transitions – *SSI completion is being tracked for both DMHAS and DDS and there is ongoing coordination with the DCF Revenue Enhancement around IV-E issues which may impact the timing of SSI applications. There is consideration of doing additional tracking specific to DDS youth in FY 17 because there have been transitions delayed due to SSI issues.*
5. Develop practice guides for DCF staff around screening, eligibility, referral and transition to DMHAS and DDS – *draft outline was developed and reviewed with the Clinical Community of Practice; their request was to convene a sub-committee with representatives from among the Regional Resource Group staff in the DMHAS/DDS liaison roles, to assure local level input to the development of the document. Over this past year, multiple meetings were held to obtain input from this group. There are a number of outstanding issues yet to be resolved but the Program Director for the Office of Interagency Client Planning is preparing a draft document for review and discussion. The goal is to complete the draft and pursue review across the system before the end of FY 2017. As part of this process, a checklist for DDS transition will be prepared and piloted prior to completion of the practice guide.*

6. Development of a more formal transition protocol between DCF and DDS which accounts for the various ways in which a child/youth might transfer from DCF to DDS – *this will be reviewed as part of the revision of the MOA between DCF and DDS.*
7. Identify 1-3 interagency pilot projects addressing special needs populations for youth who “fall between the cracks” and/or don’t meet eligibility criteria of current agencies. This involves working with DDS, DMHAS, CSSD, DSS and the Office of Policy and Management to develop a cross- or multi-agency funding mechanism to assure service availability for these youth – *the Inter-Departmental working group has shifted its focus; while originally the plan was to implement an Interagency Case Review team, this was put on hold because there are several other forums in which complex cases are reviewed. A detailed review of “stuck” cases was completed and identified that there are very few that require multiple agencies at the table. DCF is waiting for the changes to be completed between DDS and DSS for review of the ID/ASD cases. At this time, given the foundation of collaborative relationships, DCF is able to work on addressing individual need on a case-by-case basis.*
8. Develop a specific plan for transition of youth to DMHAS and DDS in foster care settings; for DDS this includes a collaboration between the staff working with DDS licensed Community Care Homes and the DCF Foster Care staff to review licensing, rates, provider and family expectations and services offered in each model, develop a system to educate current foster care parents on DDS CCH options and cross-train staff – *ongoing discussions with DMHAS and DDS have made this a greater priority and more a “regular” part of the work; DDS has been willing to meet directly with families around CCH development but also to look at the impact on services when a child/youth is adopted or a transfer of guardianship occurs. This has been very helpful in educating both staff and families. This has allowed a shift in focus to the area of adoption and the impact for families with children who need services from DDS. DDS has agreed to give “DCF age out status” to individuals who have an adoption subsidy over a certain amount, indicating the youth has more intensive needs. Collaboration between DDS Regional staff and the DCF Adoption Subsidy unit has increased and a plan is in process to notify families so they are aware of this option and know who to contact at DDS. This will be*

ongoing through the next fiscal year. In general, staff contact and training is focused on the notion that DMHAS and DDS are not a “permanency plan” and that staff need to think more broadly around resources and supports (families, friends, community members, etc) for DCF youth. It is hoped that the practice guide will be helpful in getting information to staff who can, in turn, communicate more effectively and accurately with families regarding what is/is not available within the DDS system.

[The CT Behavioral Health Partnership \(CT BHP\)](#)

The CT BHP is a legislatively mandated collaboration between the Department of Children and Families (DCF), the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS) and is designed to create an integrated behavioral health service system for Connecticut’s Medicaid populations, including children and families who are enrolled in HUSKY Health and DCF Limited Benefit programs. The State Agencies have contracted with Beacon Health Options (formerly, Value Options, Inc.) to serve as the Partnership’s Administrative Services Organization which provides utilization management, clinical oversight and quality assurance activities related to all Medicaid funded behavioral health services and selected DCF grant funded services.

The Partnership’s goal is to provide access to a more complete, coordinated, and effective system of community based behavioral health services and support. This goal is achieved by making enhancements to the current system of care that:

- Support recovery and access to community services,
- Ensure the delivery of quality services to prevent unnecessary care in the most restrictive settings
- Enhance communication and collaboration within the behavioral health delivery system and with the medical community, thereby improving coordination of care
- Improve network access and quality
- Recruit and retain traditional and non-traditional providers

In Calendar Year 2015, almost 50,000 Medicaid enrolled children and youth (under age 18)

utilized a behavioral health service and approximately 5700 of these individual children were involved with DCF through child welfare, juvenile justice or voluntary services. 2015 CT BHP program targets for youth involved a continued focus on identifying youth with frequent and unnecessary behavioral health visits to the ED in order to propose crisis planning and diversionary interventions. Utilizing Medicaid claims data, reports are now available for DCF staff that identify DCF -involved youth who are frequent visitors to an Emergency Department (ED) due to a behavioral health concern so that crisis planning can be effectuated. Similarly, reports that identify DCF youth who are experiencing inpatient overstay or repeat hospitalizations are also available to assist in the identification of youth who might need assistance from a Regional DCF Integrated Service System or other DCF supported treatment planning activity to promote or maintain discharge.

A statewide meeting between DCF senior administrators and clinical staff and hospital ED Administrators and staff was held in January, 2015 to review ED utilization data, discuss diversionary resources and identify regional service gaps. As a result of this meeting, all six DCF regions have continued to meet with local hospitals to facilitate increased communication and collaboration on a local level for DCF youth when seen in crisis in the Emergency Department.

The Partnership also continues to focus on strengthening the provider network for IICAPS, an intensive home-based intervention designed to help youth with psychiatric challenges who have had previous inpatient stays to succeed at home and in the community. This past year, each of the 20 IICAPS provider agencies received individual Provider Analysis and Reporting documents that monitored individual provider performance against an established set of service goals. These reports have been used to shape performance towards desirable treatment outcomes that include connection to appropriate care post IICAPS, client maintenance in the community, and client access to medically necessary psychotropic medication. Approximately 30% of the 2500 families receiving this intervention over the past year were DCF involved.

[ACCESS MH](#)

Implemented in June 2014, ACCESS-MH CT provides telephonic psychiatric consultations by child and adolescent psychiatrists to Primary Care Physicians in the state for all children under 19 years of age regardless of insurance coverage. The program allows for face-to-face consultations when a telephone consultation with a child psychiatrist and/or clinician is not able to completely address the PCP's questions. Care coordinators and family peer specialists assist in obtaining identified services. The three "hub" providers contracted to provide the services are Wheeler Clinic, The Institute of Living, and Yale Child Study Center. The program is managed by Beacon Health Options with DCF oversight. Each hub is comprised of a child psychiatrist, behavioral health clinician, family peer specialist and a care coordinator. The hours of operation are from 9 a.m. - 5 p.m. Monday through Friday.

In the first year and a half of the program (June 16, 2014-December 31, 2015):

- 81% of pediatric and family care practices are enrolled – that's over 1,400 prescribing physicians across the state
- Since inception, the program has served 1,732 unique youth and their families – this is an increase of 263 unique youth since last quarter
 - 51% were adolescents 13yo-18yo
 - More male than female with 55%/45% split respectively
 - 12% were noted to be DCF involved
- 7,588 consults provided statewide since inception (only 34% of the consults involved HUSKY youth)
 - 1,292 in this quarter, this is an increase of 147 consults from last quarter
 - 45% were direct consultations with the PCP;
 - 54% were care coordination and consults with the family
 - 10 face to face assessments were provided this quarter; 88 total since inception
- 96% of the initial calls from the PCP were answered within 30 minutes/82% of those were warm-line transferred to the psychiatrist on-call

- PCP satisfaction rate remains at 4.9 out of 5

CAFAP

Since 1995 DCF and The Connecticut Association of Foster and Adoptive Parents have engaged in a partnership benefiting thousands of children and families. The Connecticut Association of Foster and Adoptive Parents makes a difference in the lives of foster, adoptive and relative caregivers by providing support, training, and advocacy. They receive an average of 150 inquiries to the KidHero line a month. There are currently 1,999 DCF licensed families; CAFAP provides support to all DCF licensed families.

Beginning in 2014, CAFAP partnered with DCF on several initiatives including a foster care satisfaction survey, health and wellness initiative, increasing foster parent participation in post-licensing training and increasing the number of families/individuals who inquire about becoming foster parents. CAFAP has increased the ability of their KidHero inquiry process to track how an individual became aware of the need for foster parents and maintains contact with the inquirer until he or she can attend an open house. CAFAP has begun sending monthly KidHero inquiry reports to every region and compiles this information on a quarterly and annual basis.

CAFAP has been very responsive to the increasing focus on placing children with kinship families and in maintaining those placements through the services of the CAFAP liaisons. Each DCF Office has a CAFAP liaison working with the local Foster Care units to help maintain the placement, provide services to the foster family and child(ren) and to collaborate with DCF on achieving permanency. In 2016-2017 we expect to see the partnership with CAFAP continue to grow. One new area of focus is on CAFAP's recent development of a new online training system for post-licensing trainings called, "ProProfs". This system enables foster parents to complete post-licensing modules from any computer with Internet access and not have to travel to a training. The first online module (Cultural Competency) went live in April 2016. The ProProfs training system is able to aggregate module results and report to CAFAP and DCF what modules are being completed and where improvements in the system are needed. We expect this will aid in the increase of completion rates for post-licensing

trainings.

Juvenile Court

DCF has engaged in a variety of collaborative efforts with the Judicial Branch and its partners in an effort to meet the various mandates, goals and objectives to assist individual and systemic improvements to the lives of children and families in CT.

For example:

1) DCF worked with the Office of the Public Defender, the Office of the Attorney General and the Superior Court for Juvenile Matters to plan and present at the annual Child Welfare Law Symposium which presented various topics on child welfare and the law to the juvenile court defense bar, assistant attorneys general, DCF staff, Juvenile Court judges and court personnel.

2) DCF collaborated with the Office of the Public Defender and the Superior Court for Juvenile Matters to plan and present the Permanency Law Forum. The attendees included DCF staff, members of the child welfare bar and juvenile court judges and court personnel.

3) DCF continued its ongoing collaboration with the Judicial Branch, Department of Mental Health and Addiction Services, Office of the Attorney General, Office of the Public Defender and the substance abuse provider community on the RSVP program. In 2015 the program expanded to two more juvenile courts. The program offers parents who abuse drugs and alcohol and who have lost custody of their children due to child abuse and neglect a recovery case manager, expedited access to treatment services and more intense juvenile court proceedings.

DCF Headstart Partnership

For over 15 years the CT Headstart State Collaborative Office (HSSCO) has staffed, funded and co-convened this valuable collaboration to work better together in support of families. DCF and Head Start staff from the 14 local DCF Area teams from across the state come together quarterly with their key partners, including but not limited to: ECCP,

Supportive Housing for Families, local Birth to Three programs, and Child First, to strengthen their understanding of the various programs and foster working relationships and collaboration to better support families.

[The Connecticut Parents with Cognitive Limitations Work Group \(PWCL\)](#)

The PWCL was formed in 2002 to address the issue of support of parents with cognitive limitations and their families. Members include all of the major human services state agencies (Department of Children and Families is the lead; other state members include: Departments of Correction; Housing; Social Services; Developmental Services; Public Health; Mental Health & Addiction Services, Office of Early Childhood) as well as a diversity of private providers. Although the number of families headed by a parent with cognitive limitations is uncertain, and identification is one of the group's challenges, it is estimated that at least one third of the families in the current child welfare system are families headed by a parent with cognitive limitations. These parents may be unidentified or may be misidentified as mentally ill or as substance abusers. When they cannot meet the expectations of the available programs and services, they are often labeled as "noncompliant", or "uncooperative."

This population needs to be recognized as distinctive and in need of specific services tailored to its needs. Currently, there are few community supports tailored to meet the on-going needs of these families who often require longer term services than most of our systems currently fund.

To address these issues, The Workgroup developed a training on "Identifying and Working with Parents with Cognitive Limitations" which has been offered in many communities throughout the State and additional trainings will continue to be offered each year. To date, the Workgroup has trained close to 3,100 service providers through the work of an interdisciplinary, interagency rotating training team. In addition to offering a conference for administrators and supervisors, and an international conference, the Workgroup also created an Interview Assessment Guide to assist workers in identifying these families. The

Workgroup has drafted recommendations regarding the use of plain language in communicating with all parents and developed a training on plain language.

The Department established an internal Workgroup to make recommendations regarding our practice with these families. Those recommendations are currently being reviewed. Planning is in process regarding a training for clinicians on conducting Parenting Competency Based Assessments. Expertise for this specific population is limited nationally and we are working with one such group to establish this training.

The Workgroup's Annual meeting will take place in September and will focus on poverty, its impact on these families and policy and practice implications.

The Connecticut Council on Developmental Disabilities funding allowed the Workgroup to contract with an evaluator to do a 10 year evaluation of the trainings and to develop an online evaluation, including a pre and post-test. The Council, in its 5 year strategic plan identified parents with disabilities as one of its top 3 priorities.

[Early Childhood Cabinet](#)

The Early Childhood Cabinet, originally created in 2005 as the Early Childhood Education Cabinet, was renamed the Early Childhood Cabinet in the 2014 legislative session to reflect the cabinet's renewed interest in all areas that impact young children and their families. The Early Childhood Cabinet looks to provide an aligned system of early childhood education delivery in Connecticut.

The Cabinet is co-chaired by CT's Lieutenant Governor and the Commissioner of the Office of Early Childhood. Cabinet membership includes the following representatives:

- Department of Developmental Services,
- Department of Public Health
- Department of Social Services
- Department of Children and Families

- State Department of Education
- Office of Policy and Management
- Commission on Children
- Family Resource Center
- Local Education Agency
- CT State Employees Association
- Early Childhood Community Educator
- Early Education and Child Care Provider
- Grossman Family Foundation
- Headstart State Collaboration Office

The Cabinet has articulated four priority areas:

- Quality Data Systems
- Early Learning Standards
- Family Involvement / Home Visitation
- Professional Development / Workforce

In June 2012, three additional work groups were formed:

- Health Promotions
- Public/Private Partnerships
- Quality Rating and Improvement System (QRIS)

Under the leadership of CT's Lieutenant Governor and Office of Early Childhood Commissioner, the Cabinet focused their work in 2015 on how the state could better meet the needs of young children and their families experiencing homelessness. Representatives from the housing community joined the subcommittee consisting of state agency administrators and provider organizations to create a legislative and administrative policy and practice agenda. The work culminated in a report to the legislature with specific recommendations including but not limited to: better identification of families, including improved data collection, identifying and overcoming barriers to service access, and

connecting actual services and supports through case management. The proposal includes budget-neutral policy changes identified by the Office of Early Childhood, Department of Social Services and Department of Housing to work collaboratively, in partnership with DCF, to better target supports to families with young children who are homeless. A workgroup has been established to develop a plan to implement the proposed recommendations put forth by the Early Childhood Cabinet.

[CT's Home Visiting Consortium](#)

The establishment of the Home Visiting Consortium was a result of legislation (PA 15-45) that was passed in 2015. The group is charged with developing a plan for implementing the recommendations put forth in the 2014 Home Visiting Report submitted by the Office of Early Childhood. Membership includes the following stakeholders:

- Family members (4) who are receiving services or have received services within the last five years from one or more home visitation programs in the state
- Representatives (8) from the home visitation programs in the state, at least four of whom shall utilize different home visitation models
- United Way of Connecticut 2-1-1 Infoline
- Birth to Three
- Connecticut Head Start State Collaboration Office
- Office of Early Childhood
- Department of Children and Families
- Department of Developmental Services
- State Department of Education
- Department of Mental Health and Addiction Services
- Department of Public Health
- Office of the Child Advocate
- Commission on Children

Four priority areas have been identified by the Consortium as follows:

1. Strengthen the Referral Infrastructure for Home Visiting Programs (include access to services and referral structure);
2. Develop a communication strategy to increase public awareness, knowledge and perception of home visiting programs;
3. Workforce Development – establish a core set of competencies and coordinate training; and

4. Develop program standards that promote high quality programs and outcomes

Subcommittees have been developed to work on the priority areas identified above. The Consortium meets on a quarterly basis. It is anticipated a draft plan will be completed by January 2017.

[CT Children's Behavioral Health Plan](#)

During the 2013 legislative session, the General Assembly passed Public Act 13-178, which directed the Department of Children and Families to produce a children's behavioral health plan for the state of Connecticut by October 2014. The Act required development of a comprehensive and integrated plan that meets the behavioral health needs of all children in the state and that prevents or reduces the long-term negative impact for children of mental, emotional, and behavioral health issues.

The original plan was submitted in October 2014. As recommended in the plan, DCF formed a Children's Behavioral Health Implementation Advisory Board in March 2015. In June 2015, tri-chairs were identified and appointed. The team is comprised of other state agencies named in the original legislation, family members, providers and advocates. The Implementation Board is further supported in legislation passed in 2015 in the form of Public Act 15-27, An Act Concerning the Implementation of a Comprehensive Children's Mental, Emotional and Behavioral Health Plan. The Board meets quarterly and three subcommittees were formed that include not only members of the Board but a broader audience as well.

In October 2015, a Progress Update was submitted to the Legislature. The report include reports from five state Departments contributing over fifty activities underway to support the seven thematic areas of the Children's Behavioral Health Plan. These activities and the thematic areas are grounded in the belief that Connecticut will achieve a truly integrated behavioral health system that cares equally for all children, youth and their families, (regardless of race, ethnicity, insurance status or income) through a multi-state department and multi-stakeholder partnership with families, children and youth as equal partners in all system transformation efforts.

[State Interagency Coordination Council](#)

Part C of the IDEA (Individuals with Disabilities Education Act) and our state's Birth to Three legislation established the **Connecticut Interagency Birth-to-Three Coordination Council** (ICC or SICCC) consisting of representative members appointed by the Governor and leaders of the State House of Representatives and State Senate. The council's role is to advise and assist the lead agency (Office of Early Childhood) in the implementation of the Birth to Three System.

Members of the Coordinating Council include a number of state agencies including: Department of Public Health, Office of Protection and Advocacy, Department of Developmental Services, Department of Insurance, Department of Social Services, Department of Children and Families, and the Department of Education. Other members include several Early Intervention Providers, Parents, and representatives from Early Headstart Programs, the state legislature, and the American Academy of Pediatrics.

The function of the Council per CT Law 17a-248b is to:

1. Assist the lead agency in the effective performance of the lead agency's responsibilities, including:

- Identifying the sources of fiscal support for early intervention services and programs
- Advising on priority areas and measures for quality assurance of programs
- Assignment of financial responsibility to the appropriate agency
- Promotion of interagency agreements

2. Advise and assist the Commissioner of the Office of Early Childhood on issues concerning:

- The development of standards and procedures
- Identifying barriers that impede timely and effective services delivery
- The adoption of rules and regulations

Following a strategic planning meeting, three subcommittees were established designed to focus on the following areas:

1. Quality/Systems
2. Legislative/Fiscal
3. Communication and Education

The SICC and subcommittees meet on a quarterly basis to enhance the partnership and collaboration among key stakeholders and will continue to focus on the areas identified above this upcoming year.

[Overview of Supportive Housing for Families Five Year Federal Grant \(ISHF\)](#)

The Connecticut Department of Children and Families (DCF) and The Connection, Inc. (TCI), have developed a mature relationship, collaborating to meet the needs of child welfare involved families who experience severe housing barriers. The grant is designed to provide an enhanced version of the already well established Supportive Housing for Families Program in order to better meet the mental health and trauma needs of the parents and children served by the program. The Intensive Supportive Housing for Families Program (ISHF) is a 5-year initiative to develop, implement, and study the effectiveness of a supportive housing program for families who come to the attention of the child welfare system due to *severe housing issues and high service needs*.

By employing an integrated, collaborative, cross-system intervention model, the project aims to:

- reduce child welfare system contacts, maltreatment, child removal and foster care placement
- increase family housing stability
- increase parental employment

DCF continues to collaborate with state partners, community agencies, and service providers to implement the new program. However, DCF's two primary partners are The Connection

Inc. (TCI), who will provide intensive housing and case management services, and The University of Connecticut (UConn) researchers, who will evaluate the program.

In year one (Oct.1, 2012-Sept. 30, 2013), the ISHF grant team developed the program's implementation plan. This included the following activities, events, and trainings:

1. Implementation of Triage Procedures
 - a. Completion of Referral Form/Intake process
 - b. Selection of Vocational Screeners/Assessment
 - c. Training of DCF workers on Screening Criteria for ISHF
2. Development of Supportive Housing Service Array
 - a. Review of Evidence Based Outcomes of all providers
 - b. Contact three lead connections from Region 3 DCF Advisory Board to create sub-committee around streamlining collaboration
 - c. Creation of a Vocational Curriculum
 - d. Dissemination of Information through local networking in Region III
3. Creation of Customized Case Management
 - a. Hiring of 3 full-time ISHF Case managers and 1 full-time Vocational Specialist,
 - b. Completion of trainings for ISHF Staff
 - c. Completion of ISHF Program Manual
4. Evaluation (Local and Cross-Site)
 - a. Determine data collection plan
 - b. Complete UConn and DCF Internal Review Board Applications
 - c. Final program study consent form
5. Sustainability
 - a. Conduct regular management meetings
 - b. Establishing ISHF Program Advisory Board

In year two of the project (Oct. 1 2013 –Sept. 30 2014) there was continued work in the areas cited above including the following:

1. Review triage process to ensure quality
2. Review target population demographics to ensure we continue to serve the highest need clients.
3. Creation of Vocational and Resource Manuals
4. Development of Motivational Interviewing supervision track
5. Revision of client satisfaction survey
6. Collaboration with the Three Branch Institute
7. Establishment of the Project Advisory Board

In year three (Oct. 1, 2014- Sept. 30, 2015) there have been several areas of focus including: administration of the project advisory board, targeting families with housing needs at Intake into the Child Welfare System via an assessment tool, and expanding the ISHF project model into the DCF Hartford Area Office. The ISHF project has received 254 applications from 12-12-13 to 3-31-15 with 94 eligible and randomized to the project.

The Project Advisory Board called the *CT Collaborative on Housing and Child Welfare* is a subcommittee of the “Three Branch Institute” focused on improving the social and emotional well-being of child welfare involved children in participating states by facilitating more effective coordination between the work of states' executive, legislative and judicial branches of government in participating states. On Monday September 29, 2014 the advisory board held its first kick off meeting, with keynote speaker Dr. Kenneth Hardy. The meeting was well attended by state officials, community providers and Supreme Court judges. The second meeting was held in the Spring of 2015 and included an overview from Connecticut’s housing advocates on state policy, initiatives, and proposed legislation regarding homeless families, an update on the grant and utilization of the new assessment tool, and workgroup assignments that are focused on system change within areas (education, employment, and housing) that impact families and their vulnerability to becoming homeless.

The *Quick Risk Assessment Family Triage (QRAFT)*, the abbreviated version of the Risk Assessment Family Triage tool, was developed by the evaluation team and implemented by DCF Intake Workers to assess all new families reported to the child welfare. The goal of this additional screen was to evaluate families housing needs at the beginning of child welfare

involvement and prompt immediate referral of families who appear to have severe housing problems to the supportive housing project. Implementation of this process began in early November 2014. The evaluation team conducted an analysis on all the QRAFT data collected and produced the first technical report on the QRAFT titled *“Implications for Client Targeting and Enrollment in CT’s Housing and Child Welfare Demonstration”* on February 23rd 2015. Feedback received indicated the process was useful, not burdensome, and provided significant housing data on families that would not have normally been collected at Intake in Connecticut’s child welfare system. DCF officials agreed to maintain this process in the project’s initial region and will utilize the same process during the expansion into the Hartford area and eventually statewide.

Expansion to the DCF Hartford Area Office is currently underway with the hiring and training of new Connection Inc. staff as well as planning and preparation with Hartford DCF staff. Communication with key stakeholders in the Hartford area has also begun. The Supportive Housing Project began accepting referrals in the Hartford DCF Office on July 1st 2015.

The ISHF project will continue the following activities within the next year:

1. Continue to evaluate the referral process and the target population to ensure quality, compliance and that the highest need families are served.
2. Continue building community resource manual
3. Enhance collaboration with all service providers through interdisciplinary teaming and include housing authorities.
4. Enhancement of program curriculum, core skill sets and training
5. Analyze and report out on client data
6. Conduct focus groups with Case Managers and clients
7. Establish and utilize data-sharing agreements between state agencies
8. Continued work on Engagement and Cost studies.

Information in this section can be found in the CFSR/APSR items 1-36 that were submitted in the CT March 2016 self-assessment and the two June 2016 updates.

Systemic Factors

Information in this section can be found in the CFSR/APSR items 1-36 that were submitted in the CT March 2016 self-assessment and the two June 2016 updates.

Case Review System

The Office of Administrative Case Review (OACR) is a statewide operational unit responsible for the Administrative Case Review (ACR) system across the six (6) regions of the Department. As the cornerstone of the Department's Continuous Quality Improvement (CQI), the OACR is helmed by a Program Director (PD) who reports to the DCF Chief of Quality and Planning. Four (4) Program Managers are assigned to oversee the daily regional operations of the ACR process, which includes the direct supervision of fifty-two (52) ACR Social Worker Supervisors (SWS) who sit in the Area Offices. As reported in the most recent APSR submission, the OACR continues to partner with the Department's Office for Research and Evaluation to engage in activities that will ensure the ACR process remains consistent and reliable across reviewers.

The ACR process assures that each child has a case plan designed to achieve placement in a safe setting that is the least restrictive, most appropriate and in close proximity to the parents' home, consistent with the best interest and specialized needs of the child. DCF Policies 36-1 through 36-5, "Case Planning" and 36-11-1 through 36-11-2, "Administrative Case Review", in conjunction with the Case Planning Practice Guide (issued March 2014) provide agency social workers key information as it relates to best practice guidelines around case planning with children and families. These guidelines not only include timeframes for the development of case plans, but also include salient information with regard to the development of case plans with families and children, specifically active engagement throughout the case planning process. As part of the case review, the ACR Supervisor also ensures the case plans being reviewed include the required provisions, and

documents the findings in the Administrative Case Review Instrument (ACRI). The completed ACRI is then provided electronically to the social worker, supervisor and manager of the case with specific information and feedback related to the required provisions.

The ACRI also captures meeting participant information and method of participation (in-person or via teleconference). While the Department has improved efforts to engage parents in case planning and increase participation in ACRs, there is still work to be done. As the development of the new SACWIS system continues, so do discussions related to the use of current technology in notifying parents and youth about ACR meetings.

In CY 2015, there were over 12,500 ACR meetings held. This number includes ACRs for all children in placement, regardless of age, a portion of in-home cases, and all families with at least one child in care. These reviews continue to occur every six (6) months.

In preparation for the ACR, the OACR SWS conducts a comprehensive case review of the electronic record, which includes reading the case narratives for the entire period under review (PUR), which can be sixty days if the child newly entered care, or up to six months

Measure	Statewide			
	2015			
	Strength		ANI	
	#	%	#	%
Timely Case Plan	12392	95%	656	5%

if the child has been in care and this is a subsequent review. The ACR SWS also reviews the written case plan, which must be submitted to them by the CPS social worker seven (7) days prior to the meeting, though the agency does allow for case plans to be submitted up to three (3) days before the ACR date. Any case plans that are submitted to the ACR SWS with less than three (3) days before the review are rated as “no case plan” (not timely case plan). This data element is tracked and reported out on by regional office leadership as the Department is committed to ensuring that all children have a written case plan. In CY 2015, the Department achieved having a “Timely Case Plan” in 95% of the total case plans rated for this item. Again, the timeliness as rated in the Case Practice Report is in relation to the ACR meeting date and ensures that a written case plan is provided to the ACR SWS in advance of the review meeting. Following the ACR meeting, social work supervisors are required to

approve the reviewed case plan no later than twenty-five (25) days following the ACR meeting.

The Department also has an “Exception Report” which identifies children in placement (CIP) for whom there is not a current case plan in LINK within 180 days. According to the CIP Dashboard report for 1/1/16, there were 3,998 CIP and of those, twenty-nine (0.7%) of children in care, ages 0-17, appeared on this report as having no current case plan within 180 days of either the most recent case plan or entry into care . This report is utilized by Area

Age of CIP	No Plan?
1	1
2	1
3	1
4	1
7	2
8	2
9	2
13	2
14	2
15	4
16	4
17	7
Grand Total	29

Offices to identify any children in care for whom a case plan has not be created in the system in a timely manner. As part of the CFSR Statewide Assessment, ACR Social Work Supervisors participating in the focus group confirmed that it is very rare for them to encounter an instance in which a child in placement does not have a case plan in accordance with required timeframes.

In reviewing the narratives and through discussion at the review meeting, the OACR SWS is responsible for assessing a variety of case practice indicators that highlight family and child/youth engagement in case planning, including the “family feedback” documented by the social worker in the case plan. In this section, the social worker reflects on the family’s feedback as related to case planning, case goals and progress. These indicators provide the Department with critical information related to case

Case Practice Report

The Case Practice Report identifies areas of strength and areas needing improvement for Parents are defined as biological parents, adoptive parents, guardians, psychological par prior to removal, and assessed in the ACR process.

User may view additional areas of case practice by clicking in the Measure box. The repo

Actions | 1 of 1 | Find Next | 100%

SI.No	Measure	Statewide	
		2015	
		#	%
1	Visitation with Child and Parents	5469	63%
2	Frequency of visits - Parents	8113	63%
3	Frequency of visits - Father	3232	58%
4	Frequency of visits - Mother	4881	68%
5	Quality of visits - Parents	8418	66%
6	Quality of visits - Father	3374	60%
7	Quality of visits - Mother	5044	70%
8	Frequency of visits - Child	9181	75%
9	Quality of visits - Child	9334	76%
19	Parent Needs	3101	72%
20	Needs Assessed - Fathers	2897	74%
21	Needs Assessed - Mothers	3600	83%

planning and engagement. Following facilitation of the ACR meeting, the OACR SWS enters their assessment and findings into the Administrative Case Review Instrument (ACRI) which

is used to feed the Department's Case Practice Report, a report that provides the agency valuable information with regard to case practice and outcomes for children and families.

Based upon ACRs held in CY 2015, the Practice Report highlights the Department's strengths in some of the practice indicators that have a strong correlation to quality case planning and family engagement. The numbers for each indicator vary because they are based on the individual participants, not the total number of meetings held. The Department's "Purposeful Visitation Guide" and "Case Planning Practice Guide" both emphasize the importance of family engagement in case planning and the direct connection to visitation with parents and children. ACR SWS utilize this lens as they assess case practice during their reviews.

In preparation for Round 3 of the CFSR, the agency conducted pilot reviews utilizing the OSRI and OMS. As a result the agency was able to utilize OMS reports to assess performance across all items, including Item 13, Child and Family Involvement in Case Planning. The pilot data reflects a strength rating in 50% of the eighteen (18) cases rated for this item and often where there were areas noted as needing improvement, there was a connection to the frequency and quality of visitation. Likewise, in those reviews where involvement in case planning was noted as a strength, there was evidence of ongoing discussions with the child and parents specific to case planning and in interviews, parents and children acknowledged their inclusion in case planning. The feedback obtained in DCF's CFSR Phase 2 and Phase 3 pilots is consistent with the feedback the ACR supervisors have provided through their case reviews and have documented in the ACRI. While parent engagement in case planning is not captured as a single data element, ACR supervisors do assess for parent and child engagement in case planning as part of their qualitative review and capture this within the "case plan assessment" section of the ACRI as a narrative entry.

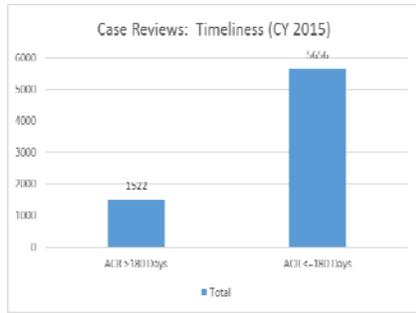
Currently, the ACR notifications are generated through LINK, the agency's SACWIS system. When a child enters placement for the first time or when a child remains in care and it is 120 days since the most recent case review a notification occurs. This allows for a 60 day window for the next review to be scheduled. This automated system helps the Department

to ensure that each child has an ACR scheduled, at which time the written case plan will be reviewed with the family and other invited participants. Each regional office has an Office Assistant who is responsible for scheduling these case reviews. In some cases the automated notification is delayed, particularly in those cases where the placement has not yet been able to be entered into the SACWIS system. Office Assistants across the state have implemented a process to capture these entries through a review of the Foster Care “placement log” which identifies each entry into care, including those not yet entered into SACWIS. The system allows the Office Assistants to create a “meeting window” in the SACWIS system and schedule the ACR within the required timeframe. As the Department continues to plan for the new SACWIS system, ACR scheduling remains a priority. Office Assistants as well as ACR managers and supervisors are participating in these discussions in an effort to improve the ease in which reviews are scheduled in the future system.

The agency’s case review system has been designed to ensure that a periodic review for each child occurs at least once every six (6) months through the Administrative Case Review (ACR) process. As a child enters care and the entry is documented in LINK, there are triggers to alert the ACR Office Assistant and the CPS staff that an ACR meeting needs to be scheduled within 60 days of entry into care, and a case plan written and submitted in advance of that meeting. Similarly, following the first ACR, the system is designed to automatically calculate the due date for the next review, 180 days from the last ACR, and automated notifications are sent beginning at the 120th day.

There are several automated reports utilized by the ACR Office Assistant (OA) to ensure all reviews that should have been scheduled are in fact scheduled in the appropriate time period. The primary reports are the “Proposed/Due” report and the “Anticipated” report. As new entries into care are documented in SACWIS, the data populates the “Due Report” and office assistants run this weekly to schedule reviews timely. This report identifies the maximum due date for a case review to occur (180 days) and the OA schedules accordingly. Once a case plan review has been conducted for a child in care, as long as s/he

Office	CIP <18 Reviews
Bridgport Office	544
Danbury Office	324
Hartford Office	1181
Manchester Office	588
Meriden Office	360
Middletown Office	238
Milford Office	479
New Britain Office	582
New Haven Office	593
Norwalk Office	259
Norwich Office	871
Torrington Office	250
Waterbury Office	900
Willimantic Office	658
Grand Total	7958



remains in care, the anticipated report automatically calculates the due date for the next case review and that date will reflect in the “anticipated” report, which allows for advanced scheduling of reviews. The following table reflects the case reviews in 2015 for children in care under the age of 18 in 2015; when cross-walking this data with the “due

report” for 2015, there are no children in care under 18 for whom a case review was not conducted. Some of these reviews were not timely, but through ongoing review of the reports, OA’s are able to identify any reviews that may not have been scheduled.

The agency has a report to assess the attainment in reviewing cases at least every 180 days. For CY 2015, the data shows that 78.8% of the ACRs for children in care were held within 180 days and 97.5% of these reviews were held within 210 days from the last review, within 30 days of the due date. Of those reviews held beyond 180 days, 42.2% went beyond by only 1-5 days, and 60.7% went over by 1-10 days.

The Department also has a report that indicates those case review meetings that have been rescheduled and the reason for the rescheduling. Typically ACR meetings are not rescheduled unless at the request of the parent, the parents’ attorney, or if a key participant was not identified on the initial invite. When meetings are rescheduled, the Office Assistants make every attempt to reschedule as close to the initial date as possible.

In about 10% of the ACRs in the SACWIS system a “proposed” or due date is not identified in the meeting window field, so these were excluded from the timeliness data. It is likely that the number of meetings held within 180 days is actually higher because often those meetings without a “due date” indicated in the SACWIS system are those that the office assistants manually create in the system to ensure these meetings are held timely. This is an issue that was previously identified in the 2008 CFSR. The OACR Management team has begun data reviews related to

# Days Beyond 180	Total Beyond 180 Days	
1-5	642	42.2%
6-10	281	18.5%
11-30	415	27.3%
>30	184	12.1%
Grand Total	1522	100.0%

this issue and also received feedback from the Office Assistants (OAs) responsible for scheduling these meetings. For example, if a child enters care and is placed with a relative, if that relative is not yet in the LINK system as a licensed provider, the social worker is unable to reflect that placement in LINK, which results in no notification to the Office Assistant that a meeting is due to be scheduled within sixty (60) days. As previously referenced, OA’s will review the new placement logs and manually create meeting windows for any child the automated notification was not sent for.

Data from a Foster Care Survey conducted by the Department in 2015 offered the following findings with respect to how foster parents and youth respectively viewed aspects of the ACR process. The results from youth reflect some areas of concern, particularly with respect to their perception of the value of the ACR. Based upon this feedback, the OACR leadership team is developing a plan to outreach to youth to further assess this issue and formulate strategies to enhance the benefit of the ACR for youth.

ACR Social Work Supervisors, as part of their case review for children in care, assess the timeliness of permanency hearings to ensure that a hearing occurs no later than twelve (12) months from the

	Yes	No	Grand Total
Hearing with in 12 Months	4171	323	4494
Hearing with in 12 Months	92.8%	7.2%	100.0%

date the child entered foster care and no less frequently than every twelve (12) months thereafter. A review of the ACR data for this element, as related to case reviews conducted during CY 2015, reflects that in nearly 93% of the reviews, permanency hearings were found to have occurred within twelve months from the date of entry into foster care and 88.7% occurred no less frequently than every twelve (12) months thereafter.

The court also provides the agency with data for “time to subsequent permanency hearing” which is a Court Performance measure that is calculated for the State Court Improvement Grant. For the children who exited care in FY15, the percentage of permanency plan dispositions that were held within 365 days of the prior permanency plan disposition was 94%.

	Yes	No	Grand Total
ThereAfter 12 months	4133	527	4660
ThereAfter 12 months	88.7%	11.3%	100.0%

FY14/15				
# PP	# Within 365 Days	Average	Median	%Within 365 days
2092	1962	306	311	94%

The ACR process also assesses for the filing of termination of parental rights (TPR) in accordance with required provisions. As part of the ACR meeting preparation and case review, the ACR Social Work Supervisor is responsible for reviewing the placement information for the child and documents the findings on the Administrative Case Review Instrument (ACRI). The

	Yes	No	Grand Total
in care >=15 months cumulative in last 22 months?	3313	3917	7230
	45.8%	54.2%	100.0%

ACRI has specific questions related to the time in care and specifically, the filing of TPR for those children in care >=15 cumulative months in the last 22 months.

During CY 2015, ACRI data reflects that 45.8% of the reviews reflected that children were in care 15 or more of the most recent 22 months. It is important to note that the data is based on ACRs, so children who had two ACR meetings during this timeframe, and were in care 15 or more months at the time of review, are likely reflected twice (once for each review).

As part of the case review, the ACR supervisor documents not only whether or not a child has

TPR Filed	Permanency Goal	#	%
YES	Adoption	155	15%
	APPLA	20	2%
	TOG: Sub	20	2%
	Reunification	15	1%
	(Blank)	2	0%
	TOTAL		212
NO	Reunification	270	26%
	Adoption	178	17%
	TOG: Sub	224	22%
	APPLA	122	12%
	LTFC Relative	16	2%
	TOG:Non-Sub	7	1%
	(Blank)	4	0%
	TOTAL		821
TOTAL	TOTAL	1,033	100%

been in care 15 or more months cumulative in the last 22 months, but also whether or not a TPR has been filed. The agency also captures this data in the Exit Plan Monthly Plaintiff Report (table to the left).

In a report run March 6, 2016, the data reflects that for approximately 79% of the children under 18 who have been in care for fifteen (15) or more months, TPR has not been filed. In reviewing the data, specifically for those children in care fifteen or more months where no TPR petition has been filed, the documentation reflects that for 26% of these children there is a documented reason for not filing TPR. For approximately 74% of

the 821 children, there is no documented reason in the record as to why the agency has not filed for TPR, which means that for these 606 children, either the agency should have filed and hasn't, has filed and did not document the filing in the SACWIS system, or there is a reason for not filing and the agency has not documented this in the electronic case record. During a CFSR stakeholder focus group with ACR staff on May 18th, 2016, the ACR reviewers consistently reported that it has been their experience in reviewing cases that most often there is a documented reason for not filing TPR that can be found in the case record. ACR supervisors indicated that the reason is not always documented in the specific field in the SACWIS system where the reports are generated from, but that they do see evidence of reasons being documented in the case file and/or in narratives within the SACWIS system.

“Time to filing a Termination of Parental Rights Petition from Removal Date” is a Court Performance measure that is calculated for the State Court Improvement Grant. The following table was provided to the agency by the court for the cohort that includes all TPR petitions filed during FY15. The data is based on the removal date of the child (date of 96 Hour Hold, Order of Temporary Custody or Commitment order) to the date the Termination of Parental Rights Petition was filed.

FY14/15						
#TPRs Filed	# Within 15 months	# Within 24 Months	Average	Median	% Within 15 months	% Within 24 Months
511	332	441	16	13	65%	86%

Notification to caregivers is also built into the ACR scheduling process and although a report can be produced as requested, there is no management report

	Yes	No	Grand Total
Letter Generated 21days Before Meeting	31,700	35,595	67,295
	47.1%	52.9%	

that has been put into production so that this data is available on an ongoing basis or at specific points in time. The agency

Caregiver Type	Timely Notice	Not Timely	Total
Adoptive Parent	235 46.5%	270 53.5%	505
Foster Parent	2324 43.4%	3037 56.6%	5361
Grand Total	2559	3307	5866

expectation is that caregivers are notified of the ACR no later than twenty-one (21) days prior to the meeting.

LINK report data reflects that 47.1% of the notification letters were generated twenty-one (21) or more days prior to the ACR being held. The letters are generated by the ACR OA as part of the scheduling process, but this relies on the area office social worker having updated address information as well as having identified all of the necessary participants. Once the social worker has completed this, s/he checks of a box in LINK to indicate “all necessary participants have been identified”. The OA can then proceed with generating the notification letters. While the data reflects when letters are generated, there is no data point that specific captures whether or not caregivers are successfully notified. It is an expectation that social workers communicate important meeting dates, including court dates and case review dates, to caregivers as they get scheduled. In a foster parent satisfaction survey conducted in 2015, 79.1% of foster parents surveyed indicated they are consistently notified of scheduled court hearings and a higher percentage (87.9%) also reported having an opportunity to be heard in a review or court hearing.

Statement	n/N	Percent
Foster parent being notified consistently of scheduled court hearings	159/201	79.1%
Foster parent having an opportunity to be heard in review or hearing	182/207	87.9%

Next, CGS Sec. 46b-129(k) mandates that Judicial provide notice of permanency hearings to parents. Judicial has indicated that they do not currently track notices, but are working on developing, implementing and piloting a data entry program (CPMOH) that will capture information during the court hearing. As a part of the program, court staff will note who is

present during the hearing. That may help identify hearings where foster parents have participated.

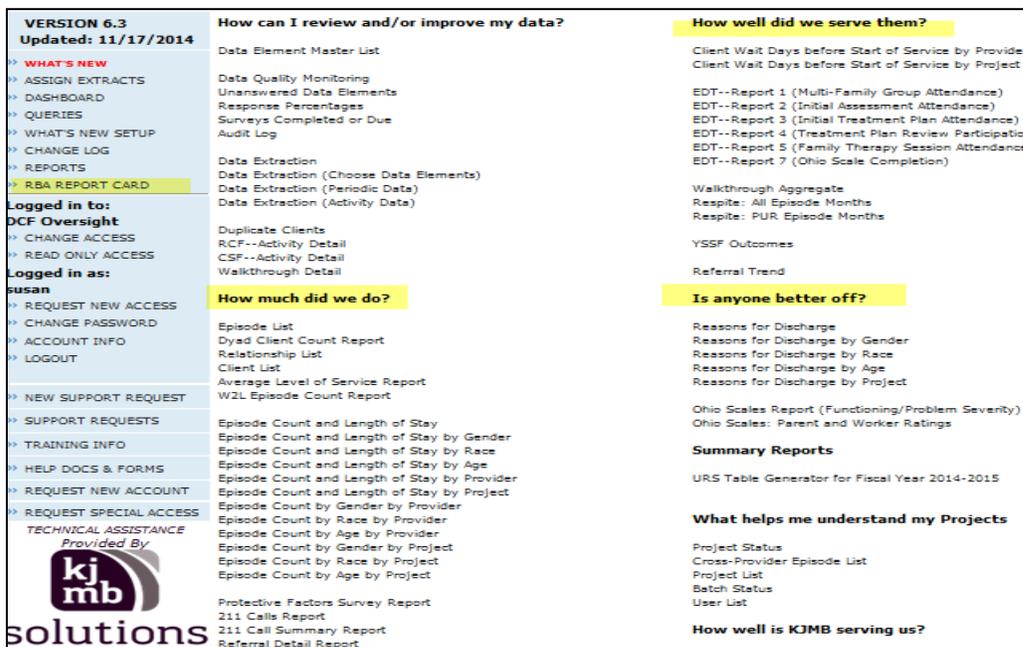
The Department Office of Administrative Case Review (OACR) continues to partner with the Office for Research and Evaluation (ORE) to develop and implement its CQI activities, which includes transitioning from ACRI as the case review tool, to the OSRI in the near future. As previously indicated, the Department is currently in its second month of the CFSR and has opted for the state-administered CFSR. Prior to the start of the official CFSR on April 1st, 2016, the Agency conducted a series of CFSR Pilots, which spanned over ten months and included the use of the Federal OSRI, the conducting of interviews and the establishment of a tiered quality assurance process. The CFSR pilots, as well as the official CFSR, have been led by ORE in partnership with OACR staff.

OACR and ORE outreached to other partners, including but not limited to the Quality Improvement Council (QIC), the Court Monitor's Office, Training Academy, Area Office staff and the OACR Advisory Group to participate in the official CFSR as well as all three phases of the pilot. During the next year, OACR will focus on transitioning to the OSRI as the case review tool and continue to partner with ORE to maintain the QA process that has been in place during both the pilot and official CFSR.

The Department employs a variety of means to identify the strengths and needs of its service delivery system. For example, the Department employs a dedicated Program Director level position that leads DCF's RBA and performance expectation activities. This manager works with DCF's Contracts Division, ORE and Program Development and Oversight Coordinators (PDOCs) who are assigned to oversee all of the Department's contracted services. This position has worked to support all DCF contracts having outcome measures. A guidance has also been created to direct the development of performance measures for our contracted services. Practice Guides have also been developed for some service types to concretize service and performance expectations that are outlined in the contracts.

Provider Information Exchange-PIE

In 2009, the Department launched the Program and Services Data Collection and Reporting (PSDCRS) system. It has been rebranded as PIE- Provider Information Exchange. PSDCRS is a real-time, client level reporting system that allows for program and performance monitoring of DCF contracted services. Reports, dashboards, and data extracts (access to raw data) from PSDCRS allow the assigned PDOCs (and Contracted Providers) to evaluate the quality and efficacy of DCF funded services. PSDCRS data reports are categorized within a RBA framework to allow PDOCs, Systems Program Directors (managers in each region who oversee the local DCF service array), and contracted providers to understand and view service provision through the lens of *How Much, How Well* and *Is Any One Better Off?* The below screen shot shows the reports layout within PSDCRS.



in

Some programs PSDCRS

also collect periodic data (e.g., client data updates ever quarter or six months). Activities or event level data is also collected for select service types in PSDCRS. This level of data allows for the Department to assess information about key service provision (e.g., face to face contact with a client, duration of visits, location of services, participants, etc.). PSDCRS

collects post-discharge/aftercare data for some services. An example of aftercare data would be evidence of supporting transition and monitoring stability of a step down from Therapeutic Foster Care to core foster, relative placement or reunification.

The system also collects data on outcomes using a variety of assessment tools. Some behavioral health programs use the Ohio Scales, which is a normed, clinical assessment instrument, to monitor child functioning and improvements. Some substance abuse programs use the Global Appraisal of Individual Needs (GAIN). The North Carolina Family Assessment Survey (NCFAS), Ages and Stages Questionnaire and/or the Protective Factors Survey are used by other DCF funded programs to determine client improvements pertaining to the area of family support early childhood services.

Program Development Oversight and Coordinators (PDOCs) and Regional Systems Program Directors (SPD) use these data to assess program effectiveness, performance, and compliance.

Excel Pivot Table training has been provided to these positions as a means to support more complex analyses. It is expected these data are shared and discussed with contracted providers to support positive outcomes and aid with any performance improvement as may be identified.

Pursuant to the PDOC General Role and Expectation guidance, “[t]he PDOC is expected to monitor and coordinate the quality and effectiveness of the programs under their purview. They are to work with providers, the Regions and other DCF offices and units with respect to assuring quality, supporting services’ sustainability, and facilitating ongoing service improvement.”

The guidance further states “[t]he PDOC must understand, engage, use and disseminate data, both qualitative and quantitative, about their service(s). These positions should ensure that providers are achieving the outcomes outlined in their [Scope of Services] and work with them to ameliorate areas of challenge and underachievement [and] . . . develop strategies for improvement.”

As a means to provide information exchange and support program oversight, PDOCs are

expected to convene regular meetings with DCF contracted providers (i.e., no less than quarterly.) The discussion of data is to be a standing agenda item at these meetings. The Department's Senior Leadership also meets regularly with the Provider Associations and convenes two meetings of all its POS Contracted Providers and Credentialed Services Providers.

Site visits by PDOCs and DCF licensing visits are another means by which the functioning and performance of contracted providers is evaluated. Both site visits and licensing visits typically involve the qualitative review of provider records, including client files. Site visits may range from a half day to two full days on site. The findings from site visits and licensing reviews are shared with providers. If needed, corrective action plans are developed to remediate any identified challenges.

In addition, the Department has contracts with entities that serve as Performance Improvement Centers (PICs). These bodies provide technical assistance to aid with service quality and outcomes of care. Some of the functions of a PIC include:

- Developing documents, identifying screening and assessment measures, and measuring treatment fidelity across sites.
- Identifying training needs, developing a standardized training curriculum, identifying expert trainers, ensuring delivery of required trainings, and ensuring the quality and effectiveness of the training curriculum.
- Quality data maintaining
- Monthly, Quarterly and Annual Data reporting
- Annual training plan (10 modules each) with technical assistance offered three (3X) times.
- Analyzing data to ensure services are accessible and capacity is sufficient and ensure that services are of the highest quality.
- Identifying important goals and associated outcomes and measuring achievement of those goals.
- Oversight of provider annual performance improvement plans
- Quarterly Performance improvement site visits

There are currently three PICs. The below chart identifies the PICs and the entity that administers them.

PIC Type	Contracted Entity
Emergency Mobile Psychiatric Services (EMPS)	Child Health and Development Institute (CHDI)
Differential Response Services (DRS)	UConn School of Social Work

Regular reports are promulgated from these entities. All the EMPS PIC reports are available online via the following link: <http://www.empsct.org/reports/>

The Department has made tremendous infrastructure investment and strides over the last 4 years to cultivate a robust learning culture and data environment. Myriad data reports and dashboards are available for DCF staff and for DCF contracted providers. These readily available data sources support the Department in making timely, data informed decisions. Such information allows DCF to assess and evaluate its performance/outcomes and that of its providers in a more comprehensive and robust way.

Presently, the Department is working with the University of Kansas (KU) to upgrade our Results Oriented Management (ROM) reporting portal. The Department has been using ROM for a number of years, but the current upgrade gives DCF access to a variety of new reports, filtering options and data displays.

Staff and Provider Training

Please see the “Program Support” section regarding the Department’s Training for staff. For additional information regarding training for staff who oversee contract services be refer to the “Service Coordination” section.

With respect to Quality Assurance, staff training is another means by which the Department will be improving outcomes. Program Development and Oversight Coordinators (PDOCs) are assigned to all of DCF’s POS contracted services. These individuals are expected to partner with contracted providers, Regional/Area Office Staff, Systems Program Directors (SPDs), and Central Office Divisions to ensure the provision of effective quality services. Ensuring that the PDOCs and SPDs have the necessary skills and direction to successful fulfill their

responsibilities is crucial. The Department has begun meeting with the PDOCs, SPDs, and Grants and Contracts Specialist as a joint group to share the Department's priorities and to disseminate data and other resources. More advanced metrics training has been provided (i.e., Pivot Tables and Advanced Analytics conducted by Chapin Hall out of the University of Chicago) to support them in conducting more depth analyses of provider program data.

Broader data and Quality Assurance training for DCF Child Protection Staff is also in development. The Department is collaborating with Casey Family Programs to create a data curriculum for DCF staff and to bring a child welfare data fellowship initiative to Connecticut. In addition, the Department's Workforce Development/Training Academy is working to embed greater data and outcome measurement exposure into the pre-service curriculum for DCF Social Worker Trainees.

As a means to support training for foster parent, the Department has a contract with the Connecticut Association of Foster and Adoptive Parents (CAFAP) that includes a range of support, education, training, and advocacy services to foster families, adoptive families and relative caregivers intended to address and meet their needs, encourage and facilitate ongoing education and skill development, and allow foster children to live in safe and stable home settings.

For families licensed by private agencies (e.g., Therapeutic Foster care), their training is tracked by their parent agencies. The Department engages in periodic random reviews during quality assurance site visits to assess each providers systems and will make recommendations for improvements.

In 2015 DCF contracted with the Children's Alliance to implement a new trauma-informed statewide training curriculum for foster and adoptive parents called: Trauma Informed Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP). TIPS-MAPP is fully implemented and is currently being delivered as the only statewide foster and adoptive pre-licensing training curriculum by both the Department and private Child Placing Agencies (CPAs). This ensures consistency in that all prospective parents receive the same training and carry the same expectations. Since December 2014, 130 DCF and private agency staff have been certified to train prospective foster and adoptive

applicants in this curriculum. Additionally, there are two approved statewide trainers to deliver a, “train the trainer” approach in order to sustain the self-sufficiency of this initiative. Providers were also trained in cultural humility in Six Core Strategies (Violence prevention), and in permanency preparation work.

Next, staff at congregate care facilities are monitored by the Department's Licensing Unit for completion of mandatory training (e.g., CPR, first aid, ESI, mandated reporting). The DCF Office of Children and Youth in Placement (O'ChYP) has begun to message to all congregate care providers the need for annual staff training plans. The plans would be submitted to the Department on an annual basis and feedback provided. This language has been added to the Scopes of the TGHs, but these amendments have not yet been executed.

Service Array and Resource Development

Please see the “Service Coordination” section for additional information regarding current and emerging mechanisms for ensuring and monitoring the breadth and effectiveness of the service system. In addition, throughout this report, the Department describes the various services and supports that are available to assess the strengths and needs of children and their families, and those that enable children to remain safely with their parents.

The Department also makes available wraparound funds and supports the creation of Unique Service Expenditure (USE) plans to ensure that service are individualized. There were a total of 133 active USE plans between 1-1-2014 and 12/31/2014 (CY-14). One hundred and thirteen (113/85%) of the USE plans were unduplicated during CY 2014. The data is below:

Region/AO	# USE Plans	% of Total
Region 1	5	3.76%
Bridgeport	3	2.26%
Stamford	2	1.50%
Region 2	33	24.81%
Milford	19	14.29%
New Haven	14	10.53%
Region 3	12	9.02%

Middletown	5	3.76%
Norwich	7	5.26%
Region 4	37	27.82%
<hr/>		
Hartford	19	14.29%
Manchester	18	13.53%
Region 5	14	10.53%
<hr/>		
Danbury	2	1.50%
Torrington	7	5.26%
Waterbury	5	3.76%
Region 6	32	24.06%
<hr/>		
Meriden	15	11.28%
New Britain	17	12.78%
Grand Total	133	100.00%

2. Total \$ spent on USE plans (estimated costs):

Row Labels	\$ Estimated Costs	\$ Average of Estimated Costs
Region 1	245,286.40	49,057.28
<hr/>		
Bridgeport	107,172.00	35,724.00
Stamford	138,114.40	69,057.20
Region 2	651,806.20	19,751.70
<hr/>		
Milford	460,510.60	24,237.40
New Haven	191,295.60	13,663.97
Region 3	300,236.35	25,019.70
<hr/>		
Middletown	197,837.20	39,567.44
Norwich	102,399.15	14,628.45
Region 4	1,210,457.40	32,715.06
<hr/>		
Hartford	649,641.90	34,191.68
Manchester	560,815.50	31,156.42

Region 5	170,089.58	12,149.26
Danbury	22,861.20	11,430.60
Torrington	80,445.78	11,492.25
Waterbury	66,782.60	13,356.52
Region 6	278,623.80	8,706.99
Meriden	101,644.60	6,776.31
New Britain	176,979.20	10,410.54
Grand Total	2,856,499.73	21,477.44

Service Code	TX_SRVC_PMT
294	Temporary Care Services -In Home
590	Clothing - In Home
591	Furniture
592	Rental Assistance - In Home
593	Utilities
594	Medical Treatment-BehaviorHealth In Home
596	Assessment, In Home
597	Behavior Management In-Home
598	Case Management In Home
606	Other Family Supports
608	Supervised Visit In-Home
609	Therapeutic Support Staff In-Home
620	Support Staff In-Home
634	Extended Credentialed Services-USE
635	Assessment & Planning for USE
636	Intensive IndividualSupport for USE
637	Extended Contract Services-USE
638	Difficulty of Care Payment for USE Class
639	Other Services USE
776	After School Srvs, Traditional grde 9-12
777	After School Srvs, Youth grades K-8
778	After Schl Srvs, Clinical suprt K-8
779	After Schol Srvs Clinical suprt 9-12
796	Security deposit In Home
592	Rental Assistance - In Home

Wrap dollars are also used by the Department to better support individualized servicing. As of May 1, 2015, over 16,000,000 has been spent over the course of State Fiscal Year 2015. The side graphic is a screenshot of some of the areas in which the Department has used Wrap funds.

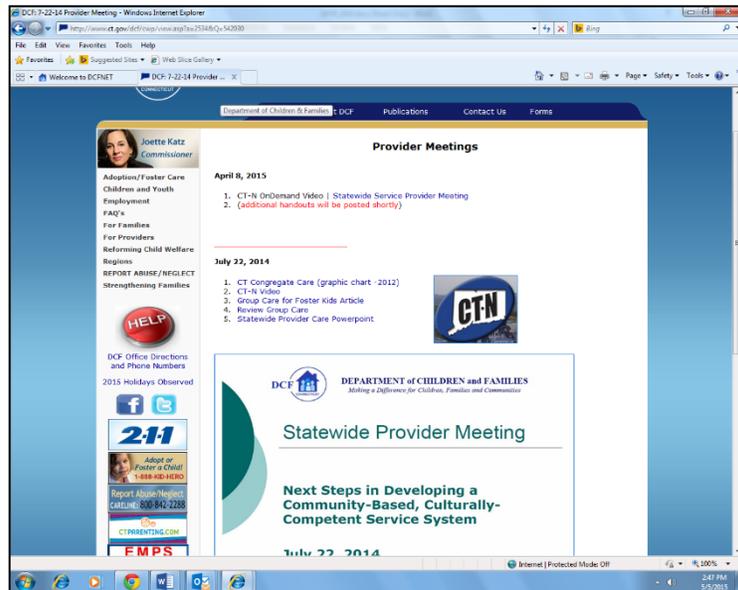
Agency Responsiveness to the Community

Please see the “Collaboration” section for an overview of the Department’s various Community Partnerships. In addition to those articulated in that section, pursuant to Connecticut statute 17a-4, the Department convenes a Statewide Advisory Council (SAC). The SAC is to be comprised of 15 members, appointed by the Governor.

The primary duties of the Council are to: review policies; recommend programs, legislation or other matters that will improve services for children, youth and families; review and advise the Commissioner on the proposed agency budget; perform public outreach to educate the community regarding policies, duties and programs of the Department and issue any reports it deems necessary to the Governor and the Commissioner

Information in this section can be found in the CFSR/APSR items 1-36 that were submitted in the CT March 2016 self-assessment and the two June 2016 updates.

Finally, twice a year the Department convenes a statewide meeting for all its provider agencies. An invitation is extended to the SAC. The Department shares information about its service array, upcoming initiatives and relevant data. The attendees are given an opportunity to ask



questions of the Commissioner and her leadership team. These meetings are televised on the public Connecticut Television Network (CTN) and the PowerPoint presentations are posted on the Department's website. Please see the screenshot of these postings. It is also a hyperlink that will take you to the actual webpage. The last Statewide Provider Meeting was held on April 8, 2015. Regional breakout sessions occurred with the theme of local needs identification. The next meeting is scheduled for August 14, 2015.

FAVOR has had a statewide meeting this fiscal year at FAVOR to provide training and assist the CRPs in defining the agenda for the year.

The Western CRP chose to focus on Voluntary Services. They have met monthly throughout the year to get trainings, review how voluntary services is run in Connecticut and other states and to plan data collection efforts. They have conducted 3 focus groups of families in the community and providers to explore how families learn about voluntary services and the perceptions about it. They are particularly interested in understanding why some communities, particularly African American families, do not use voluntary services, as well as the experiences that families have when they are receiving voluntary services.

The Eastern CRP has focused on youths transitioning out of DCF custody. They have met regularly in Middletown to receive training and discuss issues related to transition. They have reviewed the policies and examined data that was provided to them by DCF. They are in

the process of reanalyzing the data by race-ethnicity to determine whether there are health disparities.

[Foster and Adoptive Parent Licensing, Recruitment, and Retention](#)

Over the past 4 years, the foster care units have refined systems for quality assurance to ensure that state licensing standards are complied with. This includes development of checklists and protocols, as well as review by multiple layers of staff (e.g., social worker and supervisor). Random audits of all cases by supervisors and managers also occur. Further, an electronic system was created that complements our State SACWIS system (eDocs). It requires the scanning and uploading of certain required background check documents and the entering of dates of completion for other required elements. In addition to being reviewed by DCF foster care staff, these required elements are also periodically reviewed by the department's Revenue Enhancement Division.

Next, trained foster care support staff visit DCF licensed foster homes on no less than a quarterly basis and have monthly phone contact with all foster parents who have DCF-involved children in their homes. Any safety concerns are pursued via a system called Assessment of Regulatory Compliance (ARC). If safety concerns are identified, a range of responses could occur depending on the level of risk identified (e.g., from corrective action to removal of the child from the home.)

As a means to better support children's permanency, each DCF Region generates a Recruitment and Retention plan for the year and each plan includes elements specific to the recruitment of families who reflect the ethnic and racial diversity of children who need families. Child specific recruitment activities, which are guided by the race and ethnicity of the targeted child, do occur.

In addition, the Department has a contract with the Connecticut Association of Foster and Adoptive Parents (CAFAP) to develop and carry out recruitment and retention activities across the state. Key provisions from the CAFAP contract that speak to the expectations with respect to diverse staffing and recruitment are as follows:

The Contractor must ensure that they have a culturally and linguistically diverse staff that is reflective of the community they are to serve. This staffing constellation must demonstrate:

- (a) experience providing services to diverse populations;*
- (b) multi-lingual capabilities that are relevant to the families to be served;*
and
- (c) knowledge of the cultural, linguistic or experiential backgrounds of the families to be served.*

The Contractor will maintain the capacity to provide all services identified in this contract in both English and Spanish. At a minimum, three (3) Bi-Lingual staff will be employed to meet this requirement.

The Contractor will engage in recruitment efforts to develop a skilled, caring and diverse pool of foster families and adoptive families that demonstrate the ability, willingness and commitment to meet the safety, emotional and permanency needs of children in out of home care. The Contractor will utilize innovative, comprehensive and best practice strategies to recruit families committed to being a resource for children in the care of the Department of Children and Families. Efforts will also relate to the private foster care agencies at the discretion of DCF. The Contractor will engage in targeted efforts to increase the number of families available to care for children in the following categories:

- children ages 0-5;*
- adolescents*
- children with complex medical needs;*
- sibling groups;*
- African American children.*

Recruited families will reflect the racial and cultural diversity of the children and youth in need of placement, including, but not limited to African American, Hispanic, and Gay and Lesbian families. The Contractor will develop and implement an annual recruitment plan that supports, complements and enhances the Department's recruitment plans and activities.

While the contract does set forth these expectations, it does not appear that the Department is regularly analyzing these data in those above categories. That will be an area for improvement.

Last, there are Foster Care Program Managers in all 6 DCF Regions who meet regularly. They are supported in outreaching across regions for resources when they have none available. In addition, adoptive placements are registered through a statewide DCF body – The Adoption and Permanency Resource Exchange. These staff, who also spend several days each week in the Area Offices, make all of those families equally available across the State.

3. Plan for Improvement and Progress Made to Improve Outcomes

Plan for Improvement

Information for this section can be found in the CFSR/APSR items 1-36 were submitted in the CT March 2016 self-assessment and the two June 2016 updates.

Implementation Supports

Progress Made to Improve Outcomes

Information in the sections above can be found in the CFSR/APSR items 1-36 were submitted in the CT March 2016 self-assessment and the two June 2016 updates.

Change Management

In 2012, The Department of Children and Families (DCF) established the Change Management Committee, charged with coordinating statewide change initiatives to ensure effective and consistent implementation in all regions, facilities and the central office. Embedded in this design are multiple communities of practice composed of representatives who come together either based on their function within the organization or their role relative to a specific initiative. There are currently eleven (11) communities of practice (COP). The 11 overarching committees include:

- **Office Directors:** charged with leading area office, special investigations unit, and Careline statewide change initiatives to ensure effective and consistent case practice.

- **Systems Directors:** charged with assisting in shaping and implementing major system-wide policy and practice initiatives while also providing a mutual learning environment among colleagues to support effective and consistent practice. The focus of this COP will be the implementation of Connecticut's Behavior Health Plan.
- **Clinical Directors:** charged with assisting in shaping and implementing major system-wide policy and practice initiatives while also providing a mutual learning environment among colleagues to support effective and consistent practice. This COP's focus is system development.
- **Intake:** charged with planning statewide change initiatives to ensure effective and consistent intake practice in all regions.
- **Adolescent:** charged with providing guidance, input, feedback, recommendations and expertise to senior leadership by ensuring ongoing planning and development of comprehensive, individualized, and coordinated programs to meet the needs of youth in every facet of out of home care.
- **Juvenile Justice:** charged with providing guidance, input, feedback, recommendations and expertise to senior leadership by ensuring ongoing planning and development of comprehensive, individualized, and coordinated programs to meet the needs of youth with juvenile justice involvement.
- **Foster Care:** charged with recommending system improvements and coordinating the implementation of statewide change initiatives relative to the placement of children and youth in foster care.
- **Early Childhood:** charged with coordinating statewide change initiatives to ensure that policy development and statewide practice changes are implemented relative to the topic of early childhood.
- **Nursing:** charged with being a leader in providing compassionate and respectful care to CT children and their families directed by the most current nursing research and the standards of nursing best practice.
- **Fatherhood:** charged with the development and implementation of strategies for promoting the inclusion of fathers and their extended kinship networks in the child welfare process.
- **Quality Improvement Council:** charged with reviewing and implementing projects to ensure standardized quality practice in all regions, facilities, and the central office as part of the DCF quality improvement plan.

Charters developed by each COP are reviewed on an annual basis to reflect progress towards outlined goals and the development of new areas of focus. While reviewing and revising the current charters, COPs are applying a Results Based Accountability Framework.

In 2015, the Department continued to advance the implementation of key practice changes that were guided and informed by the Change Management process including:

- Child and Family Permanency Teaming

- Implementation of a new tools to enhance the assessments and provision of services for adolescents in care and adolescents involved with the Juvenile Justice System
- Implementation of a new foster care training curriculum
- Implementation of a tiered classification system for contracted service providers
- A number of new and revised policies and practice guides that reflect practice changes
 - The development of an Early Childhood Policy and Practice Guide
 - A revised Post-Secondary Education Policy
 - A revised Investigation Policy
 - A revised Voluntary Services Policy
- Developing recommendations to enhance practice in key areas, such as fatherhood engagement, working with the adolescents including those involved with the juvenile justice system, and in early childhood.

The Change Management Committee together with the Communities of Practice have been instrumental in offering critical feedback and recommendations relative to practice and system changes, informing the timing and staging of implementation and supporting sustainability of key initiatives and system reform efforts.

Differential Response

On March 5, 2012, the Department of Children and Families launched its Differential Response System (DRS). Both the DCF Strengthening Families Practice Model and Differential Response System are based upon renewed efforts to positively engage and empower families using a team approach that emphasizes listening, discovering strengths and viewing family members as key to any solution.

In 2013, the Department implemented a QA Case Review to help evaluate our Family Assessment Response (FAR) practice. The findings of the case reviews were intended to help inform policy and practice changes to enhance service delivery. In January 2014, the FAR Quality Assurance Report was completed and disseminated to staff. The findings prompted some fairly significant practice/policy changes designed to enhance the quality of FAR assessments, including policy clarification regarding commencement, documentation, required case contacts, collateral contacts, supervision, and frequency of contact with the family during the assessment process, as well as establishing timeframes for completion of work. FAR Policy and Practice Guides were modified as a result of this review.

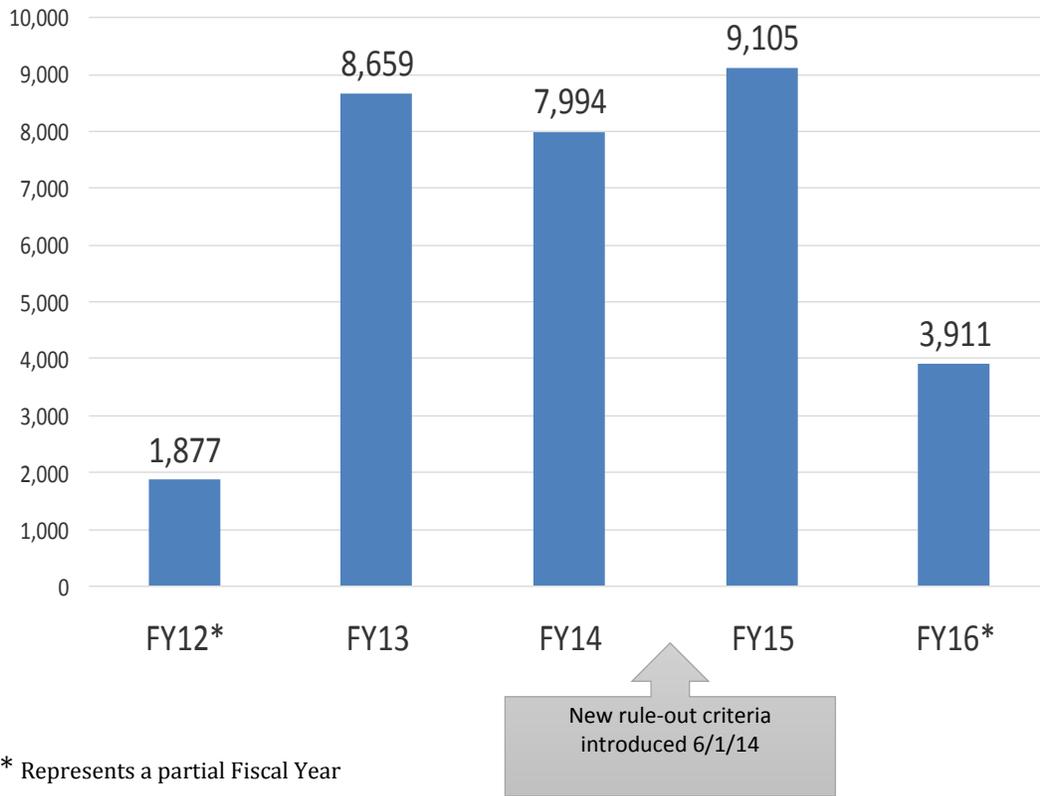
Since implementation, staff have requested the ability to change tracks between FAR and Investigations. Our current system only allows a track change from FAR to Investigations. Unfortunately, given our implementation of a new LINK system, there has been a moratorium with respect to making significant changes to our current SACWIS. In June 2014, the Department reduced the Rule-Out Criteria from 15 to 5. The current Rules-Out are as follows:

1. A new CPS report on an active, ongoing services case (excluding Voluntary Services) or a report on an active investigation;
2. Congregate care, foster care (excludes allegations involving biological/adoptive children of the foster parent), persons entrusted;
3. Current report with allegations of Sexual Abuse against a parent, guardian or person given access;
4. Prior child fatality due to abuse and neglect; or
5. Previous adjudication of Abuse/Neglect in SCJM

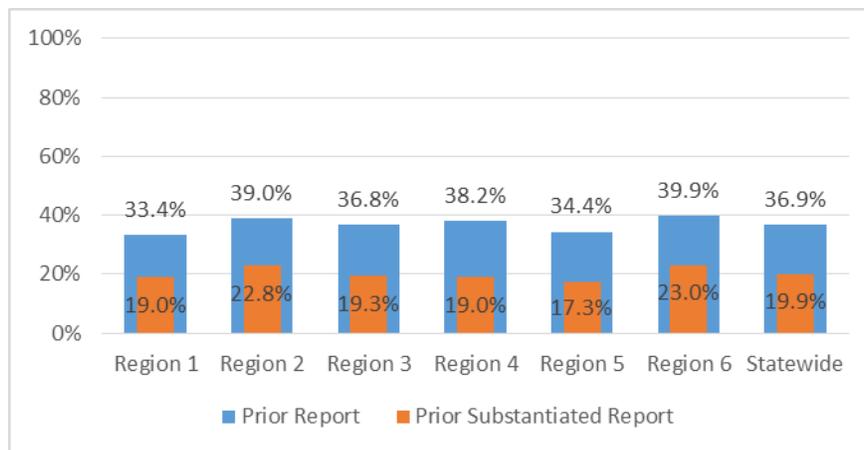
For the remaining 72 hour reports, the track is determined based on an assessment of the family following face-to-face contact, not on the presenting allegations at time of the call to the Careline. This approach promotes informed decisions around track determination based on a more thorough assessment of safety, risk, and needs of the family, and gives families increased access to services in the community to meet their needs.

Prior to the change in Rule out criteria, CT had been averaging 35% of CPS Reports designated as a FAR. For Calendar Year 2015, 43% of CPS Reports were designated as FAR.

As of 12/31/15, there have been a total of 31,546 unduplicated FAR families served since FAR's implementation.

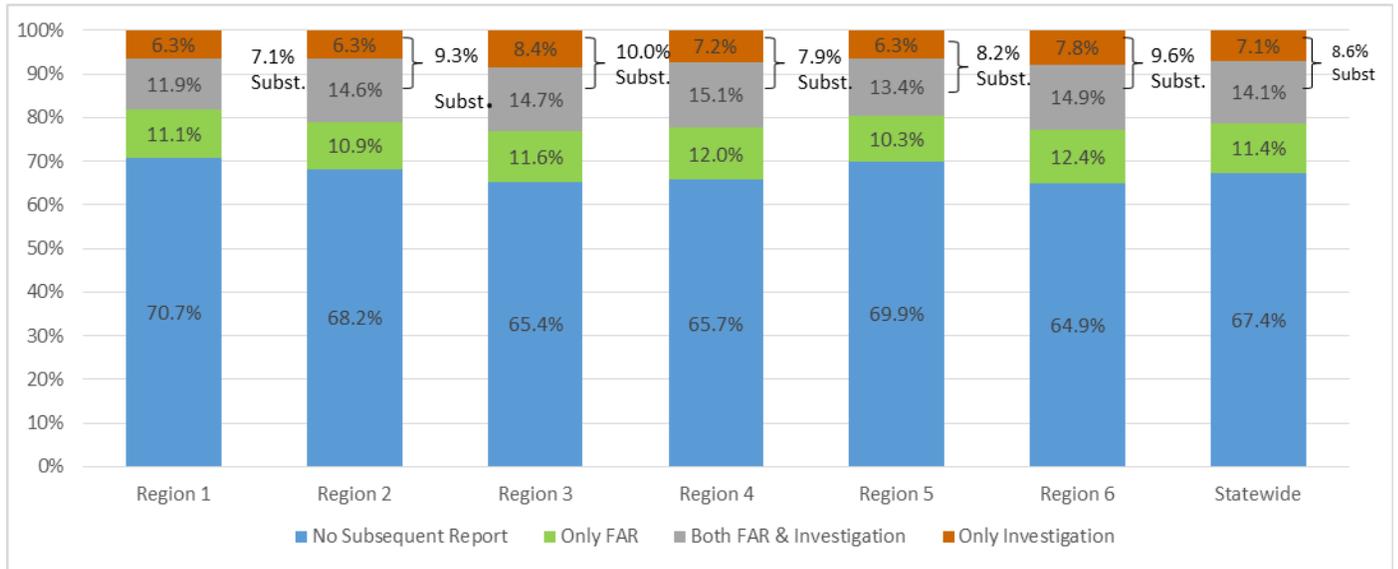


The following chart represents families who have received a FAR by their prior history (including substantiated history). Data: 3/5/12-12/31/15.

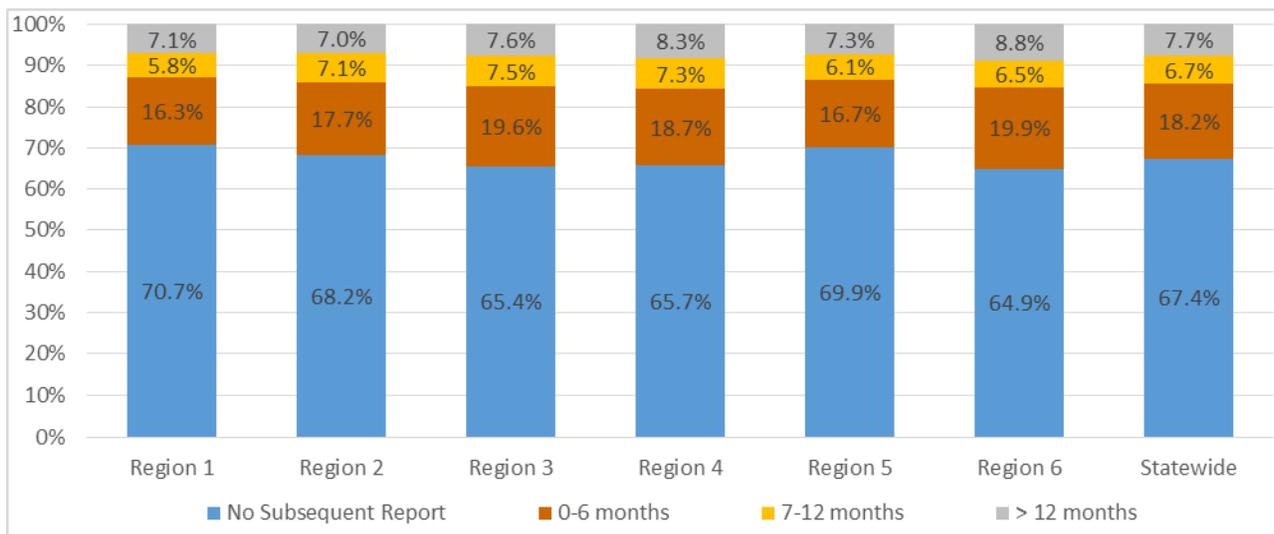


Statewide, 36.9 % of all FAR families had prior CPS reports and 19.9% of all FAR families had a prior substantiated report.

The following chart represents families who received a subsequent report. 67.4% of families who received a FAR, have not had a subsequent report. For families who received a subsequent investigation, 8.6% were substantiated. Data: 3/5/12-12/31/15.



The following chart represents families who received a subsequent report and the timeframe in which a subsequent report was received. Of the families who receive a subsequent report, most occur within 6 months. Data: 3/5/12-12/31/15.



UConn School of Social Work continues to function as our Performance Improvement Center completed a Survival Analysis, focusing on the risk factors included in our Structured Decision-Making (SDM) Risk Assessment Tool that were prevalent in families who had subsequent reports. The chart below represents the risk factors identified in families with subsequent reports:

Risk Factors from the Risk Assessment Tool	% More Likely To Have a Subsequent Report
Homeless at time assessment	60.1%
Youngest child <2 years	36.6%
Four or more children involved in CAN incident	30.7%
Child has delinquency history	25.1%
Primary CG has own CAN history	24.0%
Primary CG has any alcohol problem	22.8%
Number of prior investigations	22.4%
Child MH/BH Problems	21.1%
2+ domestic violence incidents in household in past year	20.9%
Primary CG has mental health problem	19.4%
Secondary CG has any drug problem	14.6%
Physical/developmental disability	13.3%
Current complaint is for neglect	12.2%
Any prior abuse investigations	11.5%
Primary CG has any drug problem	10.6%

CAN =Child Abuse and Neglect History; CG = Caregiver; MH/BH= Mental Health/Behavioral Health

The chart below represents the risk factors identified in families with subsequent substantiated reports:

Risk Factors from the Risk Assessment Tool	% More Likely To Have a <u>Substantiated</u> Subsequent Report
Homeless at time of investigation	112.7%
Youngest child <2 years	89.7%
Medically fragile	66.2%
Primary CG has any alcohol problem	47.0%
Primary CG has any drug problem	41.4%
Current complaint is for neglect	41.1%
Primary CG has mental health problem	32.0%
Primary CG has own CAN history	31.9%
Number of prior investigations	26.3%
Household has previously received CPS	15.8%

CG = Caregiver; CPS = Child Protective Services

Representatives from the Careline and Area Office staff continue to meet monthly to address policy/practice issues relative to our intake practice. A workgroup was established to review our existing assessment tools, conduct research and develop specific recommendations to

enhance the quality of our assessment process. The Department will continue utilizing the Structured Decision Making Tools and are currently exploring with the developer (Children's Research Center) the costs associated with updating the tools, staff training (focusing on tool integration into practice), and the development of a Quality Assurance Plan. This will be an area of focus this upcoming year.

In April 2012, funding was allocated by the legislature to provide continued support to families within their own community. Community Partner Agencies were selected through a statewide procurement process in all six DCF regions to further support families and connect them to an array of community supports and resources designed to promote the safety and well-being of children and their families. The program was designed to engage families who received a Family Assessment Response and connect them to concrete, traditional and non-traditional resources and services in their community. This inclusive approach and partnership, places the family in the lead role of its own service delivery. The primary role of the Contractor is to assist the family in developing solutions, identify community resources and supports based on need and help promote permanent connections for the family with an array of supports and resources within their community, utilizing a Wraparound Family Team approach and philosophy. Contracted agencies have access to regional wrap funding to help families meet their basic, concrete needs. In July 2012, additional funding was appropriated by the legislature to increase statewide capacity of the program. In two of the six regions, one additional provider was added to provide this service to families within the region.

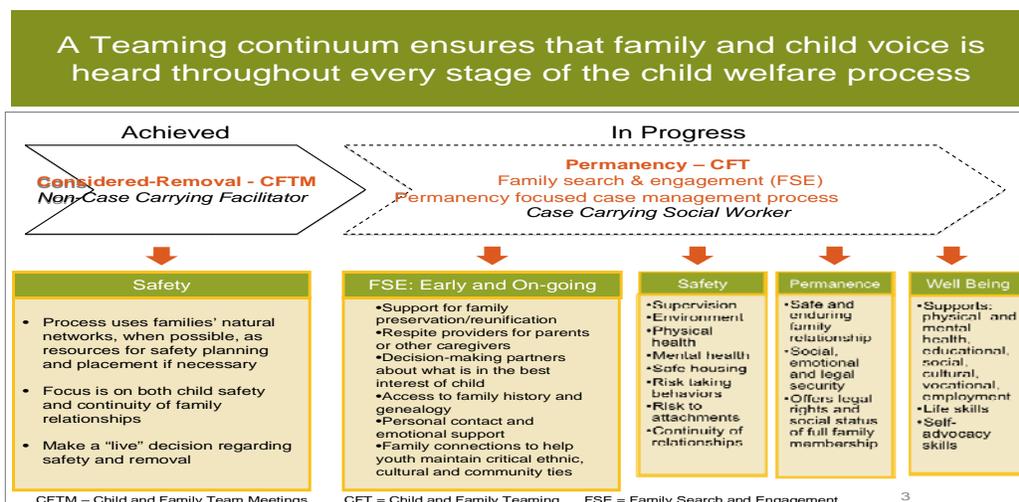
The University of Connecticut's (UConn) School of Social Work continues to function as the Performance Improvement Center (PIC) for the Community Support for Families (CSF) Program. Much of their initial focus was on improving the quality of data entered by CSF staff into the Provider Information Exchange (PIE). Both PIE and LINK data extracts continue to be sent to UConn on a quarterly basis. Last year, the Department expanded the current Memorandum of Agreement (MOA) to have the PIC evaluate all our FAR data. This allows us to compare outcomes for families and target specific interventions based on evaluation findings. UConn, DCF Regional and Central Office staff, and staff from the CSF Program

continue to meet every 6 months to share and review data and discuss programmatic issues relative to FAR and the CSF Program. This past year, the Department has been working with providers and DCF staff to refine the Scope of Service, develop Performance Measures for the program within the RBA framework and develop Data Dashboards for the program for each region. The NCFAS-G was added to the CSF Program to provide a more consistent approach to assessing families, informing service delivery, and evaluation. The UCONN MOA is in process of being amended to include investigation cases to further evaluate our overall intake response. This will be an area of focus this upcoming year. In addition to the department's practice of posting the DRS reports on line, legislation passed this session also expects the department to submit annualized data to the legislature.

A DCF Central Office Program Development and Oversight Coordinator facilitates monthly meetings with CSF Directors/Managers, UCONN staff and DCF Regional Liaisons to provide technical assistance and support to both DCF and CSF staff, coordinate training activities, address implementation issues, and coordinate quality improvement and evaluation activities relative to the program.

CT's Teaming Model

The Department continues to build a teaming continuum that ensures that child and family voice is heard throughout every stage of the child welfare process



The implementation of Child and Family Team Meetings has been a core part of the Department's move to a more family-centered, strength-based practice, exemplified most clearly in the DCF Strengthening Families Practice Model. Teaming is the Department's family engagement strategy to ensure case plans are strength based and responsive to each family's unique needs and values. The Department believes this collaborative approach that fully engages families in developing and identifying solutions will lead to better outcomes for children and families.

Our teaming work has been divided into three distinct phases as follows:

Phase 1

The implementation of **Team Decision Making**-Step Down meetings (TDM) for youth in congregate care settings. TDMs were utilized for youth in congregate care settings to determine if children/youth could be returned to family or transition to a less restrictive setting. This teaming approach helped to ensure early discharge planning and appropriate lengths of stay.

Phase 2

Several years ago, DCF worked closely with Annie E Casey Foundation Child Welfare Strategy Group to develop and implement a Considered Removal Child and Family Teaming model (CR-CFTM). This approach attempts to preserve the family unit, minimize disruption and trauma associated with the removal, placement and separation of the child from his/her family.

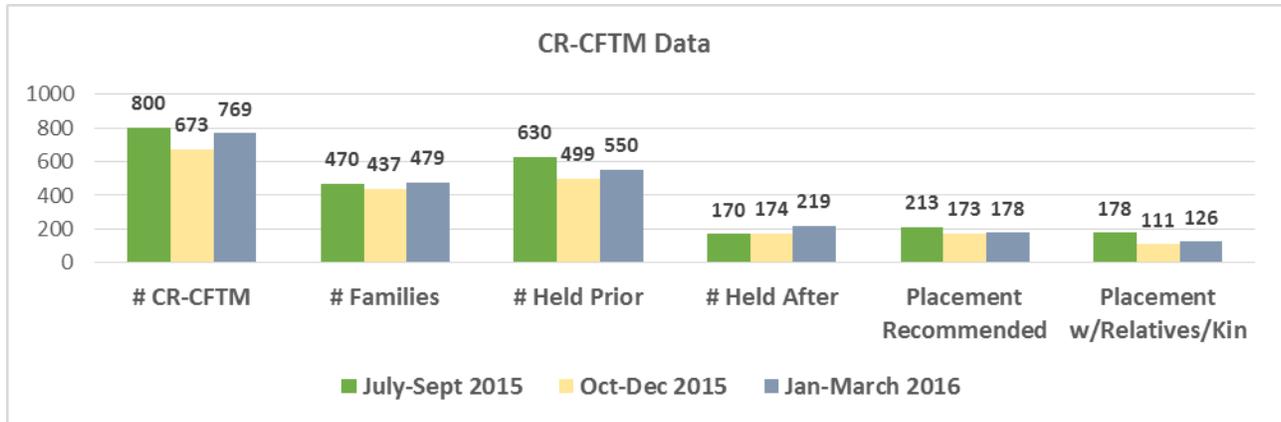
The consistent and effective use of the Considered Removal process promotes family engagement, can restore safety, social and emotional well-being, and secure family permanence for the child.

The key practice elements of the CR-CFTM are as follows:

- Meetings are held prior to removal of a child (based on the identification of an SDM Safety Factor) from the home unless the family situation requires an emergency removal to ensure child safety;
- If child has been removed as a result of an emergency placement, a meeting will occur within two (2) business days, prior to the filing of a Motion for Order of Temporary Custody. By policy, every child who enters DCF care will have a Considered Removal Child and Family Team Meeting.
- A trained facilitator (non-caseload carrying) leads the team meeting;
- The focus of the meeting is on child safety and making a “live” decision regarding a child's removal from the home. Given the limited time and often emergent circumstances of the meeting, in-depth case planning is not the focus or goal of the meeting;
- The voice of the youth or child is represented at the table; and
- Parents, family members, professionals and interested community members are involved in safety planning and removal-related decision making.

On February 11, 2013, the Department implemented CR-CFTM statewide. Monthly consultation days with the CR-CFTM Facilitators and Casey were held for one year post implementation for coaching, training, and case consultation. Meetings are held on a quarterly basis to review our CR-CFTM practice.

The Department continues to review data relative to the CR-CFTM process.

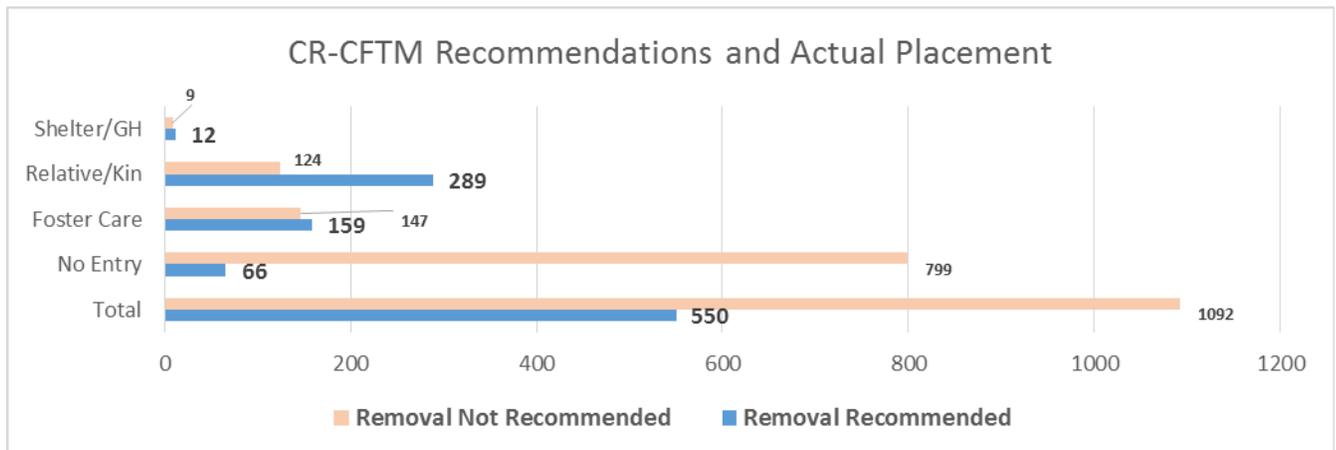


This represents CR-CFTM data from July 2015 through the end of March 2016.

- 75% of meetings are held prior to the child’s removal.
- Of the meetings held prior, only 34% of children are recommended for removal.
- 74% of children are recommended for placement with relatives/kin.

Although we have seen an increase in the number of children recommended for removal when compared to prior quarters, there has been an increase in children recommended for placement with relatives/kin.

The chart below represents CR-CFTM data from 7/1/15-3/31/16 for meetings held prior to removal (N=1642) to compare the recommendation of the meeting regarding removal, whether the child was placed, and the actual placement setting for the child.



88% of children who were the subject of a CR-CFTM and recommended for removal entered care. 52.5% were placed with relatives/kin.

26.8% of children entered care when removal was not recommended at the CR-CFTM. Most of these children (13.4%) were placed in foster care; 11.3% placed with relatives/kin; and .8%

were placed in shelter/group home. Of the 550 children recommended for removal at the CR-CFTM, 66 (12%) did not enter care.

Our CR-CFTM practice will continue to be an area of focus for the Department. This year, our primary focus will be developing a statewide QA Plan and Case Review tool.

The Department is currently in phase 3 of our teaming continuum.

Phase 3

Permanency teaming is a collaborative approach to permanency planning for children/youth in foster care or at risk of entering the foster care system. The desired outcomes of permanency teaming are as follows:

- identification of a legal parent;
- achievement of legal permanence for the child/youth; and
- establishment of a natural network of supportive relationships.

This teaming approach is used for every child/youth served in-home as well as those children/youth entering foster care or congregate care settings, regardless of their permanency goals.

Permanency teaming is consistent with the practice of engaging families and community members in safety planning and placement-related decision-making, and includes an active family search and engagement practice component. This teaming process includes a blend of individual and joint conversations as well as large group meetings throughout the life of a case.

Permanency Teaming is the primary means by which caseworkers engage a child/youth's natural network (birth parents, extended family, other important adults) and conducts ongoing case management activities.

The purpose of teaming is to ensure decisions are made on behalf of child/youth with their active participation (or their voice) and to support the continuity of safe family relationships and connections with other caring adults.

The model is utilized within the broader context of child-centered, family-focused permanency practice. Listed below are the basic elements of our permanency teaming approach:

- involves a team and a social worker facilitator;
- is customized to fit the child/youth's needs;
- uses Family Search and Engagement to reconstruct a child's/youth's relationships over time and in locating family members and others who will participate in Permanency Child and Family Teaming. In the case of in home situations, it is designed to develop and support the family's natural support network;
- uses outreach to maximize participation of youth and family members;
- shares responsibility for planning and decision making among team members;
- addresses safety, permanency and well-being;
- identifies a permanent legal parent for each child/youth to provide day-to-day parenting that is safe and emotionally secure;
- reflects a sense of "urgency" (child's sense of time) in accordance with ASFA timelines and agency case practice standards;
- utilizes a concurrent planning framework;
- includes a blend of individual, joint and large team meetings;
- prioritizes relationship-building between and among team members, especially the youth, family members; and caregivers and other adults significant to the youth
- continues as long as a child/youth is receiving DCF services and has not achieved legal permanence

This approach is consistent with the essential elements of a trauma-informed system as it attempts to minimize disruptions to safe, healthy relationships as well as separations from

attachment figures, thereby supporting children exposed to trauma and reducing potential secondary trauma.

A statewide Steering Committee consisting of regional and central office representatives have been meeting monthly since July 2013 charged with overseeing the development and implementation of permanency teaming. The Steering Committee developed three subcommittees focused on key implementation issues: Data, Communications, and Training.

The focus again this year has been predominately to build internal capacity of regional staff to support full implementation of Permanency Teaming. Much of the work cited in last year's report has continued.

In June 2015, the LINK build to document large team meetings and individual and joint conversations in LINK was released. A user guide was created to assist staff with documentation. Since its release, staff have found this process cumbersome and have developed various strategies to document the permanency teaming process. As a result, the Department has no consistent approach to document the teaming process or utilize reports to provide quantitative data. Efforts are currently underway to address concerns and come up with a viable technical solution.

Members of the Communications Subcommittee of the Steering Committee developed a survey for Supervisors and Social Work staff to gage their understanding of permanency teaming. Survey results indicate the need for renewed efforts to support the full implementation of permanency teaming. The Steering Committee will be developing recommendations to present to administration. Several forums are being planned to support these efforts. This will be an area of focus for the Department this upcoming year.

[Tier System Classification of Contracted Services:](#)

Tier System Classification of Contracted Services: The Department of Children & Families (DCF) is committed to obtaining the best outcomes for all its funded programs. To that end, in

April 2015, the DCF formed a workgroup of internal and external stakeholders to work to develop a Tier Classification System that aligned several areas of work within the Department and formalize existing practices used to assess program performance. After several months of collaborative work, in December 2015, the DCF Tier Classification System was finalized and disseminated out to all DCF funded providers. Additionally, informational sessions were held at various non-profit Trade Association meetings and DCF Area Offices throughout the process to ensure adequate communication of this system to all stakeholders.

The Tier System measures general contractual requirements defined by the Department, in collaboration with provider partners. There are 25 requirements. They are broken down as follows:

Foundational Items (5 items): Review of health and safety info, written Continuous Quality Improvement plans, submission of data, written cultural competency plan, subcontract oversight.

6 Domains (20 items):

- Utilization & Timeliness
- Program Performance
- Cultural Competence
- Client/Family Feedback
- Staffing
- Administrative Performance

The requirements are grouped into three Tier Classifications and an additional Provisional Tier. They are as follows:

Tier I: A program is classified as Tier I when the program meets all applicable foundational requirements and is meeting all but two or less of the elements of performance in the six domains.

Tier II: A program is classified as Tier II when the program meets all applicable foundational requirements and is meeting all but three or four of the elements of performance in the six domains.

Tier III: A program is classified as Tier III if any one of the applicable foundational requirements and/or five or more of the elements of performance in the six domains are not

met.

Provisional Tier: New programs will have up to one year to meet Foundational elements and Elements of Performance before being classified, and may be classified sooner at the program's request.

Tier Classification of DCF funded programs began in February 2016. The following DCF funded programs were chosen to be in the first round of classification and will be scored by July 2016:

- Outpatient Psychiatric Clinics for Children/Child Guidance Clinics (26 total)
- One-on-One Mentoring programs (8 total)
- Fostering Responsibility, Education, and Employment (FREE) (6 total)
- Supportive Work, Education, and Transition Program (SWETP) (8 total)
- Short-Term Assessment and Respite Homes (STAR) (9 total)

NOTABLES:

- All data related to the scoring of programs will be housed in the Statistical Package for Social Sciences (SPSS) database. All DCF funded programs will receive a written report for review before the Tier Classification becomes final.
- Service Development Plans and Corrective Action Plans will now use standardized forms and processes for review.
- Tier Classifications and Licensing visits will be coordinated by the end of 2017.
- Bi-Monthly Tier System Implementation Meeting with stakeholders will begin in April 2016
- Program models to be included in Round II of Tier Classification will be determined at the conclusion of Round I.

DCF is committed to working with our contracted providers as partners in service delivery to Connecticut's children and families. The Department recognizes that there are unique implementation challenges to be considered when implementing a new system designed to assess contract compliance.

To that end, DCF will view programs' initial Tier ratings as a baseline score during the initial phase of this initiative. This phase will allow DCF, along with representatives from our contracted provider agencies, to explore Tier implementation challenges and explore solutions to address those challenges.

DCF is committed to implementing the Tier review guidelines in our DCF funded programs in the best way possible ensuring the system is fair and accurate. The Department looks forward to continuing its work with our provider partners throughout implementation of the Tier Classification System.

Credentialed Services

The Department has selected a group of services that are most frequently purchased through Funds for which providers must be credentialed. The credentialing process is handled through a vendor who assures that all providers have passed criminal background checks and Child Protective Services checks, as well as meeting the training and experience qualifications for each service type.

- After School Services: Clinical Support for Children
- After School Services: Clinical Support for Youth
- After School Services: Traditional
- After School Services: Youth
- Assessment
- Assessment: Perpetrator of Domestic Violence
- CHAP Case Management (open to current CHAP providers only)
- Supervised Visitation
- Support Staff
- Temporary Care Services
- Therapeutic Support Staff
- Transportation: General Livery
- Transportation: School

Each provider must sign a Provider Agreement and abide by its terms and the set fee schedule. Providers must submit applications to be re-credentialed every 2 years.

In October 2015, staff overseeing the credentialing program joined with staff in the Department's licensing unit to develop a site visit protocol specific to each services type. Beginning with Therapeutic Support Staff, the most frequently used service, a site visit team including licensing staff, a regional representative, a central office program manager and the vendor's manager of credentialing, visit the provider's service site or office. On site, they review client records, policies and procedures and general operations of the service. Site

visit reports are shared with the provider within 30 days of the visit. In addition, site visits may be conducted if a complaint is filed regarding the service that warrants on-site investigation.

The Contract Management Unit Website (Share Point):

The Contract Management Unit developed and launched a new website for Department staff featuring a thorough description of the areas of work that the Contract Management Unit manages: Purchase of Service Contracts, Personal Service Agreements, the Contract Management Library, Credentialed Services, Rate Setting, Procurements and Requests for Proposals, Amendments, and Budgets. The website also contains a wealth of information in provided links, documents, forms, and lists for all of the above services to assist Department staff with the necessary tools to navigate their work as it relates to contracts. Most recently, the Contract Management Unit expanded its Rate Setting area of work on the Share Point site to include a database for staff to easily view service rates that the Department utilizes outside of its contracting activities.

Reducing Out of State Placements

The Department continues to make significant progress to keep children in-state when residential treatment is clinically necessary. From May 2012 to May 2013, there was a 69% reduction of children placed out-of-state. From May 2013 to April 2014, the Department further reduced the number of children in out-of-state placements by 25%. That reduction has continued and currently only 13 children are placed in out of state residential facilities, 92% are placed within New England.

Efficient Use of Congregate Care

Reducing the number of children placed in congregate care setting continues to be a focus of the Department this past year. The Department saw many gains subsequent to the published Congregate Care Rightsizing and Redesign Report in 2011. The report outlined Connecticut's plan to reduce the number of children placed in congregate care settings.

The Department made practice and policy changes that promoted placement of children in family settings (including relative, kin or foster family care), commissioner approval to place any child in a congregate care settings (expanded from only children under the age of 6), a more thorough and formal assessment of family dynamics and functioning for families involved in the voluntary services program, and the implementation of the Child and Family Teaming process. Child and Family Team Meetings continue to be held, engaging youth, their families, kin, providers and other supports with the goal to determine readiness, needs and strengths to prevent children entering placement and to facilitate transition to less restrictive levels of care.

From January 2011 to April 2015:

- The Department has experienced a 17% reduction in children in placement
- The percentage of children in Congregate Care has reduced by 45%.
- The percentage of children 12 and under in placement has reduced by 80%.
- The percentage of children 6 and under in placement has reduced by 89%
- The percent of youth in state care who live with a relative or kin has increased from 21% to 35%.

Limit the use of OPPLA

In advance of the passing of Public Law 113-183 (Preventing Sex Trafficking and Strengthening Families Act) on September 29, 2014 outlining important expectations for the States, the Department had established key performance indicators intended to advance positive permanency outcomes for children and youth in care. Central to this is limiting the use of OPPLA as a plan. In order to effectuate this, a number of efforts have occurred including:

- Utilizing the permanency roundtable methodology
- Developing and implementing an OPPLA protocol
- Working group to further limit the use of OPPLA both in practice and statute

- Implementation of a Child and Family Permanency Teaming approach that puts the youth and family in the center of the teaming process
- Assignment of Permanency Exchange Specialists (PES) to youth with OPPLA as a plan to support Regional work to identify a permanent resource for the youth
- Providing training on permanency to congregate care and private foster care providers to engage them further as partners in finding permanent resources for all youth in the Department's care (Child and Family Permanency Teaming, 3-5-7 approach)
- Utilizing a national consultant to conduct a permanency workshop with teams of youth, their Social Worker and Clinician at the Department's only secure facility for boys adjudicated delinquent and committed to the Department

Since the signing of the 2014 legislation, the Department submitted revisions to State statute to comport with federal legislation and further align with agency practice that promotes positive permanency outcomes for children and youth.

Trauma Informed Continuum:

DCF was awarded the CONCEPT Trauma grant and is moving into its last year. The grant was designed to build on early efforts to become a more trauma informed system.

- To date DCF has trained all of our staff in the NCTSN Child Welfare Trauma Training and continue to train new hires.
- Laura Lipsky, author of Trauma Stewardship, conducted a two day conference in the fall of 2014. The first day for 350 staff and the second designed specifically for 90 staff connected to our Health and Wellness work.
- CT is actively involved in the New England Convening on building a Trauma-Informed Resilient Child Welfare Agency hosted by the NE Association of Child Welfare Commissioners and Directors.
- Regional and facility Health and Wellness teams develop activities and opportunities to support staff wellness and reduce secondary trauma
- The CONCEPT core team reviews all agency policy to assure a trauma informed lens is

applied. To date having reviewed and revised 23 separate policies.

- Screening has been a very involved process where the agency has benefitted from our partnership with Yale and the Child Health and Development Institute (CHDI) in testing different tools and arriving at the current tool – a 10 item screen that has been embedded into the Multidisciplinary Evaluation completed for all children 7 and above when they enter care. For younger children there is a screening tool that asks questions of the caregiver.
- One of DCF's Area Office's is also engaged in a pilot – identifying a cohort of children where screening is completed and re-administered at the time of the Administrative Case Review (ACR)
- A pilot study to validate the shorter screening tool is underway in partnership with Yale Child Study Center that involves the screening of children at intake.
- The dissemination of Evidenced Practice Models has continued including: the start of a learning collaborative in October 2014 for The Child and Family Traumatic Stress Intervention.
- In years 2 and 3 of CONCEPT TF-CBT dissemination continued and included service to the Juvenile Justice population.

Relative/Kinship Care

In 2013 and early 2014, the Department merged oversight of group care, adoption, permanency, and foster care into a new division of placement. The DCF Commissioner has set clear expectations that youth belong with families.

Results of these coordinated efforts and expectations are clear. From January, 2011 to April, 2014 our Department has seen a decrease in children in placement by 17% (from 4770 to 3971). Also since 2011, we have seen an increase in relative/kin placement from 21.1% to 35.7% (April, 2014). We have reduced out-of-state congregate care placement from 363 to 12 youth. The percent of our youth in congregate care has also been reduced from approximately 30% to 16.2% (as of April, 2014). In 2013, Regions establish "firewalls" (i.e.,

specific staff who approve all non-relative and kin placements prior to a youth coming into state custody). This individual's responsibility was to ensure that prior to a child going into non-relative or kinship care, all possible relative and kinship care supports and placement options were pursued. This "firewall" staff is a manager within each Region outside of the decision making chain of command for that specific case. As of May, 2014, the Commissioner has directed that for any DCF Area Offices whose congregate care placement rate is greater than 15%, any non-family based placements must be approved by her.

As a result of all of these efforts, during the calendar year 2012, the Department increased the percentage of children in relative and kinship care from 26.8% to 28.5%. During this period of time, the Department saw a significant reduction in the total number of children being placed into out of home care from 4,495 to 4,086. Relative and kinship placements have increased by over 12% between January, 2011 and April, 2015. As of April 1, 2015, 35.7% of children in placement are with relatives/kin. The Department has also been monitoring the rate of initial placements with relatives. In January, 2011, initial placement with relatives was 17.4%. That increased to 29.0% in May 2014. The Department also saw an increase in the total number of licensed relative and kinship homes from January, 2011 to April, 2015 from 669 to 1017.

[Adoption/Permanency Resource Exchange/Kinship placements](#)

In spring 2014, the Adoption Resource Exchange Unit underwent a name change to better represent the significant contributions they were making to the Department's permanency work and reflect the mission and goals of the Department. They are now known as Adoption/Permanency Resource Exchange (APRE). In 2014 there were 100 preadoptive families available and today there are 53 available to these children as potential resources. We believe that these numbers are dropping as more prospective adoptive families begin their adoptive journey as foster parents and adopt those children whom they foster. Photo listing on AdoptUsKids website, A Family for Every Child website, and on the DCF website where photos and videos of the child are posted and made available to the public.

4. Service Description

The Connecticut Department of Children and Families has statutory responsibility for prevention, child welfare, behavioral mental health and juvenile justice. As such, the state's service array includes a full array of programs including child abuse and neglect prevention, treatment services, foster care, family preservation services, reunification support services, independent living, services to support other permanent living arrangements and a continuum of congregate care settings.

The following chart represents our Services Continuum:

Adolescent Community Reinforcement Approach / Assertive Continuing Care (ACRA-ACC) – This is an evidence-based outpatient behavioral therapy for substance using adolescents and their caregivers. When the recovery goals are attained through ACRA, the adolescents can then be referred to the recovery support ACC portion of the service. ACC also provides case management services to assist with accessing other needed services.

Category: Family Support service

Population Served: Substance using youth between 12-17 years old

Geographic Area: Statewide

Estimated Families Served: 432

Adopt A Social Worker - This is a statewide, faith based outreach service linking an "adopted" DCF Social Worker with a faith-based or other "covenant organization" to assist with meeting the basic material needs of DCF involved families (those with protective service Social Workers as well as foster, adoptive and kinship care families). Meeting the needs of children with, for example, beds, cribs, clothing and household furnishings, will help achieve stabilization of families and permanency for the children.

Category: Family Support and Family Preservation services.

Population served: All DCF involved Families

Geographic area served: Statewide.

Number of children and families being served: Unavailable

Care Coordination - This service provides high fidelity "Wraparound" through the use of the Child and Family Team process. Wraparound is defined as an intensive, individualized care planning and management process for youths with serious or complex needs and is a means for maintaining youth with the most serious emotional and behavioral problems in their home and community. The Wraparound process and the written Plan of Care it develops are designed to be culturally competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision.

Category: Family Support Services service.

Program uses the 4 family focused fluid stages of Hello, Help, Healing and Hope. There will training this year in this new construct.

Population served: Families with a youth with a behavioral health diagnosis for whom DCF is not involved.

Geographic area served: Statewide.

Number of children and families being served: Approximately 1200

Care Management Entity (CME): designed to serve children and youth, ages 10-18, with serious behavioral or mental health needs who are returning from congregate care or other restrictive treatment settings (emergency departments/in-patient hospitals) or who are at risk of removal from home or their community. The CME will provide direct services and administrative functions. At the direct service level, the CME employs Intensive Care Coordinators (ICCs) and Family Peer Specialists (FPS) who use an evidence based wraparound Child and Family Team process to develop a Plan of Care for each child and family. At the administrative level, the CME assists DCF in developing local and regional networks of care, which includes the CONNECT federal System of Care grant activities.

Category: Family Support Services and Family Preservation service.

Population: Any child residing in a congregate care setting and child and youth who are frequent users of Emergency Departments and In-Patient settings.

<p>Geographic Area served: Statewide Number of children and families served: 150 to 160</p>
<p>Caregiver Support Team - This service is designed to help prevent the disruption of foster placements and increase stability and permanency by providing timely in-home interventions with a child and family. For kinship families, this intensive in-home service is provided at the time the child is first placed with the family. The service will be available at critical points for the duration of the placement when additional supports are deemed necessary.</p>
<p>The Child Abuse Centers of Excellence - this service provides an array of expert medical services to children who are suspected of being victims of abuse or neglect and to their families by acting as expert consultants to the Department of Children and Families staff to help ensure the safety and well-being of children Category – Family Preservation / Family Support Population served-Any child who is suspected of being victims of abuse or neglect Geographic area – statewide Number of children/families served –</p>
<p>Child First Consultation and Evaluation - This service ensures provider fidelity to the Child First model which provides home-based assessment and parent-child therapeutic interventions for high-risk families with children under six years of age. To that end, the service delivers training, provides reflective clinical consultation, analyzes data, provides technical assistance, insures continuous quality improvement, and certifies sites that have met Child First model standards. Service Category: Family Support Population(s) to be served -Children ages 0-6 Geographic areas: Statewide Estimated number of individuals and families to be served in 2016: 530</p>
<p>Cognitive Behavioral Intervention for Trauma in Schools (CBITS): is a skill based, group intervention aimed at relieving symptoms of Post-Traumatic Stress Disorder (PTSD) and general anxiety among children and youth who have experienced trauma. This school based treatment model will enhance the school's mental health service array to support student's learning potential and build resiliency. CBITS is designed to minimize developmental disruption and promote child recovery and resiliency for student participants through a cognitive-behavioral therapy approach that involves components of psycho-education, relaxation, social problem solving, cognitive restructuring and exposure. Service Category: Family Preservation , Family Support, and Adoption Promotion and Support Services Population(s) to be served -Children ages 6-17 Geographic areas: Bridgeport, New Haven, Stamford, New London Estimated number of individuals and families to be served in 2016: 540</p>
<p>Community Based Life Skills - This service, through the use of a DCF approved curriculum along with DCF approved experiential learning approaches, provides youth with a set of skills necessary to assist in their transition from DCF care to self-sufficiency. This service includes life skills assessment services followed by 80 hours of classroom educational service to the clients followed by 30 hours of 1:1 educational services. Service provides youths with life skills assessment and instruction components (for skill development and acquisition). Category: Family Support. The population served is committed youths 15 and older. Geographical area served: Statewide Number of children and families being served: 196</p>
<p>Community Support for Families - This service will engage families who have received a Family Assessment Response from the Department and connect them to concrete, traditional and non-traditional resources and services in their community. This inclusive approach and partnership, places the family in the lead role of its own service delivery. The role of the contractor is to assist the family in developing solutions, identify community resources and supports based on need and help promote permanent connections for the family with an array of supports and resources within their community.</p>
<p>Community Support Team - This service is provided in conjunction with the DCF New Haven Area Office and focuses on assessment, treatment and support for children and youth in out-of-home levels of care transitioning back to the community. Services include but are not limited to: in home clinical interventions and supports; delivery of therapeutic services that facilitate and support family problem solving; family education and guidance; and linkage to natural support systems.</p>
<p>Community Targeted Re-Entry Pilot Program (CTRPP) - This service provides pre-release and post-release services for male youth at the Connecticut Juvenile Training School (CJTS) including social and life skill building, vocational and career development, psycho-educational programming including character development and leadership and recreational opportunities. In addition, the Boys & Girls Club offers services on the campus of the Connecticut Juvenile Training School.</p>
<p>Community Transition Program - This service is provided in conjunction with the Norwich Area Office and does assessment and care planning for children / youth who are transitioning from out-of-home levels of care to the community. Services are also provided to keep children/youth who are in the community from being placed in out-of-home care.</p>

Connecticut ACCESS Mental Health: is a consultative pediatric psychiatry service to be made available to all pediatric and family physician primary care provider practices ("PCPPs") treating children and youth, under 19 years of age irrespective of insurance coverage. The purpose is to improve access to treatment for children with behavioral health or psychiatric problems, and to promote productive relationships between primary care and child psychiatry to support selective utilization of scarce resources. The program is designed to increase the competencies of Primary Care Providers to identify and treat behavioral health disorders in children and adolescents and to increase their knowledge/awareness of local resources designed to serve the needs of children and youth with these disorders.

Category: Family Support and Family Preservation

Target Population: All children and youth under 19 regardless of insurance coverage

Geographic Area: Statewide

Estimated Families Served: 5000 calls/year

Crisis Stabilization - This service provides short term, residential treatment for children with a rapidly deteriorating psychiatric condition, in order to reduce the risk of harm to self or others and divert children from admission into residential or inpatient care. Interventions offered focus on stabilization of the child's behavioral health condition including addressing contributing environmental factors and enhancing existing outpatient services available to the child.

Early Childhood Services - Child FIRST - This service provides home based assessment, family plan development, parenting education, parent-child therapeutic intervention, and care coordination/case management for high-risk families with children under six years of age in order to decrease social-emotional and behavioral problems, developmental and learning problems, and abuse and neglect.

Service Category: Family Support

Population(s) to be served – High risk DCF involved children ages 0-6 with social-emotional, behavioral developmental and learning problems

Geographic areas where the services will be available -Statewide

Estimated number of individuals and families to be served in 2017: 530

Elm City Project Launch: The purpose of the Elm City Project LAUNCH grant (ECPL) is to promote the wellness of young children from birth to 8 years by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. The grant offers the contractor a 5-year award to develop, implement and study the effectiveness of an integrated and collaborative health and mental health service system for children 0-8 and their families in New Haven, Connecticut. To that end, this grant is designed to strengthen and enhance the partnership between physical health and mental health systems at the federal, state and local levels. Connecticut's Elm City Project Launch (ECPL) project will use a public health approach to promote children's health and wellness with efforts that promote prevention, early identification and intervention.

EMPS - Crisis Intervention Service - EMPS Crisis Intervention Service (EMPS) is a mobile, crisis intervention service for children experiencing behavioral health or psychiatric emergencies. The service is to be delivered through a face-to-face mobile response to the child's home, school or location preferred by the family, or in rare situations through a telephonic intervention.

Category: Family Support Services and Family Preservation service.

Population: Any child 0-18 residing in the state of CT.

Geographic Area served: Statewide

Number of children and families served: over 18,000 calls and over 12,000 episodes of care

EMPS-Crisis Intervention Service System - Statewide Call Center - This service is the entry point for access to the Emergency Mobile Psychiatric Service System for children and youth in the State of Connecticut. The Statewide Call Center receives calls, collects relevant information from the caller, determines the initial response that is needed, and links the caller to the information or service required. In addition to these primary functions, the Statewide Call Center also collects data regarding calls received, triage responses and referrals to EMPS contractors. The Call Center analyzes data and compiles reports for use by DCF, the Statewide Call Center, EMPS contracted service providers, and other entities as determined by DCF. The Statewide Call Center operates 24 hours per day, 365 days per year.

Category: Family Support Services and Family Preservation service.

Population served: Any child 0-18 residing in the state of CT.

Geographic Area served: Statewide

Number of children and families served: over 18,000 calls.

Extended Day Treatment (EDT) - This service is a site-based behavioral health treatment and support service for children and youth with behavioral health needs who have returned from out-of-home care or are at risk of placement due to mental health issues or emotional disturbance. For an average period of up to six months, a comprehensive array of clinical services supplemented with psychosocial rehabilitation activities are provided to maintain the child or youth in his or her home. The purpose of this service is to provide the clinical treatment and supports necessary to successfully stabilize and maintain children/youth in their own homes and communities. These efforts focus on: the prevention of hospitalization and out-of-home placement, unless clinically necessary; the provision of clinical treatment and specific behavioral assistance; and the engagement and support of families and caregivers. The primary goals include but are not limited to: stabilizing the child/youth's symptoms and behavior; improving the child/youth's mental, emotional, and social well-being, thus increasing the level of overall functioning in the community setting, both at home and school; and strengthening the family by enabling the family/caregiver to manage the behaviors of the child/youth more effectively.

Category: This service covers all service categories; Family Preservation, Family Support, and Adoption Promotion and Support Services.

Population served: Ages 5-17
Geographical Area: Statewide (19 sites)
Number of Children Served: 1073

Family Based Recovery - This service is an intensive, in-home clinical treatment program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance abuse. The overarching goal of the intervention is to promote stability, safety and permanence for these families. Treatment and support services are provided in a context that is family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance abuse treatment for the parent(s) and attachment-based parent-child therapy to the parent-child dyad.
Category: Family Support Services and Family Preservation service.
Population served: An infant (birth – 3 years) who is at risk of an out-of-home placement due to parental substance abuse. A parent who has used substances within past 30 days
Geographic area served: Statewide
Number of families to be served: Annual Capacity: 240 Clients (Length of service is variable 7 - 18 months, depending upon needs of the family)

Family and Community Ties - This service is a foster care model that combines a wraparound approach to service delivery with professional parenting for children with serious psychiatric and behavioral problems. This service is differentiated from other foster care services by (a) the frequency and intensity of clinical contact and (b) flexibility in providing "whatever it takes" to preserve the placement of a child in a family setting. Within this program, foster parents will serve as full members of the treatment team and will complete intensive training in behavior management.
Category: Adoption Promotion and Support Services service.
Population served: Children with serious psychiatric and behavioral problems
Geographic area served: Statewide
Number of families to be served: Approximately 53.

Family Support - This service provides coordination and facilitation of five parent support groups with goals of peer support, information on appropriate parenting skills, and education on the development of effective coping strategies. The five groups consist of (1) the CT Chapter of the National Alliance for the Mentally ILL, (2) a support group for mothers who have experienced a sexual assault in their pre-parenting years, (3) a parent education group, "Parents Night Out", (4) a parent /child play group for parents with children age birth to three years old that includes an "in home" education component, and (5) a Gamblers Anonymous support group.

Foster and Adoptive Parent Support Services - This service, through a private statewide agency, provides support and training to foster and adoptive parents. Services include, but are not limited to: a buddy system; post licensing training; a quarterly newsletter; an annual conference; periodic workshops; respite care authorization; and a fiduciary role for open adoption legal services. In addition, support staff (i.e. "Liaisons") are posted in most of the DCF Area Offices in order to assist foster and adoptive families who call with questions or require resolution of individual issues. The Liaisons also assist DCF staff with area recruitment and retention activities and serve on committees where a foster / adoptive parent perspective is needed. Childcare is also provided to the licensed families at these support groups
Category: Adoption Promotion and Support Services service.
Population served: All licensed families (all license types)
Geographic area served: All areas of the state
Number of families to be served: All licensed families (all license types)

Foster Care and Adoptive Family Support Groups - This service provides both avenue and child care for support group meetings for foster care and adoptive families as a means to aid in the retention of foster homes and placement stability within foster and adoptive family settings. Childcare is also provided to the licensed families at these support groups.
Category: Adoption Promotion and Support Services service.
Population served: All licensed families (all license types)
Geographic area served: All areas of the state
Number of families to be served: On Average there is approx. 6 to 10 licensed individuals at the support groups.

Foster Family Support - This service provides a variety of support services to children in DCF care who are living with foster and relative families in Bloomfield. The support services include, but are not limited to: individual, group and / or family counseling; crisis intervention, social skills development; educational activities; after school and weekend activities.
Category: Adoption Promotion and Support Services.
Population served: All licensed families (all license types)
Geographic area served: Waterbury and Torrington
Number of families to be served: 20 per month. The Contractor will maintain the capacity to serve at least 20 foster parents per support group meeting and provide for child care and child activity programming for up to 20 children per support group meeting, while the licensed foster and adoptive parents are meeting.

Foster Parent Support for Medically Complex - This service, largely through the organization of a group of volunteers, provides foster care

recruitment, respite and support focused on maintaining and growing the number of foster and adoptive parents who work with medically complex children in the Waterbury and Torrington area office towns. There is a child care/activity component to the program and a limited amount of money is available for participating foster parents. There are two yearly celebrations, a holiday party and annual picnic.

Fostering Responsibility, Education and Employment (F.R.E.E.) - This service provides reentry support to adolescents and young adults who have been committed to DCF as delinquent and who are returning to their community from out-of-home care, including public and private congregate care treatment settings, Connecticut Juvenile Training School (CJTS), and youth correctional settings (e.g. York, Manson).

Service provision begins while the client is in congregate care and continues for a period of time after his/her return to the community and includes an array of services to support the adolescent's growth in all areas of functioning as well as family-focused interventions that build on natural supports, by accessing services and opportunities available in the local service continuum.

Service type: Family Support, Family Preservation

Target Population: DCF youth, male and female, ages 15 through 19 years old, who are residing in the region and who are committed as delinquent. Exceptions will be made on a case by case basis for: 1) those younger than 15, as well as, 2) adolescents involved with the department who present with delinquency issues but are not committed as delinquent.

Geographic Area: Statewide

Estimated Families Served: 297 slots contracted FY 15

Functional Family Therapy (FFT) - This service provides an intensive period of clinical intervention, family support and empowerment, access to medication evaluation and management, crisis intervention and case management in order to stabilize children at risk of out-of-home placement due to mental health issues, emotional disturbance or substance abuse, or to assist in their successful return home from an alternative level of care. This service is delivered in accordance with the tenets of the evidence based model known as Functional Family Therapy (FFT). 25% of the capacity is available to youth involved with DCF Juvenile Service - Parole. Length of service averages 4 months per youth served. Services include flexible, strength-based interventions, offered primarily in the client's home as well as in community agencies, schools and other natural settings.

Category: Family Support and Family Preservation service.

Population served: Service is for DCF and non DCF involved youth ages 11-18 for whom there is a behavioral health diagnosis.

Geographic area served: All areas of the state except for the New Britain catchment area.

Number of families to be served: 557

High Risk Infant Program For Incarcerated Mothers - This service provides assessment, prenatal education, infant care planning, case management, and referral and service linkage for women who are pregnant, ready to deliver and are incarcerated or are pregnant and will be discharged from York Correctional Institution (YCI) in Niantic.

Category: Family Preservation, Time Limited Family Reunification, Family Support & Support Service.

Population to be served: 100% incarcerated pregnant woman at York Correctional Institution (YCI)

Geographic location: Services are located in New London, program service residents statewide.

Estimated number of individuals to be served: 40 people annually.

Intimate Partner Violence (IPV-FAIR) - The goal of the service is to establish a comprehensive response to intimate partner violence that offers meaningful and sustainable help to families that is safe, respectful, culturally relevant and responsive to the unique strengths and concerns of the family. This four (4) to six (6) month service provides a supportive service array of assessments, interventions and linkages to services to address the needs of families impacted by intimate partner violence. The service will respond to both caregivers and the children. The Fathers for Change Promising Practice Model will also be offered through the IPV-FAIR Service. This service will offer intervention to fathers of children under age 10 who have been an offender of intimate partner violence and have co-occurring substance use issues. Safety planning will be at the center of the IPV-FAIR service provision.

Category: Family Preservation, Family Support, Time-limited Family Reunification service.

Population Served: DCF families and Community Support for Families Program families impacted by Intimate Partner Violence.

Geographic Area: Statewide

Estimated number of individuals and families to be served: 120 – 180

Intensive Family Preservation - This service provides a short-term, intensive, in-home service designed to intervene quickly in order to reduce the risk of out of home placement and or abuse and/or neglect. Services are provided to families 24 hours per day, seven days a week with a minimum of 2 home visits per week including a minimum of 5 hours of face to face contact per week for up to 12 weeks. Staff work a flexible schedule, adhering to the needs of the family. A Standardized assessment tool is used to develop a treatment plan. As needed families are linked to other therapeutic interventions and assisted with basic housing, education and employment needs including making connections with non-traditional community supports and services.

Category: Family Preservation service.

Population Served: The target population for this service includes DCF active in-home cases only. This service is delivered when there is an emerging removal concern for children from birth through 17 years of age.
Geographic Area: Statewide
Estimated number of Individuals and Families to be served – A minimum of 1,062 families will be served annually.

Intensive In-Home Child and Adolescent Psychiatric Services IICAPS - (Consultation and Evaluation) - This service provides program development, training, consultation, and clinical quality assurance for all Department of Children and Families (DCF) approved Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) service providers. The IICAPS statewide providers work with children and youth who have returned or are returning home from out-of-home care and who require a less intensive level of treatment, or are at imminent risk of placement due to mental health issues or emotional disturbances.
Category: Family Preservation and Family Support. and Adoption Promotion and Support Services
Target Population: Children and adolescents ranged in age from 4-18 years with complex psychiatric disorders
Geographic Area: Statewide
Estimated Families Served: 2100-2250 annually

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) - This service is a curriculum based treatment model designed to divert children and adolescents, i.e. those who have a DSM-IV Axis I diagnosis and who exhibit complex behavioral health needs, from psychiatric hospitalization or to support discharge from inpatient levels of care. This is an intensive, home-based service designed to address specific psychiatric disorders in the identified child while remediating problematic parenting practices and/or addressing other family challenges that effect the child and family's ability to function. This service offers five levels of intervention, from as little as 1-3 hours per week to as much as 12-20 hours per week.
Category: Family Preservation and Family Support. and Adoption Promotion and Support Services
Target Population: children/youth with psychiatric disorders who have been hospitalized
Geographic Area: Statewide
Estimated Families Served: 2100-2250 annually

Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE) - This service provides a comprehensive and multidisciplinary out-patient assessment to assist in treatment planning for children and youth that are involved in the Juvenile Justice System. The unit of service for this program is a CORE EVALUATION that includes full intelligence testing, personality assessment, substance abuse screening, home visit and family assessment, and evaluation of educational problems and/or learning disability and a report completed within 28 days. These children/youth need a comprehensive, forensic evaluation that focuses on biopsychosocial factors that impact the child/youth's ability to remain in the community. DCFIE are for children/youth, ages 7 through 19, who are both DCF-involved and also involved in the juvenile justice system. These children/youth need a comprehensive mental health evaluation which can be completed in a community-based setting.
During breaks in the daily evaluation process, there are recreational and group activities for the children / youth.
Category: Family Preservation and Family Support.
Target Population: JJIE are for court-ordered children/youth, ages 7 through 19, with priority given to children/youth who are currently in a CT Juvenile Detention Center or have been recently released from detention.
Geographic Area: Statewide
Estimated Families Served: 164

Juvenile Review Board (JRB)

The Juvenile Review Boards (JRB) are organized groups of community volunteers such as police, youth service bureaus, schools, and agency professionals that work to divert children and youth from the juvenile justice system. Children and youth between the age of 7 and 17 that are first time misdemeanor offenders or that qualify under the Families with Service Needs (FWSN) statutes are eligible for JRB services.
Service type: Family Support, Family Preservation
Target Population: Ages 7 through 17 who have been referred to the Juvenile Review Board (JRB), are first-time offenders and have committed a misdemeanor offense or referred to court for behaviors under a Family with Service Needs ("FWSN") petition.
Geographic Area: Hartford, New Haven and Bridgeport
Estimated Families Served: 600 slots contracted FY 15

Juvenile Review Board Support and Enhancements

Juvenile Review Board Support and Enhancement provides funding to local Juvenile Review Boards to create, support and enhance services delivered to youth served by the Juvenile Review Board (JRB).
Service type: Family Support, Family Preservation
Target Population: Ages 7 through 17 who have been referred to the Juvenile Review Board (JRB), are first-time offenders and have committed a misdemeanor offense or referred to court for behaviors under a Family with Service Needs ("FWSN") petition
Geographic Area: Norwich, Willimantic, Middletown, New Britain, Meriden, Waterbury, Torrington, Danbury
Estimated Families Served: unknown

Juvenile Sexual Treatment (JOTLAB)- This is a comprehensive community based rehabilitative treatment program that serves adjudicated and non-adjudicated male and female youth ages 8 through 17, who have engaged in inappropriate and abusive sexual behaviors. Services include: a comprehensive clinical evaluation; individual psychotherapy – bi weekly for each youth; family counseling – monthly for each child and/youth and their family; psycho-educational therapy groups – twice weekly for each youth; social skill building groups – twice weekly for each youth. This service is a specialized extended day treatment program.

Category: Family Preservation, Family Support, and Adoption Promotion and Support Services.

Target Population: DCF referred children and youth ages 8 to 17, who are appropriate for community-based treatment for problem sexual behaviors.

Geographical Area: New Haven and Milford

Number of Children Served annually: 91

Mental Health Consultation to Childcare - This service promotes and facilitates the early identification of behavioral challenges and mental health needs in children who participate in daycare and early childhood education settings. Once needs are identified, strategies which prevent children from disrupting from their homes and day care settings are implemented. Families are given opportunities to partner as active participants at multiple levels including: home visits, center-based planning, child specific intervention strategies and collaborative planning and implementing strategies and activities within the classroom.

Category: Family Preservation; Family Support

Population(s) to be served - Early childcare and education staff, DCF-involved biological parents, foster, and adoptive parents, and any other caregivers in a child's life providing services to families and children ages Birth to 60 months (5 years old) and Birth to 72 months (6 years old) for DCF children in Foster Care, with challenging behaviors and/or social and emotional needs. Services may also be provided to DCF-involved women and their children housed in substance abuse residential programs.

Geographic area served – Statewide

Estimated number of individuals and families to be served – 150 early childcare centers, 400 teachers and assistant teachers, 90 Core Classrooms, 1,200 children within the Core Classrooms, 120 "at risk of expulsion/suspension" children and 400 service visits to involved families per quarter.

Modular Approach to Therapy For Children – MATCH

MATCH is a scientifically supported treatment for children 7-15 years old. MATCH is for children and adolescence who struggle with problems related to anxiety, depression, trauma and/or disobedient and aggressive behavior. MATCH is being decimated to 22 agencies statewide over 5 years.

Category: Family Preservation, Family Support

Target Population: DCF referred children 7-15 years old

Geographical Area: Statewide

Number of Children Served annually: 100

Multidimensional Family Therapy (MDFT) - This service provides intensive home based clinical interventions for children, ages **11 - 18**, with significant behavioral health service needs who are at imminent risk of removal from their home or who are returning home from a residential level of care. After a comprehensive evaluation, a strength-based Individualized Service Plan is developed to include goals, interventions, services and supports that address the issues and problems threatening the maintenance of the child in the home or the return of the child to the home. Staff work a flexible schedule, adhering to the needs of the family. Average length of service is 3 - 5 months per family. Family-based intensive in-home treatment for children & adolescents (aged 9 – 18 years) with significant behavioral health needs and either alcohol or drug related problems, or are at risk of substance use.

Category: Family Preservation service.

Population Served: Youth ages 11-18 years (9 - 18 for Special Population teams) with complex substance abuse and mental health service needs

Geographic Area – Statewide

Estimated Individuals and Families to be served: 961

Multidimensional Family Therapy (MDFT) Consultation and Evaluation - This service provides program development, training, clinical and programmatic consultation to statewide DCF funded Multidimensional Family Therapy (MDFT) providers that integrates the standards and practices consistent with MDFT requirements and MDFT quality improvement programming. In addition, this service provides program development, training and clinical consultation for the Family Substance Abuse Treatment Services (FSATS) teams who serve the former Emily J class members.

Category: Family Preservation service.

Population Served: Youth ages 11-18 years (9 - 18 for Special Population teams) with complex substance abuse and mental health service needs

Geographic Area – Statewide

Estimated Individuals and Families to be served: 961

Multidimensional Treatment Foster Care - This service is an evidence-based treatment program that increases developmentally appropriate normative and pro-social behaviors in children and youth who are in need of an out-of-home level of treatment and care. All youths in the program receive an all-inclusive array of services including a range of interpersonal skill training, supportive therapy, school-based behavioral interventions and academic supports, psychiatric consultation and medication management. Foster parents receive behavioral parent training and support while birth parents and/or caretakers receive family therapy and aftercare supports.

Category: Family Support, Time-Limited Family Reunification

Target Population: Juveniles ages 10 – 17 who are currently in or recently have been released from a pre-trial detention center and identified by the

Court as at-risk for or requiring treatment in a residential level of care.
Geographic Area: Waterbury, Danbury, Torrington.
Estimated Families Served: 22. 10 youth (9 to 12 month duration)

Multidisciplinary Examination (MDE) Clinic - This service provides a comprehensive multidisciplinary evaluation including medical, dental, mental health, developmental, psychosocial and substance abuse screening for children placed in DCF care for the first time. A comprehensive summary report of findings, compiled from the multidisciplinary team and written by the Foster Clinic Coordinator is completed on each child referred for service. As appropriate, referral(s) to a specialized service are made.
Category – Family Preservation / Family Support
Population served – each child placed in an out of home setting
Geographic area – Statewide
Number of children served – 1145 (5/1/2014 – 4/30/2015)

Multidisciplinary Team – This service promotes the coordination of investigations of and interventions for cases of child abuse/neglect among agencies, including DCF, police, medical, mental health, victim advocates, and prosecutors. Cases are referred to the regularly scheduled team meetings by DCF, law enforcement or other agency members of the team. A team Coordinator assumes the coordination and administrative responsibilities in addition to being an active member of the team. Training in aspects of child abuse and the investigation process is provided to the team members.
Service Category: All service Categories
Population served: Any child in Connecticut that is a victim of sexual abuse including child sex trafficking, severe physical abuse or death of a child.
Geographic area: Statewide, There are 17 MDT's throughout the state of Connecticut serving the entire state.
Number of children being served: The number is fluid; all cases of sexual abuse including child sex trafficking, severe physical abuse and death of a child is reviewed. During the 2014 calendar year over 1,500 cases were reviewed by MDT's in Connecticut.

Multi-systemic Therapy (MST) - This service, using a national evidence-based treatment model, provides intensive home based services to children who are returning or have returned from a residential level of care or are at imminent risk of removal due to mental health issues. After a comprehensive evaluation, a strength-based Individualized Service Plan is developed to include goals, interventions, services and supports that address the issues and problems threatening the maintenance of the child in the home or the return of the child to the home. This service promotes change in the natural environments ... i.e. home, school and community. Interventions with families promote the parent's capacity to monitor and intervene positively with each child and/or youth. The clinical supervisor and therapists have daily contact with each family served including providing 24 hour a day, 7 day a week access. Average length of service is 3 - 5 months per family.
Category: Family Support and Family Preservation service.
Target Population: Youth between 12-17 years old who have returned or are returning home from out-of-home care or who are at imminent risk of placement due to substance use, risk of substance use, or conduct disorders
Geographic Area: DCF catchment areas in Bridgeport, Hartford, Manchester, Milford, New Britain, New Haven, Norwich, Waterbury, and Willimantic
Estimated Families Served: 432

MST- Family Integrated Transitions - This service uses the evidence-based Intensive Home Based (IHB) treatment model, *Multisystemic Therapy - Family Integrated Transitions (MST-FIT)*, through a license by the University of Washington, Seattle, to provide integrated individual and family services to children/adolescents with co-occurring mental health and chemical dependency disorders during the period of their re-entry from residential or juvenile justice facilities back into their communities. MST-FIT promotes behavioral change in the natural environment including helping parents learn to monitor and to intervene positively with their children/adolescents.
Category: Family Support and Family Preservation service.
Target Population: Youth on Parole ages 12-17 ½ years. Has a co-occurring mental health and substance use disorder. Has a committed caregiver. Currently living in a residential or juvenile justice facility and scheduled to return home within 2 months. Youth has received DBT therapy while in placement or willing to learn it during FIT treatment
Geographic Area: Danbury, Hartford, Manchester, Middletown, Milford, New Britain, New Haven, Torrington, Waterbury
Estimated Families Served: Annual Capacity: 60

MST - Building Stronger Families - This service, using a national evidence-based treatment model, provides intensive family and community based treatment to families that are active cases with (DCF) due to the physical abuse and/or neglect of a child in the family and due to the abuse of or dependence upon marijuana and/or cocaine by at least one caregiver in the family. Core services include: clinical services, empowerment and family support services, medication management, crisis intervention, case management and aftercare. Average length of service is 6 - 8 months per family.
Category: Family Support and Family Preservation service.
Target Population: Families who have A child between 6 - 17 years old. An allegation of abuse or neglect within past 180 days, and at least one caregiver with alcohol or drug abuse related problems.
Geographic Area: Meriden, New Britain, Hartford, Waterbury, New Haven
Estimated Families Served: Annual Capacity: 84

MST-Consultation and Evaluation - This service provides for clinical consultation to State-wide Court Support Services Division (CSSD) and DCF

funded Multi-systemic Therapy (MST) providers in order to integrate the standards and practices consistent with MST Network Partnership requirements and MST quality improvement programming. In addition, the service provides training in the theory and application of MST for clinicians, supervisors, administrators, policy makers employed by DCF, CSSD and their contracted MST providers.

MST - Problem Sexual Behavior- This service provides clinical interventions for youth who be returning home from the Connecticut Juvenile Training School (CJTS) or a residential treatment program after having been identified as being sexually abusive or displaying sexually reactive and/or sexually aggressive behaviors and who have been assessed to need sexual offender specific treatment. The service is based upon an augmentation of the standard MST team model, an evidence based clinical model with an established curriculum, training component and philosophy of delivering care. The average length of service is 6-8 months per youth / family. All clients referred receive a comprehensive evaluation resulting in a multi-axial diagnosis and individualized treatment plan.

Category: Family Support and Family Preservation.

Target Population: Adolescents 10-17.5 years (exceptions for older youth on a case-by-case basis). Convicted and committed to DCF as delinquent due to a sexually abusive offense and who require sex offender specific treatment; or Convicted and committed to DCF as delinquent and who display sexually aggressive/inappropriate behavior and who require sex offender specific treatment; or Not convicted for sexual abuse specific offenses but this issue has been identified and other inclusion/ exclusion criteria are met.

Geographic Area: Statewide

Estimated Families Served: Annual Capacity: 96

MST for Transition-Aged Youth - This service provides intensive individual and community based treatment to transition-aged youth with both antisocial behaviors and serious mental health conditions. The three primary goals of the intervention are to reduce antisocial behaviors and recidivism, treat the mental health condition, and treat existing substance use disorders. The four secondary goals are to encourage vocational engagement (schooling, training or working); improve social relationships; support community-based housing; and improve client parenting skills when appropriate.

Category: Family Support and Family Preservation.

Target Population: Youth aged 17-20 years inclusive. Serious mental health condition and/or substance abuse disorder, and Involvement with JJ or CJ system

Geographic Area: Bridgeport, Meriden, Milford, New Haven, Waterbury

Estimated Families Served: Annual Capacity: 30

New Haven Trauma Network - The New Haven Trauma Network is a collaboration led by Clifford Beers Clinic that has four (4) components: Care Coordination, Short term assessment, screening, and direct service for children; Trauma informed training & workforce development. These Four Components will be a trauma-informed collaborative network of care to address adverse childhood experiences (ACE). The network will involve the Greater New Haven community and its focus aims to: a) Create a safer, healthier community for children and families; b) Reducing community violence; c) Reduce school failure and dropout rates; d) Reduce incarceration rates; e) Improving overall health of children and families; and f) Coalition or network infrastructure support.

One on One Mentoring (OOMP) - This service contracts with local service providers statewide to supply adult mentors to DCF involved adolescents ages 14-17 and 18-21 who remain involved with DCF following their commitments. The providers recruit, screen and train eligible candidates to become mentors, partner with DCF social workers then match approved mentors with DCF committed adolescents and young adults. The goal of the mentoring program is to provide an important and long lasting relationship to adolescents who are placed outside of their homes. Mentors are involved in the adolescent's life as a guide, a positive role adult model and a confidant. Mentors maintain weekly contact with their mentees and visits face to face at a minimum of three times a month. The program aims at maintaining these relationships on a long term basis. Ideally, the relationships evolve into permanent, life-long friendships.

Category: Family Support and Family Preservation service.

Population to be served: DCF involved adolescents ages 14-17 and 18-21 who remain involved with DCF following their commitments. Exceptions are made for younger youth or youth are not committed to DCF on a case by case basis.

Geographic location: Statewide

Estimated number of individuals to be served: 175 people. Capacity of 280.

Outpatient Psychiatric Clinic for Children (aka Child Guidance Clinic) - This service provides a range of outpatient mental health services for children, youth and their families. Services are designed to promote mental health and improve functioning in children, youth and families and to decrease the prevalence of and incidence of mental illness, emotional disturbance and social dysfunction. DCF-involved children; referred through local systems of care, care coordinators, and Emergency Mobile Services; children who are the victims of trauma and/or physical and/or sexual abuse and/or neglect and/or witness to violence in the home or external to the home and/or who have experienced multiple separations from loved ones; children who are at risk of psychiatric hospitalization or placement into residential treatment; children being discharged from psychiatric hospitals or residential treatment; children with severe emotional disturbances such as conduct disorders and oppositional defiant disorders; children with significant, persistent psychiatric conditions; children who are court involved; children whose families are financially unable to obtain mental health services elsewhere in the community; children experiencing Reactive Attachment Disorders; children who experience Post Traumatic Stress Disorder; children who exhibit sexually reactive behaviors and children who exhibit sexually predatory behavior.

Category: This service covers all service categories; Family Preservation, Family Support, and Adoption Promotion and Support Services.

Target Population: Children 3-17
Geographical area: Statewide (26 sites)
Number of Children Served Annually: 24,743

Parenting Class - This service provides parenting education and skill building in English, Spanish and or Portuguese to parents in the Greater Danbury area.

Performance Improvement Center - This service, Performance Improvement Center (PIC), supports and sustains the delivery of high quality Emergency Mobile Psychiatric Services (EMPS) and, Care Coordination (CC) throughout the state of Connecticut by directing and implementing quality improvement activities and standardized training and workforce development activities to EMPS, and Care Coordination contractors. Quality Improvement activities include the collection, analysis, and reporting of quality improvement data provided by the EMPS Call Center (211) and EMPS contractors (and sub-contractors) and the care coordination contractors. Monitoring and supporting EMPS and Care Coordination quality is provided by a combination of consultation, satisfaction surveys, fidelity ratings, and other activities. Training and workforce development activities for Care Coordination and EMPS include the provision of pre-service, in-service and special topic training in the core competencies necessary to operate a quality service. Additionally, on-going monthly quality oversight through coaching and mentoring is provided for Care Coordination providers.

Category: Family Support and Family Preservation service.

Population: The contractors who provide EMPS and Care Coordination services to children and families in CT

Geographic Area served: Statewide

Number of children and families served: EMPS serves over 12,000 episodes of care and care coordination serves over 1,200 to 1,600 families annually.

Permanency Placement Services Program (PPSP) - This is a permanency placement service for DCF committed children who are considered difficult to place in adoption due to special needs. Services include: completion of documents to legally free a child for adoption through Juvenile Court; recruitment, screening, home studies and evaluations; pre and post adoption placement planning and finalization services and reunification services with biological parents. A written service agreement, mutually developed between DCF and the provider, is made prior to the commencement of services, and includes the type(s) of service(s) to be provided and time to be spent on each service.

Category: Family Support and Adoption Promotion and Support Services Service.

Population served: any child in DCF care for whom adoption recruitment & preparation or child and family permanency work is necessary.

Geographic area served: Statewide.

Number of families to be served: 101. This number is fluid based upon the requested contracted service.

Physical and Sexual Abuse Evaluation - This service provides sexual and physical abuse evaluations including a comprehensive and specialized medical examination, psychosocial assessment and a forensic interview of the child in order to determine if abuse has occurred. The evaluation process includes: an initial psychosocial assessment of the family; a physical exam; laboratory work; and a forensic interview of the child, when appropriate. This service also provides the referring DCF worker with a written report within 30 days of the initial evaluation.

Category – Family Preservation

Population served – any child who presents in need of these services in the community and at hospitals

Geographic area – statewide

Number of children served – 1220 (870 physical abuse and sexual abuse evaluations and 350 child protection team consultations)

Preparing Adolescents for Self-Sufficiency (PASS) - This service is a Group Home, i.e. a congregate-care behavioral health treatment setting for children and youth. Additionally, as a Preparing Adolescents for Self-Sufficiency (PASS) Group Home, this service provide an environment that fosters individualized maximum outcomes in the areas of education, vocation, employability, independent living skills, health, mental health, community connections, and permanent connections.

Category: Family Support and Family Preservation

Target Population: Youth who meet PASS Group Home level of care based on the criteria established by the Behavioral Health Partnership (BPH).

Geographic Area: Statewide

Estimated Families Served: 62

Prison Transportation – This service provides bi-weekly transportation for children and youth so they can visit their mothers or guardians who are in prison at York Correctional Institution. Children/youth in DCF custody are given priority. The service includes toys, books and other forms of entertainment for children to use during travel time. Social work support is available for children who experience emotional difficulty on the way to, during and/or returning from the visits.

Project SAFE- This is a statewide program that provides priority access to substance abuse evaluations, outreach and engagement and outpatient substance abuse treatment to parent/caregivers who are involved in an open DCF case. Project safe is a single point of entry for evaluations and toxicology screening. Additional services include assisting families to gain access to mental health, medical, social, educational, vocational, housing and other services essential to meeting basic human needs. These services, funded by both DCF and DMHAS, are provided without regard for ability to pay.

Category: Family Support.

Target Population: DCF involved parents and caregivers

Geographic Area: Statewide

Estimated Families Served: Varies (approximately 7,000).

Recovery Case Management (RCM) – This service provides intensive recovery support services and case management. RCM facilitates treatment and recovery supports for caregivers and families.

Category: Family Preservation and Family Supports.

Target Population: DCF involved substance using parents and caregivers with children at home but at risk of removal

Geographic Area: DCF catchment areas in Bridgeport, Hartford, Middletown, New Britain, Norwalk, Norwich, and Willimantic

Estimated Families Served: Varies (combined capacity with RSVP is 220- RSVP families get priority).

Recovery Specialist Voluntary Program (RSVP) - This service provides intensive recovery support services, case management, and random observed alcohol and drug screenings for parents and caregivers.

Category: Time Limited Family Reunification and Family Supports.

Target Population: DCF involved substance using parents and caregivers whose children have been removed

Geographic Area: DCF catchment areas in Bridgeport, Hartford, Norwalk, New Britain, and Willimantic

Estimated Families Served: Varies (combined capacity with RCM is 220).

Residential Substance Abuse Treatment- New Choices – This is short-term residential substance abuse treatment program that assists youth achieve their recovery goals. New Choices integrates Adolescent Community Reinforcement Approach (ACRA) and Assertive Continuing Care (ACC), an evidence-based substance abuse treatment program for youth. Following discharge from New Choices, the adolescents can then be referred to the recovery support ACC portion of the service. ACC also provides case management services to assist with accessing other needed services.

Category: Family Support.

Target Population: DCF referred or court involved substance using boys between the ages 12-17, who meet the criteria for the ASAM Level III.5 (Clinically Managed Medium-Intensity Residential Services, are enrolled in high school, have a Full Scale IQ of 70 or more, and have a disposition plan at discharge for returning to the community

Geographic Area: Statewide

Estimated Families Served: 72

Respite Care Services - Respite Care Services - This service provides brief and temporary home and community based care for children and youth who have serious emotional disturbance (SED). This service is offered to families in order to provide relief from the continued care of a child or youth complex behavioral health care needs, to limit stress in the home environment and to prevent family disruption and/or the need for out of home care for a child with SED. This care is part of an integrated behavioral health care plan. Up to 45 hours of respite can be given to a family within a 12 week period with any extension based upon DCF approval. When respite is provided in a group setting, there is at least one (1) respite worker for every three children.

Category: Family Support and Family Preservation.

Population served: Service is for non DCF involved youth ages 4-17

Geographic area served: All regions except region 3

Number of families to be served: 224

Reunification and Therapeutic Family Time – Reunification Readiness Assessment, Reunification Services, and Therapeutic Family Time are designed for families with children (from birth to age 17) who were removed from their home due to protective service concerns. These three service types are available to families as three separate components based on the needs of the family. Families can be referred for this service immediately following a child's removal from the home or at any time during their placement.

Reunification Readiness Assessment uses a standardized assessment tool to develop service plan. Therapeutic Family Time is made available for families and assists the provider in assessment by using the Visit Coaching model. This component provides feedback and recommendations to the Department regarding the family's readiness for reunification

Reunification Services also uses a standardized assessment tool to develop the service plan, delivers a staged reunification model to support families throughout the reunification process, adopts the Wraparound Model design to engage the family and build their networks of support, delivers Therapeutic Family Time component using the Visit Coaching model and offers a Step Down option, if families require additional supports.

Therapeutic Family Time – Uses the Visit Coaching Model, uses the Keys to Interactive Parenting Scale (KIPS), an evidence based tool to effectively measure parent child interaction and parenting behaviors, preserves and restores parent/child attachment and facilitates permanency planning and emphasizes a continuity of relationships.

Category: Time-Limited Family Reunification and Family Support service.

Population Served – The target population includes only those families whose children are in imminent danger of out of home placement or cannot return home without intense services. Families to be served include biological and adoptive families referred by DCF and includes DCF active families only. For all services except Therapeutic Family Time, the permanency goal for the referred child must reunification.

Geographic Area – Statewide

Number of Families to be served – A range of 635 – 700 families will be served annually.

Sibling Connections Camp - This service is designed to engage, support and reconnect siblings who are placed in out of home care by providing a week long overnight camp experience focused on strengthening sibling relationships and creating meaningful childhood memories.

Channel 3 - Sibling Connection Camp provides a normative activity for sibling groups in placements. Implementation of the program affords foster and biological families the opportunity to send their children (part of a sibling group where at least one child is in placement) to a week-long overnight camp. The camp activities are designed for sibling connection and/or reconnection.

Category: Family Support and Family Preservation.

Target Population: Children ages 8 to 17. The children are part of a sibling group, where at least one sibling is in placement.

Geographic Area: Statewide

Estimated Families Served: 80

Short Term Assessment and Respite Home (STAR)- This service is a temporary congregate care program that provides short-term care, evaluation and a range of clinical and nursing services to children removed from their homes due to abuse, neglect or other high-risk circumstances. Staff provide empathic, professional child-care, and develop and maintain a routine of daily activities similar to a nurturing family structure. The children and youth receive assessment services, significant levels of structure and support, and care coordination related to family reunification, or matching with a foster family or a congregate care setting, as appropriate.

Short-Term Family Integrated Treatment (SFIT): is a short-term residential treatment option providing crisis stabilization and assessment, with rapid reintegration and transition back home. The primary goal of the program is to: stabilize the youth and family (adoptive, biological, foster, kin, relative) and their extended social system; assess the family's current strengths and needs; identify and mobilize community resources; and, coordinate services to ensure rapid reintegration into the home. It is an alternative to psychiatric hospitalizations and admissions to higher levels of care, and diverts placement disruptions. The program serves DCF involved children and adolescents ages twelve (12) - seventeen (17) with the ability to seek a waiver through DCF licensing for children under the age of 12. Many of these children will have experienced multiple disruptions or a particularly traumatic event and have significant mental health and/or medical and high-risk behavior management needs.

Statewide Family Organization - Statewide Family Organization - The Statewide Family Organization will provide three levels of service and supports to families who have children with serious behavioral or mental health needs. At the direct service level, there are "Community Family Advocates" who provide brief and long term support to parents and caregivers using a wraparound Child and Family Team meeting approach and a peer support and assistance framework. At the regional level, "Family System Managers" are responsible for working closely with DCF Regions and the Connecticut Behavioral Health Partnership (CT BHP) to assist them in developing linkages between local community groups and identifying and supporting informal support and service networks for families. At the statewide level, "Citizen Review Panels" are responsible for giving feedback to the Department regarding child protection services and for providing training and disseminating information to service providers and the public to enhance the ways families can positively impact the child protection and child treatment systems.

Category: Family Support and Adoption Promotion and Support Services.

Population served: They work with non DCF involved families in CT.

Geographic area served: One contract Statewide for non DCF involved families

Number of families to be served: The number served is not quite clear as they work training large groups, engage communities with the FSM positions and serve over 600 with the Advocates.

Supportive Housing for Families - This service provides subsidized housing and intensive case management services to DCF families statewide for whom inadequate housing jeopardizes the safety, permanency, and well-being of their children. Intensive case management services are provided to assist individuals to develop and utilize a network of services in the following areas: economic, social, and health. Housing is secured in conjunction with the family and the Department of Housing (DOH) provides a Section VIII voucher. Priority access is determined by the chronological order of referrals.

Service Category: Family Support

Population to be served: DCF involved families with housing barriers who are homeless or at risk of homelessness.

Geographic area served: Statewide

Estimated number of individuals and families to be served in 2016- over 500

Supportive Work, Education & Transition Program (SWETP) - This service is a community-based stand alone, staffed apartment program that serves adolescents, age 16 and older, who are committed to DCF. The program focuses primarily on the developmental issues associated with the acquisition of independent living skills, including but not limited to: inter-personal awareness; community awareness and engagement; knowledge and management of medical conditions; and maximization of: 1) education, 2) vocation, and 3) community integration. There is on site, awake supervision, 24 hours a day, and seven days a week. Activities involving resident youth are supervised and managed at a level consistent with the nature of the activity and the individual needs of the involved youth.

Service Category: Family Support

Target Population: Youth 16 or older and Committed Abused, Neglected or Uncared For or Dually Committed to DCF

Geographic Area: Statewide

Estimated Families Served: 26

Therapeutic Child Care - This service offers a range of support services for children in a child care facility, including parent-child programs and an after school program. The target population is children ages birth to 8 years old. The primary activity is the teaching of parenting skills as parents participate with their child in the child care setting. With new understanding and skills on the part of the parents, DCF is less likely to become involved and children are less likely to be removed from the home.

Category: Family Support, Family Preservation ,Time-Limited Family Reunification categories
Population(s) to be served: Children aged 0-5 with behavioral issues transitioning to regular day care or kindergarten
Geographic area to be served: Bridgeport, New Britain and Waterbury.
Estimated number of families to be served: Currently the number of children being served is approximately 19.

Therapeutic Foster Care (Medically Complex) - This service approves, provides specialized training, support services and certifies families to care for children with complex medical needs. The population served is DCF referred, mixed gender children and youth with complex medical needs from birth through 17 years. A child with complex medical needs is one who has: a diagnosable, enduring, life-threatening condition; a medical condition that has resulted in substantial physical impairments; medically caused impediments to the performance of daily, age-appropriate activities at home, school or community; or a need for medically prescribed services.
Category: Family Support, Family Preservation ,Time-Limited Family Reunification categories
Population(s) to be served: Children with complex medical needs
Geographic area to be served: Statewide.
Estimated number of families to be served: Currently the number of children being served is approximately 7.

Therapeutic Foster Care - This service is an intensive, structured, clinical level of care provided to children with serious emotional disturbance (SED) within a safe and nurturing family environment. Children in TFC receive daily care, guidance, and modeling from specialized, highly trained, and skilled foster parents. TFC families receive support and supervision from private foster care agencies with the purpose of stabilizing and/or ameliorating a child's mental/behavioral health issues, and achieving individualized goals and outcomes based upon a comprehensive, multifocal care plan, and facilitating children's timely and successful transition into permanent placements (e.g., reunification, adoption, or independent living).
Category: Family Support, Family Preservation ,Time-Limited Family Reunification categories
Population(s) to be served: Children with serious emotional disturbance (SED).
Geographic area to be served: Statewide.
Estimated number of families to be served: 750

Therapeutic Group Home - This service is a small (4-6 bed) staffed home within a local community designed for youth with psychiatric/behavioral issues (must have an Axis I diagnosis of a particular kind). Youth entering these homes come primarily from larger residential facilities. Therapeutic techniques/strategies are utilized in the relationship with the child/family, primarily through group, milieu experiences. The service provides an intensive corrective relationship in which therapeutic interactions are dominant, thereby assisting the youth in improving relationships at school, work and/or community settings. Appropriate linkages with alternative or transition services are in place prior to a youth's discharge.

Triple P - This service utilizes the evidenced-based model, Triple P (Positive Parenting Program®) of the University of Queensland, to provide an in-home parent education curriculum along with support and guidance so that parents will become resourceful problem solvers and will be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Within the multi-tiered Triple P system, this service will use Triple P's Level 4 Standard and Level 4 Standard Teen courses. In addition to Triple P, this service will provide short term case management supports to help parents fully utilize the parenting services.
Category: Family Preservation; Family Support
Population(s) to be served - Parents with children 0-17 years of age. Priority is given to parents involved with DCF or Community Support for Families. Caseload permitting and in consultation with the DCF area office, providers may serve parents referred by other community providers.
Geographic area served – Statewide
Estimated number of families to be served : 2113 families annually

Work To Learn Youth Program - This is a youth educational/vocational program providing supportive services to assist youth, ages 14 - 23, to successfully transition into adulthood. The program provides training and services in the following areas: employment skills, financial literacy, life skills, personal and community connections, physical and mental health, and housing. Youth also have the opportunity to take part in on site, youth run businesses. The program provides youths with training and services in the following areas: employment skills, financial literacy, life skills, personal and community connections, physical and mental health, and housing.
Category: Family Support and Adoption Promotion and Support Services.
Target Population: Committed youths ages 14 to 23.
Geographic Area: .Hartford, Norwich, Bridgeport, Waterbury, and New Haven
Estimated Families Served: The agency contracted for 364 slots during SFY 15

Zero to Three – Safe Babies – the Zero to three Safe Babies Project, provides for the coordination of services to parents and children younger than 36 months in order to help speed reunification or another permanency goal when the children have been placed by court order outside of their homes for the first time. These coordination efforts involve facilitating communication and cooperation among a "zero to three team" of stakeholders (e.g. court services, infant mental health, protective services, developmental screening) and the parent(s) to develop and expedite a case specific plan of action.
Category: Family Preservation; Family Support, Time-Limited Family Reunification, and Adoption Promotion and Support Services
Population(s) to be served - parents, foster parents, and adoptive parents in the New Haven and Milford DCF area office service areas.
Geographic area served - the New Haven and Milford DCF area office service areas.
Estimated number of individuals and families to be served – 40 children 0-3 years of age annually

Service Grid

Family Preservation	Family Support	Time-Limited Family Reunification	Adoption Support
Adopt A Social Worker	Adolescent Community Reinforcement Approach / Assertive Continuing Care (ACRA-ACC)	Adopt A Social Worker	Adopt A Social Worker
Care Management Entity (CME)	Adopt A Social Worker	Caregiver Support Team	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Caregiver Support Team	Care Coordination	Community Targeted Re-Entry Pilot Program (CTRPP)	Community Support Team
Child Abuse Centers of Excellence	Care Management Entity (CME)	Crisis Stabilization	Extended Day Treatment (EDT)
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Child Abuse Centers of Excellence	Extended Day Treatment (EDT)	Family and Community Ties
Community Support for Families	Child First Consultation and Evaluation	High Risk Infant Program For Incarcerated Mothers	Foster and Adoptive Parent Support Services
Community Support Team	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Intimate Partner Violence (IPV-FAIR)	Foster Care and Adoptive Family Support Groups
Community Transition Program	Community Based Life Skills	Multidimensional Treatment Foster Care	Foster Family Support
Connecticut ACCESS Mental Health	Community Support for Families	Multidisciplinary Team	Foster Parent Support for Medically Complex
Crisis Stabilization	Community Transition Program	New Haven Trauma Network	Fostering Responsibility, Education and Employment (F.R.E.E.)
EMPS - Crisis Intervention Service	Connecticut ACCESS Mental Health	Outpatient Psychiatric Clinic for Children	Intensive In-Home Child and Adolescent Psychiatric Services IICAPS
Extended Day Treatment (EDT)	Crisis Stabilization	Prison Transportation	Juvenile Sexual Treatment (JOTLAB)
Family Based Recovery	Early Childhood Services - Child FIRST	Recovery Specialist Voluntary Program (RSVP)	Multidisciplinary Team
Fostering Responsibility, Education and Employment (F.R.E.E.)	Elm City Project Launch	Reunification and Therapeutic Family	New Haven Trauma Network
Functional Family Therapy (FFT)	EMPS - Crisis Intervention Service	Short Term Assessment and Respite Home	Outpatient Psychiatric Clinic for Children
High Risk Infant Program For Incarcerated Mothers	Extended Day Treatment (EDT)	Short-Term Family Integrated Treatment	Permanency Placement Services Program (PPSP)
HOMEBUILDERS	Family Based Recovery	Therapeutic Child Care	Work To Learn Youth Program
Intimate Partner Violence (IPV-FAIR)	Family Support	Therapeutic Foster Care (Medically Complex)	Zero to Three – Safe Babies
Intensive Family Preservation	Functional Family Therapy (FFT)	Zero to Three – Safe Babies	
Intensive In-Home Child and Adolescent Psychiatric Services IICAPS	Intimate Partner Violence (IPV-FAIR)		
Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE)	Intensive In-Home Child and Adolescent Psychiatric Services IICAPS		
Juvenile Criminal Diversion	Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE)		
Juvenile Review Board (JRB)	Juvenile Review Board (JRB)		
Juvenile Sexual Treatment (JOTLAB)	Juvenile Sexual Treatment (JOTLAB)		
Mental Health Consultation to Childcare	Mental Health Consultation to Childcare		
Modular Approach to Therapy For Children – MATCH	Modular Approach to Therapy For Children – MATCH		
Multidimensional Family Therapy (MDFT)	Multidimensional Treatment Foster Care		
Multidisciplinary Examination	Multidisciplinary Examination		

(MDE) Clinic	(MDE) Clinic	
Multidisciplinary Team	Multidisciplinary Team	
Multi-systemic Therapy (MST)	Multi-systemic Therapy (MST)	
MST- Family Integrated Transitions	MST- Family Integrated Transitions	
MST - Building Stronger Families	MST - Building Stronger Families	
MST-Consultation and Evaluation	MST-Consultation and Evaluation	
MST - Problem Sexual Behavior	MST - Problem Sexual Behavior	
MST for Transition-Aged Youth	MST for Transition-Aged Youth	
New Haven Trauma Network	New Haven Trauma Network	
One on One Mentoring (OOMP)	One on One Mentoring (OOMP)	
Outpatient Psychiatric Clinic for Children	Outpatient Psychiatric Clinic for Children	
Parenting Class	Parenting Class	
Performance Improvement Center	Performance Improvement Center	
Physical and Sexual Abuse Evaluation	Permanency Placement Services Program (PPSP)	
Positive Youth Development	Positive Youth Development	
Recovery Case Management (RCM)	Preparing Adolescents for Self-Sufficiency (PASS)	
Respite Care Services	Prison Transportation	
Sibling Connections Camp	Project SAFE	
Short Term Assessment and Respite Home	Recovery Case Management (RCM)	
Statewide Family Organization	Recovery Specialist Voluntary Program (RSVP)	
Therapeutic Child Care	Residential Substance Abuse Treatment	
Therapeutic Foster Care (Medically Complex)	Respite Care Services	
Therapeutic Group Home	Reunification and Therapeutic Family	
Triple P	Sibling Connections Camp	
Zero to Three – Safe Babies	Short Term Assessment and Respite Home	
	Short-Term Family Integrated Treatment	
	Statewide Family Organization	
	Supportive Housing for Families	
	Supportive Work, Education & Transition Program (SWETP)	
	Therapeutic Child Care	
	Therapeutic Foster Care (Medically Complex)	
	Therapeutic Group Home	
	Triple P	
	Work To Learn Youth Program	
	Zero to Three – Safe Babies	

2017 Spending Plans

Stephanie Tubbs Jones Child Welfare Services-Subpart-I-FFY2017

Services/Activities	Total Funding
Children Services Positions - Solnit North	\$1,013,007

Office Assistant Positions	\$156,786
JRA Consulting – Racism	\$90,000
CCMC	220,500
Central Office Staff	111,721
The Connection	200,000
Triple P America	\$109,860
Travel/Conferences	10,000
CCADV	\$108,000
IPV-FAIR	\$49,364
Parents with Cognitive Limitations	\$4,000
KJMB Solutions	\$90,000
CT-AIMH	\$350
Total	\$2,163, 588

[Promoting Safe and Stable Families- Subpart II – FFY 2017](#)

Services/Activities	Total Funding
Reunification & TFT Services	\$1,173,245
Community Collaboratives	\$284,700
FAVOR: Foster Care Consumer Advocate	\$50,000
UConn -Adoption enhancements	\$300,000
Easter Seals Support Group	\$20,000
Adopt a SW program	\$95,275
UConn SSW PIC	\$232,787
CT Association for Infant Mental Health	\$39,382
Total	\$2,195,389

Chafee FFY 2017

Service Description	Total Funding
Personnel Expenses	\$40,757
One on One Mentoring	\$257,013
Community Based Life Skills	\$398,430

Work to Learn	\$528,449
Youth Advisory Board Stipends	\$50,000
Total	\$1,274,649

ETV (See Section E page 174).

Service Coordination

Connecticut's service array is coordinated through a committee that oversees the development of new services and the re-procurement process for existing services. The Service Array Review and Assessment (SARA) committee is responsible for ensuring every contract in Connecticut's child welfare service array has measurable child and family outcomes. SARA is also responsible for managing the procurement process, including approving Requests for Proposals and making decisions about how to invest our resources to improve the service array. The group meets every two weeks to review current services, modify existing scopes of service and make recommendations for the development of new services when gaps are identified in the state.

The service coordination process also involves considerable input from stakeholders at all levels. The Department hosts statewide service provider meetings to gather input from contracted and credentialed providers. We also meet regularly with the provider trade associations to discuss upcoming changes in the service array. Finally, the Department recently hosted a series of community forums to gather input from parents and other community members on the mental health services array.

The Contract Management Unit in the Department's Fiscal Services Division provides an array of support services to aid the Department's Program Development and Oversight Coordinators (PDOCS) who are responsible for the oversight of the program components of the 81 Purchase of Service (POS) contracts the Department funds. Purchase of Service contracts deliver direct social services through private agencies to children and/or their families that are served by the Department. Additionally, the Contract Management Unit supports a variety of other Department units and is responsible for a number of other

activities as described below.

The Contract Management Unit has developed and delivered the following state-wide impact initiatives during the 2014/2015 fiscal year:

1. Program Development and Oversight Coordinator Training:

The Contract Management Unit designed and executed a comprehensive training curriculum for the 34 PDOCS, the 6 grant and contract specialists housed in the regions, and 6 Regional System Program Directors. The training encompassed 20 critical training areas that were delivered in four sessions, four hours per session. The goals of the training were to:

- Create consistent expectations across services
- Provide tools and supports to allow PDOCs to fulfill responsibilities
- Strengthen partnerships and communications among DCF staff to improve service development and evaluation
- Strengthen partnerships and communications with providers

2. Results Based Accountability (RBA) Performance Outcomes for all POS Contracts:

Beginning in June 2014, the Contract Management Unit has been working diligently with PDOC and community providers to establish RBA performance measures for all 81 program service types and across 135 service providers. RBA is a model of performance outcomes that are designed to:

- Promote better results for children and families
- Increase provider accountability
- Focus on whole populations as well as program performance
- Target spending to programs that work
- Help address challenges with under-performing systems

An initial review of the agency's contracts library showed that almost every service type had an outcome section as part of the contract, but on closer inspection, many of the items

identified as outcomes, did not meet the standard for RBA performance measures: the amount of services delivered; the quality of the work; and whether anyone was “better off

The department committed to ensuring all contracts had RBA performance measures; and as part of that effort, a review of the contract library was performed to determine whether there were performance measures in each scope of service, and to catalog those performance measures by the type of measure. After determining which measures would need to be re-written, department staff prioritized the work to establish RBA performance measures in all the contracts.

Programs were prioritized based on three criteria: the program’s importance to the Commissioner’s goals, the amount of dollars spent on the service type, and the number of locations where the service was being offered. Based on those criteria, programs were ranked as high, medium, or low priority.

After the initial three-tier prioritization of programs, a second level prioritization of each program was performed, based the level of effort it would take to modify the outcome section so that it would be RBA compatible. Programs were rated as “1” if it would not take a lot of work to change their performance measures; with a “2” if it needed a moderate amount of work but not an entire overhaul; and with a “3” for programs that would need a significant amount of effort to develop performance measures.

The two rankings were combined, and the work began with the programs ranked highest priority and relative ease: those with a ranking of “H-1”. That way the department was able to create traction and impact while still ramping up the process.

Currently, work has been completed on 80% of programs. By the end of SFY15, the work should be completed for 85% of programs, with the remaining 15% completed by the end of the first quarter of FY16.

3. The Tier Classification System:

The Contract Management Unit has recently embarked on a comprehensive process, in partnership with other Department units, to develop a contracted program classification tool designed to enhance the Department’s ability to evaluate contracted programs and create opportunities for ongoing Quality Improvement at a program and system level.

The overarching goal of the Tier Classification System is to ensure the quality, accountability, and effectiveness of outcomes in all Purchase of Service contracted programs. Additionally, the classification of contracted programs will enhance the Department's ability to support decision making toward the improvement of client outcomes while providing support to the contracted provider network.

4. The Contract Management Unit Website (Share Point):

The Contract Management Unit developed and launched a new website for Department staff featuring a thorough description of the areas of work that the Contract Management Unit manages: Purchase of Service Contracts, Personal Service Agreements, the Contract Management Library, Credentialed Services, Rate Setting, Procurements and Requests for Proposals, Amendments, and Budgets. The website also contains a wealth of information in provided links, documents, forms, and lists for all of the above services to assist Department staff with the necessary tools to navigate their work as it relates to contracts.

Populations at Greatest Risk of Maltreatment

Analysis of the Department's SACWIS data indicates that children ages 0 -3 are at the greatest risk for maltreatment. The below data further explicates that Hispanic and African American children between the ages of 0-3 have the highest rates of abuse and neglect.

AGE GROUP	DEMOGRAPHIC	VICTIM	POPULATION	Rate / 1000
0-3	ALL	2136	159583	13.38
	MALE	1105	81626	13.54
	FEMALE	1020	77957	13.08

	Hispanic	726	36392	19.95
	Non-Hispanic, Black	413	17479	23.63
	Non-Hispanic, White	760	87534	8.68
	Non-Hispanic, Other	237	18178	13.04
4 - 17	ALL	4736	657432	7.20
	MALE	2219	336570	6.59
	FEMALE	2488	320862	7.75
	Hispanic	1485	117833	12.60
	Non-Hispanic, Black	963	70965	13.57
	Non-Hispanic, White	1828	412258	4.43
	Non-Hispanic, Other	460	56376	8.16
0 - 17	ALL	6872	817015	8.41
	MALE	3324	418196	7.95
	FEMALE	3508	398819	8.80
	Hispanic	2211	154225	14.34
	Non-Hispanic, Black	1376	88444	15.56
	Non-Hispanic, White	2588	499792	5.18
	Non-Hispanic, Other	697	74554	9.35

Noting that young children seem to more vulnerable to fatalities and other poor outcomes, the Department embarked upon a case control study two years ago. The Department reviewed 124 fatalities involving children ages 0-3 that occurred from January 1, 2005 - May 31, 2014.

A sample of 124 DCF involved cases from the same period that did not have a fatality were also reviewed for comparative purposes. Some factors that the study identified as being more greatly associated with an increased risk for a fatality are as follows:

1. Child Age: Age is one of the most important factors associated with child fatalities.

The older the child is, the less likely the child is to die. Children less than 6 months of age are at greater risk for a fatality.

2. High Risk Newborn: Children who are high risk newborns due to medical issues were more likely to experience a fatality
3. Age of the Caregiver: Younger parents, generally between the ages of 20-24, were more greatly associated with a case involving death of a child under the age 4.
4. Behavioral Health: Caregivers with behavioral health needs, particularly those that are untreated, were associated with cases where an early childhood fatality occurred
5. Substance Abuse: Cases where there was evidence of parent substance abuse were more at risk for a child fatality.
6. CPS Reports: Families with a number of CPS reports (substantiated and unsubstantiated) were shown to be at greater risk an early childhood fatality

The Department observed that a couple protective factors that seemed to reduce the risk for a fatality included:

Assessment of Parents' Needs: Conducting initial and/or ongoing comprehensive assessment that accurately determined the needs of parents, were less likely to be fatality cases, compared to those where an agency did not make such an assessment. This suggests that an initial and/or ongoing comprehensive assessment may have a protective effect against child fatality. Given that half of the cases had these types of assessments conducted, it is recommended that the agency continues efforts to implement concrete actions to ensure comprehensive assessments for DCF involved families with children ages 0-3.

Caseworker Visits with Parents: Cases in which there was sufficient frequency of visits between the caseworker and parent were less likely to result in a fatality. This suggests that a sufficient frequency of parent-caseworker visitation may have a protective effect against child fatality. Therefore, it is recommended that efforts continue to ensure cases have a sufficient frequency of parent-caseworker visitation particularly for homes with children ages 0-3.

As a means to potentially reduce fatalities, the Department is partnering with the Eckerd Foundation to implement Rapid Safety Feedback (RSF). RSF is a qualitative review and

predictive analytics approach to identifying children who may be at increased risk for a critical or lethal maltreatment related outcome. It was highlighted as a promising practice in the Commission to Eliminate Child Abuse and Neglect Fatalities' recently released report. The Department will be focusing on its In-home cases and those investigations where a family has three or more accepted reports. RSF should begin end of summer 2016.

[Services for Children under the Age of Five](#)

Child First

Child First is a two-generation, intensive, home-based, early childhood intervention serving the most vulnerable young children and families, prenatal through age five years. Health and Human Services (HHS) has designated Child First one of the 17 national, approved, evidence-based home visiting models. Scientific research demonstrates that trauma and adversity, including maternal depression, substance abuse, domestic violence, and homelessness, lead to child abuse and neglect, as well as poor child developmental and mental health outcomes. The Child First model directly addresses these risks through (1) comprehensive assessment and treatment planning for the parent/child relationship and supports to the whole family, (2) a home-based, parent-child intervention which builds the nurturing relationship, protects the developing brain from chronic stress, and optimizes child social-emotional development, learning, and health, and (3) comprehensive, wraparound services and supports for all members of the family, to decrease the stress which is toxic to the developing brain. The primary method of treatment is the use of trauma-informed Child-Parent Psychotherapy (CPP), as developed by Dr. Alicia Lieberman, in order to strengthen the attachment between the parent and child and thereby increase the capacity of parents to nurture and support their children's development. Further, the model works to build parental executive functioning capacity. Child First includes broad collaboration among early childhood and adult providers, parents, and other stakeholders, which promotes an integrated system of community-based services and supports.

Child First currently has annual capacity to serve 1,004 children and their families per year in CT through MIECHV and DCF Funding. Child First affiliate sites were strategically placed in all

DCF Regions such that there is an affiliate serving each DCF Area Office. Even with active triaging of children and families to other less intense services the waitlist for Child First Services always remains around 300 children statewide. With an average length of stay of seven months, significant improvement is noted in the following areas:

- Decrease in child behavioral problems
- Improvement in child social skills
- Improvement in child language development
- Strengthening of the parent-child relationship
- Decrease in maternal depression
- Decrease in parent stress

Child First Inc. will also look specifically at extracting outcome measures by race and ethnicity. Child First is planning to add assessments to specifically measure the effects of the intervention on both child and adult executive functioning skills. Along with emotional health, these skills are critical for both success in school and in parental employment.

Child First continues to plan a second randomized trial with RTI (Research Triangle Institute, an international research organization) to develop a second RCT that will include a broader age range (birth to age six years), across multiple sites, including additional outcomes, and following longitudinally. This will be funded by philanthropy. It is required by DCF for Medicaid reimbursement. The Child First will soon be replicated in both Florida and North Carolina, and is still receiving inquiries from over 25 states.

Mental Health Consultation to Childcare

The state-funded CT Early Childhood Consultation Partnership (ECCP) is an evidence-based (three random controlled trials) and nationally recognized early childhood mental health consultation program designed to meet the social and emotional needs of infants, toddlers, and preschoolers. The program builds the capacity of families, caregivers, and providers by offering support, education, and consultation to promote enduring and optimal outcomes for young children.

The population served includes early childcare and education staff, DCF-involved biological parents, foster, and adoptive parents, and any other caregivers in a child's life providing services to families and children ages Birth to 60 months (5 years old) and Birth to 72 months (6 years old) for DCF children in Foster Care, with challenging behaviors and/or social and emotional needs. Services may also be provided to DCF-involved women and their children housed in substance abuse residential programs.

The geographic area served is statewide. This project has 24 full-time mental health consultants, including 5.5 FTE funded by the CT Office of Early Childhood.

The estimated number to be served is 150 early childcare centers, 400 teachers and assistant teachers, 90 Core Classrooms, 1,200 children within the Core Classrooms, 120 "at risk of expulsion/suspension" children and 400 service visits to involved families per quarter.

In the most recent quarter completed (1/1/16-3/31/16) 142 Early Childcare Centers were served, 388 teachers and assistant teachers were served, 95 Core Classrooms were served, 1,461 children were served within Core Classrooms, 147 "at risk of expulsion/suspension" children were served, including 57 DCF involved children, and 438 service visits were made to involved families. 100% of children with Child-Specific services were not suspended/expelled as indicated at the one-month follow up visit.

In SFY 2016 ECCP has served 3,015 children with classroom services and individually, 222 centers, and 789 teachers and assistant teachers. 100% of children who received Child-Specific services were not suspended or expelled at the one-month follow-up visit after completion of services.

ECCP continues to be seen as the nation's "Gold Standard" for early childhood mental health consultation services, particularly due to its manualized approach, information system, training, delivery strategies; and random controlled trials.

Connecticut's Early Childhood Consultation Partnership (ECCP) has received major national attention in the past year, including:

- ECCP Program Director Elizabeth Bicio, LCSW was identified by Georgetown University and the National Office of Head Start as an expert leader in the field of I-ECMHC and through Advanced Behavioral health (ABH) was selected to contribute to national learning materials and to work as a part of a national expert panel to begin to establish a set of national Early Childhood Mental Health Consultation (ECMHC) competencies to guide the work in the field.
- ECCP was invited, by the Early Childhood Development Administration for Children and Families U.S. Department of Health and Human Services to present at the BUILD Conference in July 2015, the presentation session focuses on how states can support children's social-emotional and behavioral health and prevent detrimental practices like expulsion and suspension in early childhood settings. CT focus is on the ECCP early childhood mental health consultation model across early childhood settings as well as a brief overview of Connecticut's new policy on expulsion and suspension practices in early learning settings.
- PA 15-96, was passed into law. Elizabeth Bicio of ABH-ECCP was invited to sit on a state panel of experts to provide support related to implementing the bill. ECCP is identified as the mental health model expert, to weigh in on providing some ideas/resources/solutions to those who are anticipating that its implementation will be challenging.
- ECCP was profiled in a national project "Learning about Infant and Toddler Early Education Services" (LITES): Identifying What Works and Advancing Model Development. The project was conducted for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services. (March 2016)
- ECCP was selected by the Substance Abuse and Mental Health Services Administration (SAMHSA), HRSA Health Resources and Service Administration

(HRSA), Administration for Children and Families (ACF) and the Education Development Center, Inc. (EDC) to join the national expert leadership team for the Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC). The Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC) Training and Technical Assistance is managed through a contract between the Substance Abuse and Mental Health Services Administration (SAMHSA) and Education Development Center, Inc. (EDC).

- ECCP is highlighted in a national document from the Administration for Children and Families (ACF) U.S. Department of Health and Human Services; “State and Local Action to Prevent Expulsion and Suspension in Early learning Settings: Spotlighting Progress in Policy and Supports,” A snap shot of the innovative policies and support strategies State and local leaders around the country are putting into place to prevent, reduce, and ultimately eliminate expulsion and suspension practices in early learning settings. (To be Released 2016)
- ECCP participated in the 2015 National Conversation: Faith Based Childcare Settings and Expulsion Intersection.

The **High Risk Infants Program** is a service for pregnant, incarcerated mothers who are at the Janet E. York Correctional Institution (YCI) in Niantic, CT. This service provides assessment, prenatal education, birth planning, case management, medical care, and referrals for pregnant women who will deliver babies while incarcerated, those who will deliver a baby shortly after being released from YCI, and services for post-partum mothers who remain incarcerated following the birth of their children.

The case manager for the program is affiliated with Lawrence and Memorial Hospital in New London, CT, where most incarcerated mothers will deliver their babies. In some circumstance mothers deliver their babies at UCONN Medical Center or Yale New Haven

Hospital. These are special circumstances when deliveries are considered high risk or there are mental health or safety concerns regarding the birth mother.

This service offers a complete individual baseline assessment of each referred pregnant inmate and a care plan for the safe placement of her newborn infant if the mother remains incarcerated through her delivery. The case manager conducts a child protective services background check of all potential alternative caretakers identified by the pregnant incarcerated mother. In addition, the case manager provides referrals for follow-up health care, including services such as WIC, Healthy Start, Birth to Three, and Help Me Grow to mothers or extended family who will be caring for the infant. Also, this service offers a weekly support group for post-partum inmates.

Monthly meetings are held between L&M Hospital, DCF, YCI, and the UCONN Medical Center to discuss the inmate mother's and infant's needs and program improvement.

There is also a Quarterly Board of Advisors meeting designed to coordinate services and develop solutions for this target population across the child welfare, hospital and correctional systems.

The purpose of this service is to decrease involvement with Child Protection and place infants with family. There continues to be consistent improvement in this area. In fiscal year 2013 - 2014, there were 20 infants born to incarcerated mothers at YCI, and 13 infants were placed in DCF foster care upon birth (65%). However, in 2014 - 2015, there was remarkable improvement in these numbers as 9 infants were born to incarcerated mothers at YCI, and only 2 were placed in DCF foster care (8%).

Therapeutic Child Care, operating within a licensed child day care program, is designed to promote, develop and increase the social emotional development and cognitive capacities of young children affected by abuse and neglect and who also have serious behavioral health issues by providing a specialized therapeutic and trauma-informed program for these young children and their families. The target population is children ages 2.9-5 years old. The

program is offered in three area offices in different regions in the state and serves approximately 30 children per site. This represents an expansion into 1 additional region. These programs differed in service delivery, staffing, and funding; the Department has worked to create greater consistency in scope of work and outcomes through network meetings and training opportunities.

The greatest number of admissions were boys. In addition, Black and Hispanic boys and girls were referred/admitted more often than children of other ethnicities. As the Department collects more meaningful data, we will be able to identify the reasons children are referred to the program and analyze the demographics in a more meaningful way. Through the meetings with providers, we have observed that externalizing behaviors are more likely to result in a referral which may help to explain why boys are referred more often than girls. We are in the process of revising the Gatekeeper's Screen to be more deliberate in our observation of internalizing behaviors.

Circle of Security Parenting (COS P)

Circle of Security Parenting© is a manualized, DVD-based, eight-session, attachment-centered parent education intervention. It is being provided in English, Spanish, and French. Circle of Security Parenting (COS P) equips parents and other attachment figures (teachers, caregivers) with some basic relationship capacities that help them provide a quality of relationship with infants, toddlers, children, and students that builds, supports, and strengthens secure attachment. This is crucial because it is within quality relationships that various capacities needed by kids to thrive in life are built. These capacities include curiosity, self-regulation, and perseverance, joy of learning, connectedness, empathy, self-motivation, impulse control, comfort using power, and trust. Parents, educators, and caregiver learn to view children's behavior from a secure base and safe haven perspective and then identify the children's underlying need being communicated by the child's behavior. COS P equips parents, teachers, and caregivers to reflect on children's behavior, reflect on their reaction to the children's behavior, and reflect on the parenting they received in their own childhood. The capacity to reflect is essential to building a child's secure attachment. COS P also

addresses two forces that are crucial to kids being equipped to thrive in life. One force is the desire in every child to explore their world. The other force is the need to be welcomed in when experiencing distress. COS P helps parents be able to recognize and support both of these forces, which is highly supportive of children's healthy development. They also learn about the importance of repairing ruptures in relationships and how to do that.

The population served includes parents with children 0-12 years of age. Priority is given to parents involved with DCF. Caseload permitting and in consultation with the DCF area office, providers may serve parents referred by other community providers. Some programs have expressed interest in using COS P with parents of adolescents as they view the relationship tools gained from COS P very applicable parent relationships with their adolescents.

The estimated number of families to be served annually is not known yet since the first COS P training for staff and supervisors was held in March 2016.

DCF is training nearly 900 staff members and supervisors in COS P from spring 2016 through spring 2019. Priority is being given to staff and their supervisors from DCF-funded programs that serve families involved with DCF. The initial groups to be trained include staff and supervisors from the Triple P Program and from the Therapeutic Child Care Program. We also plan to target cities and towns in CT that are interested in developing a community-wide approach to build and support secure attachment and have the readiness to move forward in a cross-disciplinary way.

Progress in this past year includes the following:

Communities

- An early childhood coalition in Manchester is seeking funding from the Hartford Foundation for Public Giving to focus on young children's social-emotional development. They are interested in using COS P with parents, preschool teachers, and childcare providers.

Education

- Barbara Stern is a retired elementary school principal, and Pat Howley is a coach/consultant to principals through the CT Association of Schools. After being trained in COS P they developed a one-day day training to help teachers gain and apply an attachment perspective to students' classroom behavior and learning.

Teachers are reporting it is changing their teaching. This has been offered several times to pre-K and elementary teachers in Middletown Public Schools and in Meriden, CT.

- Middletown Public Schools is offering COS P groups to preschool teachers. This grew out of several preschool teachers receiving Barbara Stern and Pat Howley's training for teachers.
- CT River Academy is interested in creating a program for 9th graders that uses COS P concepts to better understand their relationships at school.
- Susan Avena is a developmental psychologist and former professor at Trinity College. She is working with Ledyard Public Schools to help them gain and apply an attachment perspective to students' classroom behavior and learning.

Licensed Family Child Care

- All Our Kin initially took 34 licensed family child care providers through COS P groups as a way to improve the social-emotional climate of the home child care sites. They are continuing offer opportunities for other providers to receive COS P.

Foster Parents

- The New Britain DCF office is working with Klingberg Family Centers to offer COS P to foster parents.
- Caregiver Support Teams are interested in having their staff trained in COS P.

Dept. of Mental Health and Addiction Services, Young Adult Services

- Elaine Flynn-York, Director of Prevention and Parenting Services, has had over 100 staff trained to offer COS P to parents in the Young Adult Services program. This includes several doulas. DMHAS YAS has a Perinatal Support Team (consisting of certified Doulas and in-home parent educators) as well as parenting peer mentors that are trained and deliver the COS-P intervention.

Nurturing Families Network (home visitation program for 1st and 2nd time parents)

- NFN approved the use of COS P as a group parenting intervention several years ago. Several NFN programs are currently doing this.
- NFN accepted our offer to train a small group of NFN home visiting staff to be trained in COS P and use in as part of their in-home intervention. This will be done through the Fair Haven Community Health Center's (FHCHC) NFN program. A discussion will be held with the FHCHC NFN staff, state NFN staff from the Office of

Early Childhood, and DCF to assess whether it would be worth adding COS P to other NFN agencies.

Birth to Three (statewide early intervention program)

- The Birth to Three Program at SARA, Inc. KIDSTEPS in Branford has trained Birth to Three staff to offer Circle of Security Parenting as part of their work with families. Staff are using COS P with a variety of families including parents with differing needs and children with special needs.

Churches

- The Urban Alliance works with 50 churches in the greater Hartford area. They recently started Thrive, an initiative to help young children become socially, emotionally and academically prepared for kindergarten. They are interested in working with churches to offer COS P to parents and to staff in church preschools.

Integration within Agencies

- Klingberg Family Centers has 23 mental health clinicians trained to offer COS P. They are working to integrate COS P into their agency have been offering COS P groups for staff, including clinicians, managers, and administrators. They have added a 90 minute overview of COS P to their new employee orientation. They are now using concepts from COS P to strengthen their supervision of their clinicians. They are reporting that families are successfully completing treatment quicker in their Child Abuse Treatment Services since they added COS P.
- Several agencies from DMHAS' Young Adult Services are now offering COS P groups for staff as a way to integrate COS P into their agencies.

Pediatricians

- Dr. Marjorie Rosenthal has added COS P to the group well-child visits she conducts at the Yale New Haven Hospital.
- Rocky Hill Pediatrics is now referring parents to COS P groups and hope to offer groups within their office.
- Middletown is letting local pediatricians know about COS P and availability of COS P groups for parents.

Child FIRST

- Child FIRST has trained many of its staff members to use COS P. Sites are offering COS P to parents on their wait lists.

Other Innovations

- EMERGE, a New Haven transitional work training program with the goal of providing recently released ex-offenders in the Greater New Haven area with the opportunity to end the pattern of recidivism, has incorporated COS P into their treatment program.
- People from a variety of disciplines (mental health, education, child welfare, occupation therapy, home visitation, higher education) with a shared interest in attachment have formed the Attachment Network of CT to help promote a focus on secure attachment.

Evaluation

- The United Way of Greater New Haven is conducting an evaluation of their Secure Start initiative. The Yale Child Study Center is using a variety of pre-post assessment instruments before, during, and after each COS P group. They are also developing a fidelity instrument.
- The University of Connecticut, Dept. of Psychology, is offering free evaluation services to interested agencies. They use five pre-post assessment instruments, score the assessments, and report their evaluation findings to the agency.
- All Our Kin conducted an evaluation of 34 family child care providers completing COS P groups. Results were very positive and were published in the Infant Mental Health Journal.

Systems Thinking

- While the initial focus has been on building capacity in CT communities to offer COS P to parents, the use of COS P has been expanding to reach educators, including preschool teachers, and family child care providers. This is expanding the capacity and opportunity for kids to have quality relationships not only with their parents but also with their teachers and other important caregivers.
- COS P is being viewed not just as an intervention that results in improved behavior, but, more importantly, it is equipping parents, teachers, and caregivers with new relationship capabilities. These relationship capabilities allow them to provide a better quality of relationship with infants and children that best equips them with the personal and relational capacities needed to thrive in life. These capacities include curiosity, self-regulation, and perseverance, joy of learning, connectedness, empathy, self-motivation, impulse control, comfort using power, and trust.
- Quality of relationship is particularly important within an infant/child's family because it creates the foundation for children's future development. Infants and children with a secure attachment have a strong, secure foundation for future development. Infants and children with an insecure attachment have a weakened

or even quite damaged foundation that limits or even severely damages their future development.

We are beginning to view communities and families from an attachment perspective. All infants and children have relationships with their parents. However, a large number, 40% or even more in higher risk communities, of these relationships are not of the quality that best equips and supports infants and children to thrive in life.

Early Childhood Child Welfare grant, “Strengthening Families, Infant Mental Health”

In 2011, The CT Department of Children and Families (DCF) was awarded the Early Childhood Child Welfare grant, through a partnership with the CT Head Start State Collaboration Office, Head Start/Early Head Start and the Connecticut Association for Infant Mental Health, which provided to 40 DCF and Early Head Start staff, an intensive series of 8 trainings on infant mental health in the Hartford/Manchester DCF Region.

The trainings were designed to create a shared knowledge base for staff, to promote a unified approach for working with families with complex needs and to enhance working relationships among staff from the various disciplines. In addition, the training provided an opportunity to participate in reflective supervision/consultation where participants learned about reflective practice, how to promote reflection in others and practice reflection through a series of activities. Reflective Consultation/Supervision is one of the infant mental health competencies and is recommended for all persons working with infants/toddlers and their families. The training provided to DCF/EHS staff by the Connecticut Association for Infant Mental Health seeks to integrate information about the relationships between infant/toddlers and their caregivers in a practical way. The goal of the training is to understand more about parents and their young children who are not well integrated into their communities, to understand their relationships and to reflect on what that means for one’s own work. The information is presented from a strength-based perspective.

The eight full day training series has, of this year, been delivered to DCF staff and Community Providers in all six regions. The training’s focus is on working with young children and their families who are dealing with unresolved loss and trauma and how that impacts

relationships, particularly their relationships with their infants and toddlers. The topics will be related to the Competencies for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

An average of 40-50 DCF staff and their partners have attended each series. Topics included "Understanding Infant/Toddlers and Their Families;" attachment, brain development, temperament, separation, sensory integration, the Challenges of Unresolved Loss and Traumas; Reflective Practice; Infusing a Trauma Lens into Infant Mental Health Practice; Cultural Sensitivity in Relationship-Focused Settings; Assessments and Referrals and Successful Visitation for parents and infants/toddlers. Continuing education credits have been offered by the Academy to social workers. In addition, reflective supervision training was provided and practice in reflective supervision was offered through face-to-face coaching sessions.

The response to the training series has been overwhelmingly positive. The CT-AIMH and the Department are planning to offer two statewide training 8 session training series in the coming year.

CT - Elm City Project Launch – In October 2014, the Department was awarded a \$4 million grant, covering a 5 year period.

The grant is designed to promote the health and wellness of young children from birth to 8 years by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. The intent is to strengthen and enhance the partnership between physical health and mental health systems at the state and local level. The grant targets the New Haven Dwight Neighborhood with a plan to expand to other communities in the New Haven area.

Three Guiding Principles:

1. *Promotes a **Holistic Perspective***: considers all aspects of children's development (physical, social, emotional, cognitive and behavioral health);

2. *Fosters an **Ecological Framework***: Development influenced by family, home, environment, school, and neighborhood
3. *Employs a **Public Health Approach***: Works to ensure all children have the skills needed to achieve developmental milestones.

Key Elements:

FAMILY CENTERED CULTURALLY AND LINGUISTICALLY COMPETENT

Prevention and Promotion Strategies:

1. System Integration: Increase Coordination and collaboration across systems
2. Evaluation: Process and outcome evaluation
3. Workforce Development
4. Public Awareness and Media Campaign

Five Key Strategies:

- Behavioral Health in Primary Care Settings
- Mental Health Consultation in Early Care and Education
- Enhanced Home Visiting
- Family Strengthening
- Screening and Assessment

Project Launch Outcomes:

- Improved access to services;
- increased screening and early identification;
- increased public awareness about issues impacting children (0-8); and
- enhanced knowledge and capacity of workforce intervening with children.

Key Staffing:

Young Child Wellness Expert Young Child Wellness Partner
Young Child Wellness Coordinator

Requires the Establishment of Young Child Wellness Council (state and local level)

DCF Partners:

DPH	Early Childhood Consultation Partnership
Clifford Beers Clinic	New Haven Public Schools
Wheeler Clinic	New Haven Mom’s Partnership
Yale School of Medicine	CT Association for Infant Mental Health
United Way	

CT-ECPL will focus on addressing the seven priority goals, listed below, that will aid in the development of a comprehensive system of early childhood supports and services for children birth to eight years and their families.

Goal 1: Increase access to screening, assessment, referral and linkage to appropriate services to promote physical and mental health for children ages 0-8 and their families.

Goal 2: Promote the integration of behavioral health in primary care settings through workforce development and enhanced communication among pediatric care settings and other providers who serve young children and their families.

Goal 3: Promote the development of a home visiting workforce that can effectively meet the needs of young children and their families in the local and state communities.

Goal 4: Expand evidence-supported mental health consultation services into early education settings.

Goal 5: Build and enhance the capacity of families to support the social/emotional development of children perinatal through age 8.

Goal 6: Facilitate Linkages and coordination between state level entities and coordinating bodies focused on promoting optimal outcomes for child and family health and wellness.

Goal 7: Implement a social marketing and public awareness campaign.

Connecticut’s Elm City Project LAUNCH provides the opportunity to evaluate New Haven’s resources, integrate systems in the community and state, and build on workforce development and public awareness to improve the health of children birth through age 8 and their families in New Haven.

Year one of the grant was focused primarily around planning and preparation for implementation of the LAUNCH work which included the following activities:

- Contract development and execution
- Hiring of staff
- Building relationships with the various providers and systems working with young children
- Conducting the Environmental Scan at the local and state level
- Collaboration with key partners to develop the Strategic Plan for the Launch Work
- Completion of CT-ECPL Evaluation Plan

During Year 2 of the grant, the following activities/accomplishments have occurred:

- Updated and finalized the Strategic Plan
- Finalized Evaluation Plan
- Embedded clinician in three pediatric practices to conduct screening of children during well-child visits. Over 400 screenings have occurred to date. Includes referral to services when appropriate.
- Clinician conducted screening training with staff from the local homeless shelter. Shelter staff have now incorporated developmental screening as part of their overall intake practice for families entering the shelter.
- Process the track referrals to services has been developed
- Collaborated with Child First to offer TI-CPP training
- The local Coordinator has been extremely successful in recruiting parents to participate in the local Young Child Wellness Council
- Local Coordinator was appointed as a member to the local Council
- Conducted EPIC training in multiple pediatric practices in the New Haven community
- Health Disparity information has been integrated into each EPIC training
- Developed and offered first home visiting 5-day training series to 17 individuals, representing 12 agencies/organizations
- Collaboration with New Haven school to hold a Health and Wellness Fair to share resources for students and their families
- Multiple presentations conducted with community agencies/organizations to share information regarding ECPL
- Decision made for the Early Childhood Cabinet to function as the statewide council. A subcommittee is being established to identify areas of focus and membership.

LAUNCH activities will continue to further the goals and objectives of the grant. Data is being gathered to document efforts. The public awareness campaign, data collection, and work related to the local and statewide councils will be areas of focus this upcoming year.

Early Childhood Community of Practice

The Department of Children and Families supports healthy relationships, promotes safe and healthy environments and assures that the emotional and social needs of children 0-5 are met. During the 2015-2016 fiscal year, the Early Childhood Community of Practice expanded its membership to include community stakeholders from the Office of Early Childhood, inclusive of the Office of Head Start. Partnering with the Office of Early Childhood, provided an additional clarity by which to view the work within the department. In months to come, the Early Childhood Community of Practice, will seek to engage other community partners as well. Some of the highlights of this fiscal year included:

- The development of an Early Childhood Practice Guide titled “Setting the Stage for Future Success” The intent of the Early Childhood Practice Guide is to provide a framework and important information to support child welfare staff in their work with young children and their families. Formation of the guide follows a child from the first entry point of the agency to the establishment of permanency. Staff from across the department were able to provide insight into their daily work with children age 0-5 in order to provide a context for the importance of this work.
- Agency campaign establishing the creation of a pictorial image to support the title of the practice guide. This image will be used as a marketing tool going forward within the area offices and the community.
- Creation of the Early Childhood Policy

As part of the Early Childhood Practice Guide, an implementation plan was developed and approved by senior leadership to ensure the guide is reviewed and utilized in all aspects of our work. Leadership meetings are currently being conducted to provide a basic orientation

to the guide, share regional data, and share components of the implementation plan. An on-line training program is being developed with an anticipated completion date in July. All staff will be required to participate. Statewide calls and regional learning forums will also be completed. This will continue to be an area of focus this upcoming year.

During the 2015-2016 fiscal year, The Early Childhood Development Training” Promoting Health and Wellness for Infants Toddlers and Preschoolers in Child Welfare, was offered twice. There were 109 participants who participated from DCF and Head Start. The training series has been expanded to five days. The series consists of a compilation of trainers from the community and internal to DCF who have experience in the topics of child development, poverty, trauma and brain development. An additional cohort will begin in June 2016.

[Services for Children Adopted from Other Countries](#)

The Adoption Assistance Program (AAP):

The Department of Children and Families contracts with the University of Connecticut Health Center to provide post-adoption services to families that have adopted children from DCF’s custody. They also provide service to relative families who have come from the state's subsidized guardianship program. Within available funding, services may be provided to families who have adopted privately or who have adopted internationally. This program is based on an employee assistance model, i.e., to provide limited interventions and/or make referrals to local services for families experiencing a variety of problems that may or may not be directly related to adoption. This service is free of charge to families. The AAP has developed four community case managers based in 4 major geographies in the state. The Community Case manager also provides in home assessment of the family's needs and assists in coordination of appropriate services. AAP also manages the post finalization services from a program that DCF offers for children after adoption finalization. Within the context of PPSP each child adopted from DCF's foster care system is eligible for an additional 100 hours of support services from 21 CT child placing agencies.

Although the majority of their work encompasses DCF involved families, they do provide

support to a small percentage of families who have adopted children from other countries.

In 2007 the Adoption Assistance program, in concert with state adoption stakeholders, developed the "Adoption Community Network". The network's design was a collaboration of: adoption agencies, both private and public, adoptive parents and related adoption professionals. As a result of this work, the first ever website was created to manage the work of the Network. It is a source of information, training opportunities, support services and has links to state and national information regarding adoption.

As of April, 2014, there are 368 adoptive parents and professionals that have requested inclusion on the community network email distribution list. The network hosts quarterly meetings that bring adoptive parents and professional together to talk about current issues and trends in adoption and share information about resources.

5. Program Support

Staff Training

The Department of Children and Families (DCF) operates an internal Academy for Workforce Development with the primary responsibility of offering pre-service training, in-service training, and coaching to both DCF employees and community providers upon request.

The DCF Academy provides competency-based, culturally-responsive training in accordance with national standards for practice in public child welfare. The Academy encourages staff and its community partners to pursue professional education and to utilize learning opportunities to improve their work with children and families. An array of professional development programs are offered on a regular basis. The Academy offers pre-service preparation and in-service training to experienced employees and community service providers to ensure those who work with children and families possess the necessary critical information, knowledge and skills to serve them with the highest level of professionalism.

Post Masters Certificate Program

The goal of the Post Masters Certificate Program is to train child welfare professionals, community mental health providers, adoption services providers, and private practitioners to establish a cadre of adoption competent professionals in the community who can offer post adoption services with clinical expertise to children and families, particularly those who have adopted through DCF.

The Certificate Program is a collaboration of the University Of Connecticut School Of Social Work (UConn-SSW), Southern CT State University (Southern), DCF, and the Adoption Assistance Program at the UConn Health Center. This evidenced-informed training consists of thirteen class sessions held monthly from March to October, which alternate between the two universities. In addition to the classes, six case consultation sessions are provided to enhance the transfer of learning and additional case specific support. The program focuses on cutting edge practices used on a national level to improve services to children and families dealing with a myriad of issues related to permanency. Cross training between DCF staff and providers also creates an opportunity for collaboration and the creation of a shared vision of practice. The feedback from this training program continues to be overwhelmingly positive and has received national attention. The Center for Adoption Support and Education recently requested that this model be used as a demonstration site for the implementation of Training for Adoption Competencies (TAC) program in an effort to create national standards for training on adoption. The 2015-2016 cohort consisted of six DCF employed staff. The TAC students are asked to assess their pre-and post-training levels of competency on thirty-five core competencies. The training is designed to move students from beginning levels of awareness and knowledge to regular, effective application in practice. Feedback reflects consistently positive ratings of TAC quality and relevance.

MSW Field Program

The MSW Field Program began in 2004 in response to a need for additional staff development opportunities for those DCF employees seeking an MSW degree. The program is a replacement for the SWIP (Social Work Internship Program), which is now defunct. First

and second year students as well as advanced standing students have benefited from the program. Priority is given to students seeking their second-year field placement. The intent of the program is to foster support of our social workers by allowing them to meet their university requirements for 20 hours of field instruction within their regular 40-hour work week. In essence, no additional field instruction hours are required outside of the regular work week.

A major component of the program is that it allows the social workers to use their place of employment as their field instruction, while maintaining their current caseload within their current unit. A field instructor outside of the student's chain of command is utilized to ensure a separation of work and learning responsibilities. This supports the agency standard of limiting shifting caseloads. It also benefits the families and children served as they are able to maintain continuity of social workers. Finally, it benefits the social worker as he/she is given the opportunity to keep the caseload they are familiar with, yet learn to service their clients more effectively with predictably better outcomes. Flexibility also is available on a very limited basis to reassign cases or employees to other units to give employees a different learning experience on an as-needed basis and with the consent of the University involved, student's chain of command, MSW field instructor and DCF Workforce Development Academy.

Additionally, the program prepares students to look for opportunities to provide service "above and beyond the norm;" identify gaps in service delivery and provide solutions; and gain better understanding of DCF as a whole. All of this is accomplished by adhering to a strength-based perspective in keeping with the agency's mission. To date, the program continues to be successful. It has been heralded by social work supervisors, participating universities and students, as they appreciate the new perspectives on cases and learning opportunities for students.

Through a competitive interview process, in 2015-2016 nine students participated in the program and successfully completed their field placement. In 2016-2017, ten students will be accepted into the program.

DCF Stipend Program

Internship programs are one of the most effective recruitment strategies used by many professions. These programs are mutually beneficial to both the students and the agency, as the on-the-job experience is a perfect opportunity to determine suitability for the job. Special emphasis has been placed on marketing the internship program as a recruitment tool for child protective service workers. In the fall of 2010, the Academy launched its first student stipend program for external students interested in employment at DCF. In this competitive program, students in their final year of a BSW or MSW program are selected to participate in an internship process in a regional office where they receive orientation, training and real-time experience handling child welfare activities. Students receive a \$3,000 stipend to offset the cost of their education and are required to meet agency practice standards. Upon graduation and receiving a recommendation from their field supervisor, students must repeat a background check and an interview process. If successfully completed, students are prioritized in the hiring process. If no positions are available three months after their graduation date, students are released from any obligation to wait for employment or repay the stipend. To date, 10 students have successfully completed the program. The Academy has developed a process to streamline the students' applications to the Department's Division of Human Resources who has agreed to prioritize hiring to this intern cohort. This strategy will increase the number of students who apply to the Department and increase the number of qualified applicants being considered for employment.

NCWWI University Partnership

The DCF Workforce Development Academy, in partnership with the UCONN School of Social Work, is the proud recipient of the National Child Welfare Workforce Institute - CT Partnership for The Child Welfare Excellence grant. The CT Partnership offers the opportunity for the UCONN-SSW and the DCF to collaborate with the goal of refining and strengthening foundational and child welfare-related curricula content to reflect the knowledge and skills that address the increasingly complex needs of diverse families and children served by public child welfare agencies; thereby enhancing competency levels of the CT Partnership trainees and other students alike. In addition, it provides the opportunity to

collaborate on mutual objectives of addressing the need to increase the knowledge, skills, abilities and diversity of the public child welfare workforce by targeting recruitment for masters level trainees from within populations under-represented (Hispanic, male, linguistically diverse) in the current DCF welfare workforce; and to increase the pool of masters level, professionally trained social work graduates as one key strategy that can improve the quality of public child welfare practices and outcomes.

The Partnership will result in 35 Master of Social Work (MSW) graduates over a five year period, who are either currently employed at the Department or who will receive priority consideration for employment. The first year's cohort in 2014-2015 included one DCF employee and six students in the traineeship program. Of this cohort, all students received employment in the field with four being employed by the Department. The second year cohort included eight students, two of which are DCF employees. To date, two students have been hired and the remaining students have pending applications. Students accepted in the program have their final year of graduate study paid in full through this grant (\$13,714). Students choose to spend 15 or 20 hours a week in their field assignments in any of the 14 DCF area offices.

Graduate Education Support (GES)

The Graduate Education Support (GES) Program is an educational program to assist DCF employees with two or more years of employment in obtaining either an undergraduate or graduate degree in the field of Social Work/Child Welfare. This program offers employees the opportunity to work a 32 hour work week and 8 hours of work time to devote to their internship. The internship placement can be either external to the Department or at a DCF location other than the current worksite. GES recipients are obligated to complete two months of employment of service for every month of participation in the GES program, equivalent to eighteen months. The 2015 cohort included nine employees that applied and were accepted. The 2016 cohort includes ten employees located across six area offices.

Training for new workers to ensure competencies

The DCF Academy offers a series of mandatory training modules over the course of ten

months to all new social workers hired to conduct child welfare-related case activities in the regional offices. The pre-service program is designed to prepare each staff member for effective protective service/child welfare practice. There are several components to the pre-service program: classroom training at the Academy, supervised casework experience in a training unit in the regional office, and practice level activities aimed at enhancing the transfer-of-learning process. Each new hire attends 31 days of training.

In 2015-2016 the Academy has focused its efforts on training 308 new social workers and social work case aides hired by the agency. The Academy has been successful in integrating new concepts into training related to racial justice, safe sleep, health and wellness, and permanency teaming.

Further efforts at enhancing the pre-service training program are being undertaken through partnership with the Capacity Building Center for States. Since the fall 2015, the DCF Academy has been working with the Center for States to increase the use of creative scenario-based and simulation training activities in pre-service training; as well as enhance our current evaluation and transfer of learning processes to ensure classroom content is having a positive influence on social work practice and outcomes for children and families.

Social Work Case Aides:

In 2015-2016 the agency hired ten Social Work Case Aides. These individuals were provided with a training schedule that would address their professional needs and provide them with the competencies and skills needed to perform their job. These classes included the following:

- Introduction to Best Case Practice
- Values/Ethics and Use of Authority
- Worker Safety
- Car Seat
- Racial Justice
- Trauma

- Documentation/Testifying/ Supervised Visits
- The Role of the Case Aide
- Intimate Partner Violence
- Substance Abuse
- Sexual Abuse
- Online Mandated Reporter Training

In-service training for caseworkers

The Academy continues to recognize the value of providing staff with an array of in-service trainings that will strengthen their competency level. In-service training is available to all staff and is offered throughout the year. Training classes are posted in an online catalog, and staff can "self-register" with supervisory approval.

Per agency policy, all staff must attend five days of in-service training annually. Compliance with this policy is tracked during the supervisory process and has recently been emphasized as a significant factor in the professional development process by agency leadership. The Department is in the process of designing a new computerized database system, which will allow for enhanced tracking of this policy. The projected launch date of the new system is 2018. To date this fiscal year the academy offered 275 unique in-service training sessions to staff.

Life Skills

The agency has embraced a new Life Skills Assessment tool titled "LIST." This assessment tool is intended to be administered to all children in the care of the Department from the age of 13 and older. From January 2016 to present the Academy has trained 1588 agency staff on this model. The training components included in-depth discussions on the importance of Life Skills, the origin of the LIST, expectations of youth in the LIST process, and factors determining who is eligible for the LIST and how referrals should be prioritized. In the upcoming months, the academy will also provide training to designated community programs on this topic.

“Partners in Change” (PIC) Statewide Conference Calls

The PIC calls have remained a consistent venue which allows for staff to learn about and discuss topics relative to trends and initiatives within the department. There have been five conference calls from August 2015 to present date. On any given call, we may have anywhere from 10-40 people participating. PIC topics have included the following:

- Genograms
- The integration of Intake in the Permanency Teaming Process
- Grandparents as caregivers
- Application of the LIST life skills tool
- Exploration of the 3 Houses Permanency Tool

Differential Response System (DRS) Training Series

From 2015 to the present, the Academy has continued to offer the Differential Response System (DRS) Training Series to social work staff from across the area offices and Careline. The DRS Training Series was offered on three occasions, with 89 unique staff participating. Components of this series included a strong emphasis on the following:

- DRS Best Practices
- Worker Safety
- Legal Issues
- Health & Wellness
- Drug Endangered Children (DEC) Program
- Human Trafficking

Adolescent Training Series

Over recent months, there has been a large emphasis placed on the adolescents in DCF care and ensuring they have the skills and supports necessary to be productive and successful adults. The starting point has to be the social worker and ensuring that they have the knowledge and competencies necessary to work with this population. From July 2015 to the present, the Academy has offered and held two ten-day training series for social workers

who maintain caseloads of youth between the ages of 13-23. To date, 62 staff have participated in the training series. Some of the topic areas included in this training series are:

- Normal Adolescent Behavior
- Trauma/Risk Taking Behaviors
- Parenting/pregnancy
- Substance Abuse
- Permanency

Juvenile Justice Social Work Training

In the Fall of 2015, the Juvenile Justice Social Workers gained additional responsibilities related to case management services. In order to address the professional development needs of the Juvenile Justice Social Worker and their supervisors, the Academy offered staff an array of courses designed to assist with the evolution of their current role and job function. These courses consisted of but were not limited to:

- Case Plan
- Link
- Legal
- SDM
- 10 day Adolescent Training Series

Yale Supervisory Training

The DCF Academy continues to support the critical role supervision plays in child welfare practice, and continues to partner with Yale University to provide a two-day training entitled “Strengthening Supervision.” The “Strengthening Supervision” model includes three phases of supervision (engagement phase, work phase, and ending & transition phase), which encompass four functions (quality of service, administration, support, and professional development). Supervision purpose, content, frequency, length, and documentation are significant components of the two-day training. Additionally, a large component of the model is grounded in the utilization of group supervision. Group supervision allows for diverse conversation, critical thinking, and effective feedback to play a role in critical case issues. The

Academy's efforts to support group supervision are discussed further below. Twenty nine supervisors were trained in the model this fiscal year. Additionally, Yale consultants provided coaching to supervisors and managers in ten area offices this fiscal year to support continued implementation of the supervision model.

Numerous efforts to specifically support the implementation of group supervision have occurred throughout this fiscal year. The Academy has continued to offer coaching to regional supervisory staff through a two-day coaching experience. Individual conversations between "coach" and supervisor are followed by actual group supervision sessions with the supervisors' assigned staff, first facilitated by the "coach" and on the second day of the process, facilitated by the supervisor. The session concludes with the "coach" sharing feedback, answering questions, and making recommendations for improvement. This fiscal year, two supervisors participated in this unique coaching experience.

In addition to the two-day coaching, Academy staff have embedded group supervision activities into the pre-service training curriculum, as well as the post-test trainees are administered at the end of their pre-service training. These activities have demonstrated to new staff the value, structure, and benefits of group supervision; and have oriented them to the process in preparation for real group supervision sessions with their units. Additionally, numerous affinity groups, such as the Nursing Community of Practice and Office Director Community of Practice, have participated in group supervision sessions facilitated by Academy staff. Finally, a significant component of a new in-service course offered to supervisors and their units, "Group Supervision & Team Building," exposes participants to the practice of group supervision while enhancing the team's understanding of their own development, needs, and strengths. To date, six supervisors and their units have participated in this new course.

Mastering the Art of Child Welfare Supervision

In July 2015, the Academy reinstated the Supervisory training entitled "Mastering the Art of Child Welfare Supervision" in order to address the training needs of newly hired supervisors. To date, 46 staff have participated in the training. The training series builds upon the Yale

Strengthening Supervision model and also allows the staff to focus on four major areas reflected in practice:

- Transitioning from Social Worker to Supervisor
- Building Staff Capacity and Promoting Excellence in Performance
- Building the Foundation for Unit Performance
- Case Consultation and Supervision

Leadership Academy for Supervisors (LAS)

Furthermore, the Department has entered into a partnership with the National Child Welfare Workforce Institute (NCWWI) to offer supervisors an opportunity to participate in the Leadership Academy for Supervisors (LAS). The LAS is a web-based leadership training for experienced child welfare supervisors. The curriculum consists of six online modules each based on the NCWWI Leadership Model. The LAS provides 21 contact hours of self-directed online learning, with two tracks to enhance learning transfer: a personal learning plan to develop leadership skills and a change initiative project to contribute to a systems change within the agency. The inaugural cohort began last fall and is scheduled to be completed in June of 2016 with an anticipated 20 participants completing the program. Many of the change initiatives proposed by the LAS participants could have statewide implications for practice.

In-Service for Managers

In January of 2016, the Academy offered training sessions designated for managers only with the rollout of the new catalog. To date, two classes have been offered: Public Sector Management and Managing the Money both taught by Commissioner level staff and extremely well received by managers. The Academy will be offering additional classes on Data Leadership and Who's Better Off: Achieving Quality Through a Racial Lens in June of 2016.

Leadership Academy for Middle Managers (LAMM) – Connecticut Version

In 2015, the Academy continued to offer the Connecticut Leadership Academy for Middle Managers (LAMM). Mirrored after the national leadership program developed by the

National Child Welfare Workforce Institute, this program is designed to enhance the ability of middle managers to apply leadership skills to the implementation of sustainable systems change aimed at improving the lives of children and families. This series of facilitated dialogues and structured learning experiences provide middle managers with an unprecedented opportunity to self-reflect and share their experiences as an affinity group.

The leadership competencies emphasized in the training include: Leading Change, Leading for Results, Leading People and Leading in Context. A basic working assumption of this model is that a flexible structure is necessary for creating the opportunity for each manager to explore and build on his or her own strengths and professional development needs. The process begins with assessing participant's leadership style and strengths. Participants then incorporate performance management, results-based accountability and organizational development tools to support the learning process. Like the national LAMM, each manager is required to identify a Change Initiative ideally to be at least partially implemented prior to the completion of the four month learning experience. Each participant is assigned to a "Super Coach" to provide support, leadership and guidance necessary to successfully implement their Change Initiatives. The 6 "Super Coaches" include four executive level agency staff, a Casey Family Program Strategic Consultant and a former DCF Deputy Commissioner. Additionally, each participant receives individual and group coaching from Academy staff and the Chief of Quality on an as-needed basis.

This program has far exceeded the expectations of the Department resulting in statewide changes in the system as a result of several successfully implemented Change Initiatives. Seventeen managers successfully completed the Connecticut LAMM during this fiscal year.

Leadership Academy for Middle Managers (LAMM) – National Version

Thirty five managers from across the state completed the National Leadership Academy for Middle Managers (LAMM) in September 2015. This three-day comprehensive training included 360 evaluations, along with pre- and post-coaching. Each participant is currently in the process of implementing change initiatives that will have an impact on agency practice.

Technical Assistance

With the benefit of the in-depth technical assistance, a full day meeting is scheduled to kick off a time-limited working group that includes key stakeholders in the development of a coordinated and comprehensive response to CAPTA legislation specific to the notification of substance exposed infants and the development of a Plan of Safe Care. In order to develop an effective system it is essential that all of the partners that have a nexus to this work inform the process, policies and protocols. The working group includes other state department representatives including; Office of Early Childhood, Department of Mental Health and Addiction Services, Department of Public Health, Department of Social Services, participation from the Connecticut Hospital Association, the State's FASD Coordinator, Practitioners inclusive of Pediatricians and Obstetricians and Gynecology.

Services to Substance-Exposed Newborns

Connecticut is presently receiving Technical Assistance (TA) from the National Center for Substance Abuse and Child Welfare (NCSACW) for the purposes of building a statewide infrastructure to address substance exposed infants. CT has used this TA for the following activities:

- The establishment of a statewide Fetal Alcohol (FASD)/Neonatal Abstinence (NAS) statewide coordinator,
- The completion of a shared values inventory with project partners to identify mutual priorities related to the six IDTA goals (screening and assessment, engagement and retention in treatment, data and information sharing, joint accountability and shared outcomes, services for pregnant women and substance exposed infants, and safety, permanency and well-being of children and families),
- The assessment of the state's capacities and needs related to FASD/NAS
- The development and execution of a statewide plan to address FASD and NAS
- Recommendations on how to conduct financial mapping to identify and maximize fiscal resources to support ongoing FASD/NAS efforts.

CT also received a 6-month extension of this TA through September 2016 to focus specifically on CT's efforts to address CAPTA requirements specific to SEI. This TA includes:

- 1 day TA to create a cross-system response, inclusive of all state entities involved in the development of a plan of safe care, such as hospitals, early childhood, and adult service providers with the purpose of establishing a multi-system response to SEI.
- Additional TA to support the implementation of the developed plan.

In 2015, DCF and DMHAS braided funding to hire the first-ever FASD Statewide Coordinator to oversee the development of statewide FASD and NAS policy and practices, and to serve as the primary point of contact for IDTA. Among the accomplishments are:

Collaboration & Outreach

- First-ever FASD Awareness Day held in Hartford- September 2015
- FASD Training held at CT Clearinghouse- October 2015
- Project Presentations to key stakeholder groups.
- Collaborating with health care systems
- Coordinating with SHIP: Maternal & Child Health Coalition/Behavioral Health Plan, Every Woman CT

Project Operations

- Executive Implementation Team and three established Work Groups meet monthly.
- Core Team continues to meet quarterly.
- Project's Five Year Strategic Plan completed
 - State plan presented to and approved by Commissioners DCF, DMHAS, DPH- February 2016
 - Strategic Plan presented to and accepted by the Core Team- March 2016
 - Some action steps completed, others are a work in progress
- Initial Strategic Plan Report is available- April 2016
- ABH FASD webpage updated and Strategic Plan and Report posted- May 2016
- Strategic Plan deliverables already in implementation stage:
 - Initial information gathered to reinvigorate a NOFAS affiliate- February 2016
 - Training for DCF Staff on FASD, Training Academy- 3 held Winter 2015
 - Outreach at Childhood Conversations Conference in Cromwell- April 2016
 - Developed Survey of Hospitals – SEI practices and protocols- April 2016
 - Training for foster/adoptive parents on FASD (MothertoBabyCT)- May 2016
 - Meeting arranged to discuss collaboration among key stakeholders to train medical staff on SEI and Safe Sleep using on line technology
- Short-term next steps:

- Finalize outcome measures under each goal of Strategic Plan
- Create a dissemination plan for 5 Year Strategic Plan
- Disseminate Hospital Survey on SEI protocols and practices statewide and analyze results
- Continue to work on deliverables beginning with Strategic Plan Year One Priorities
- Support DCF and allied agencies in developing policy and practice to further compliance with federal CAPTA law

The Department has received technical assistance from the University of New Haven and Central Connecticut State University on risk assessment of youth in the juvenile justice system. The Department has also received ongoing consultation from Georgetown University on workforce development, data development, community based programming, graduated responses, and quality assurance within the juvenile justice system.

Connecticut was one of 6 states selected to receive in-depth technical assistance (IDTA) from NCSACW to leverage, enhance and strengthen the existing Recovery Specialist Voluntary Program (RSVP) collaboration and its linkages across child welfare, addiction treatment, and family courts to improve outcomes for substance exposed infants and their families. The existing RSVP collaboration, established six years ago using in-depth technical assistance from NCSACW to develop and implement the RSVP program, exists between the Connecticut Department of Children and Families (DCF), Department of Mental Health and Addiction Services (DMHAS), Judicial Branch, Advanced Behavioral Health, Inc., (ABH), and the University of Connecticut Health Center (UCHC).

DCF applied for and obtained a 6 month extension of the IDTA to continue to enhance this collaboration and to specifically obtain IDTA on CAPTA requirements regarding substance exposed infants. There have been several accomplishments with the IDTA to date, including the development of a 5 year strategic state plan to address substance exposed infants, including Fetal Alcohol Spectrum Disorders (FASD) and Neonatal Abstinence Syndrome (NAS).

The Department has received technical assistance from the University of New Haven and Central Connecticut State University on risk assessment of youth in the juvenile justice

system. The Department has also received ongoing consultation from Georgetown University on workforce development, data development, community based programming, graduated responses, and quality assurance within the juvenile justice system.

6. Consultation and Coordination Between States and Tribes

Connecticut currently has two federally recognized tribes: the Mashantucket-Pequot Tribal Nation (MPTN) and the Mohegan Tribe (MT). The State has maintained open communication with both tribes consistent with previous years. Activity with the tribes is most often initiated after an accepted or non-accepted child maltreatment report to the State's CARELINE.

The CARELINE screens for MPTN involvement according to a select few case addresses (known streets exclusive to the reservation). If the case address is noted as a reservation MPTN address, the report is non-accepted and the CARELINE takes the lead in notifying the tribe of the report. The tribe then chooses to investigate according to its own policies and procedures, with its own established CPS resources. The State is not involved in these circumstances. There are other circumstances in which the tribal member has an address off-reservation; in these cases the State does take action similar to non-tribal cases. The State provides immediate notice to the Tribe of the report.

Contrary to the MPTN, the Mohegan Tribe does not have any members living on a formal reservation/tribal land. As such, all reports taken and accepted by the CARELINE are investigated (traditional Investigation or Family Assessment Response (FAR)) by the State and the MT provided early notice. Virtually all CT MT and MPTN (non-reservation) reports are serviced by the Norwich Area Office in DCF 's Region 3. Upon initial face to face contact, every accepted report of child abuse and neglect is screened for race and ethnicity demographics, capturing any ICWA information not initially indexed by CARELINE. Tribal affiliation is also screened and noted at this time. Results are stored in the State SACWIS system (LINK).

Most ICWA activity has centered on the State's federally recognized resident tribes. On occasion there is activity regarding tribes in the neighboring states of Rhode Island, Massachusetts, and New York. Also notable is the practice of both casinos to exercise Native American hiring preference in their gaming and hospitality enterprise; this has resulted in many (and all required) ICWA notices to be filed with Tribes across the nation and BIA.

There is a longstanding Memorandum of Understanding between the State and the MT. There is no similar agreement with the MPTN. With or without An MOU in place, the relations between the tribes and the local DCF office have traditionally been positive and characterized by good communication.

There are ad hoc meetings scheduled with the MT. The content of the meetings is oriented to the Memorandum of Understanding. This includes case specific discussion of State interventions with MT members. The State notifies the MT of all accepted reports regarding their members. Discussion is held in a confidential meeting at tribal offices. The meetings are also used as an opportunity to advise the Tribe of new State initiatives; recent past and present discussions have included Structured Decision Making, Differential Response System and Considered Child and Family Team Meetings for Considered Removals.

Regarding the MPTN, while no formal arrangement is in place for regular meetings, there is a well noted single point of contact, their Director of Child Protection.

As noted above, the State screens for ICWA compliance with demographic inventories/interviews at the point of all DRS activity. There are additional checkpoints that also capture/create safeguards for identification/notifications. These include genograms completed with families (at investigation or FAR) and revised by ongoing State social workers in the formulation and revision of case plans; internal multidisciplinary assessments for permanency (MAPS) in which State legal and Social work staff discuss cases in which legal intervention has transpired; as well as canvassing of all parties once court involved. Consistent with ICWA, all tribes are notified of State legal activity in writing, by

USPS certified mail. For the States' two federally recognized tribes, by working convention and courtesy, telephone notice precedes written notification.

Common Juvenile Court practice finds representatives of the two local tribes present, at least for initial proceedings. Neither tribe has a formally developed system of resources (foster/host homes/group care) that allows for a divergent path from State care, should removal from home become necessary. In 2013, the State adopted Considered Removal Child and Family Team meetings and in 2014, Child and Family Permanency Teaming was implemented. For tribal families, there is explicit instruction offered by the State that the family is welcome to invite tribal resources to these meeting forums.

Jurisdiction with the proceedings occurs with exclusivity to the State juvenile court system. The MT does not seek to transfer cases to its own court network and prefers to partner with the State in the Superior Court for Juvenile Matters. Conversely, the MPTN often exercises the option of jurisdiction moving to its court network.

There have been no ICWA compliance issues identified with the MPTN or MT over the last seven years. Newly hired Social Workers are trained on ICWA during pre-service training. Additionally, when local training opportunities arise, invitations are often issued to the tribes.

There has not been any recent negotiations with the MT or MPTN specifically as it relates to determining eligibility, benefits and services and ensuring fair and equitable treatment for Indian youth under the Chafee Foster Care Independence Program (CFCIP).

A copy of the State's most recent Annual Report will be provided to the tribes post submission.

7. Monthly Caseworker Visitation

Funding has been allocated to each region to develop plans designed to promote monthly caseworker visitation. All regions have decided to utilize funding to promote our permanency teaming practice, specifically focusing on engaging youth in the case planning process. It is anticipated that funding will be fully expended by the end of the federal fiscal year.

CT continues to do well in relation to monthly caseworker visitation. Frequency of visitation continues to be discussed and monitored in supervision. The implementation of permanency teaming will further enhance the quality of worker/child visitation as the model is designed to promote discussions around the child/youth's need for safety, permanency, and wellbeing. In addition, CT has also utilized funding to support training of supervisory coaches to support social workers in conducting purposeful visits with children and caregivers. Several cohorts have participated in Dr. Rose Wentz series. Training sessions will continue.

The Department will submit our monthly caseworker visitation data by 12/15/16 as required.

8. Adoption and Legal Guardianship Incentive Payments

In 2015, Connecticut received \$66,015 in adoption and legal guardianship incentive payments. Expenditure of these funds will be documented in a budget spending plan. Limited funds have been utilized to date. The intent is to utilize these funds for initiatives and activities that support the Department's permanency work, including searching, identifying and securing adoptive homes for those children/youth for whom a permanency placement has not been previously identified.

9. Child Welfare Waiver Demonstration Activities

Connecticut has no Child Welfare Demonstration Activities.

10. Quality Assurance System

The Department's Quality Assurance system is spearheaded by the Division of Quality Improvement. It is responsible for coordinating a wide variety of efforts to systematically improve the Department's performance and the quality of its services. Overall, these efforts may involve the review of both systemic and or specific cases to determine if those cases could be handled more effectively or to learn lessons that could be applied more broadly. They also involve the collection and analysis of data on many cases, to identify areas requiring improvement and to determine whether improvement is actually occurring. In all cases, our efforts are guided by the conviction that the ongoing review and analysis of DCF's operations will lead to the improved performance across the entire Department. Quality Improvement is comprised of the following divisions:

- Administrative Case Review Division
- Ombudsman
- Quality and Planning Special Project
- Research and Evaluation

Section D: Child Abuse Prevention and Treatment Act (CAPTA)

CHILD ABUSE AND PREVENTION TREATMENT ACT (CAPTA) FFY 2016

The figures provided in the table below reflect anticipated expenditures. The programs are funded at levels that exceed the award amount. These programs are being supported through multiple year awards, including FFY 2015 and FFY 2016. The Contractors for the MDT's and Domestic Violence Services were selected through a procurement process.

Services/Activities	Total Funding	Fam Sup	Prot Svcs	Fam Pres	Reun Svcs	FP Recruit/Trng	AP Recruit/Trng
Multidisciplinary Teams	\$175,000		\$175,000				
Integrated Family Violence Services	\$8,436	\$4,218		\$4,218			
CCMC Injury Prevention Center	\$40,000		\$20,000	\$20,000			
CT Association for Infant Mental Health	\$39,382		\$39,382				
Dad's Matter Event	\$1,600		\$1,600				
FAVOR	\$36,828	\$7,365	\$7,368	\$7,365	\$7,365	\$7,365	
Total:	\$301,246	\$11,583	\$243,350	\$31,583	\$7,365	\$7,365	\$0

DESCRIPTION - CHILD ABUSE AND PREVENTION TREATMENT ACT (CAPTA)

Multidisciplinary Teams (MDT): The Governor's Task Force on Justice for Abused Children, first established in 1988, identified the need for greater coordination of agencies involved in the investigation, intervention and prosecution of child sexual abuse and serious physical abuse cases. The development of multidisciplinary teams that coordinate the early stages of an investigation has provided a means of maximizing community resources that strengthen and improve interagency response and interventions.

The purpose of Multidisciplinary Teams is to improve the investigation and prosecution of serious physical and sexual abuse cases while minimizing secondary trauma to the child. Connecticut has continued to recognize the inherent value of this collaborative effort. These teams have had a positive impact on the quality of work provided to child victims throughout the member disciplines. Connecticut utilizes state funding and the Basic Child Abuse Grant to support our Multidisciplinary Teams.

The development of teams has strengthened the joint DCF/law enforcement response and has promoted the use of trained forensic interviewers. The creation of additional teams has allowed prosecutors to have access to at least one multidisciplinary team in every judicial district in CT.

The following teams are funded under the CAPTA grant:

- Child Guidance Center of Southern Connecticut – Stamford
- Middletown Police Benevolent Association – Middlesex County
- Lawrence and Memorial Hospital – New London County
- Day Kimball Hospital – Windham County and portions of Tolland County
- Community Mental Health Affiliates – New Britain
- Charlotte Hungerford Hospital – Torrington
- Waterbury Youth Services System – Waterbury
- Clifford Beers Clinic – New Haven County

Statewide, a Program Quality Coordinator provides managerial and administrative oversight of MDT contracts and addresses issues or concerns related to service provision. The Department of Children and Families designee to the Governor's Task Force on Justice for Abused Children currently functions in this capacity.

Integrated Family Violence Program: Funding was utilized to provide support services while the department transitioned into a new model (IPV-FAIR).

CCMC Injury Prevention Center

Funding was allocated to expand the evaluation of IPV-FAIR program focusing on model fidelity, capacity and program outcomes.

CT Association for Infant Mental Health - See description under Promoting Safe and Stable Families.

Dad's Matter Event: The Department of Social Services, Department of Children and Families and the City of Waterbury will co-sponsor a Fatherhood Awareness Day 5K Race, 1 Mile Walk and kids fun run entitled "Dads Matter Too". The event focused on raising the awareness on the importance of fathers in the lives of their children and in our society. The day featured food, beverages, family friendly activities, face painting, games, vendors, resource booths for fathers and families, giveaways and live entertainment. Federal funding was used to provide T-shirts for all participants and the purchase of two bicycles to offer as a raffle prize.

FAVOR: There are a number of parent advocacy groups in the state that are designed to review Department practices specifically in the areas of behavioral health. FAVOR is a statewide Family Advocacy Organization for Children's Mental Health. Their mission is to enhance mental health services for children with serious emotional disorders by increasing the availability, accessibility, cultural competence and quality of mental health services for children through family advocacy. This organization agreed to broaden their focus and responsibilities and function as two of Connecticut's three Citizen Review Panels. In order to

support and encourage parental participation, the Department has agreed to allocate funding for members to receive stipends for transportation and daycare costs, as well as to assist FAVOR for associated meeting costs. The Executive Director of FAVOR continues to facilitate and coordinate meetings and oversee the work produced by the panels. The State Advisory Council (SAC) receives funding from the Department to support its CRP work. FAVOR functions as the fiduciary for the SAC.

[CAPTA Spending Plan FFY 2017 \(Proposed\)](#)

Services/Activities	Total Funding
Multidisciplinary Teams	\$175,000
Intimate Partner Violence-FAIR	\$50,262
CT Association for Infant Mental Health	\$39,382
FAVOR	\$36,828
Total:	\$301,472

Preventing Sex Trafficking and Strengthening Families Act, P.L. 113-183

The Governor's Task Force for Abused Children continues its efforts on the critical issues of Commercial Sexual Exploitation of Children (CSEC) and Domestic Minor Sex Trafficking (DMST) beginning in 2013. Each team was charged with coordinating training for their team with a goal to have every team trained in one year; as of January 20, 2015 all teams have been trained. In addition to the rollout of the training the Co-Chair of the Executive Committee has visited every team in an effort to meet the various team members, understand the local challenges and discuss the Human Trafficking initiative ensuring commitment across the state. As of July 2014 each team has been reporting monthly on the number of associated cases and outcomes to the Governor's Task Force: of the 94 unique CSEC/ DMST referrals in 2014 to DCF 21 referrals were reviewed by an MDT. There has been team restructuring to ensure the leads of this effort are grounded in DCF regions and the local

MDT's; new structure supports intensive case management, local service development and law enforcement collaboration. The HART Leadership Team has been restructured to include all the DCF HART Liaisons, 3 MDT Coordinators and the Director of the Connecticut Children's Alliance with specialty membership based on current team efforts. The HART Team has been restructured and is now tri-chaired including one DCF HART Liaison and one MDT Coordinator. The coordinator for the GTF is now a member of the Department of Children and Families (DCF) Human Anti-Trafficking Response Team (HART) and DCF local HART liaisons are accessing the resources of their local MDT teams. DCF received a new grant on September 30, 2014, Grants to Address Trafficking within the Child Welfare Population, Connecticut's Human Anti-trafficking Response Team (HART) Project providing the first trafficking related funds to support these efforts. The grant included a full-time HART Coordinator hired through the Village for Children and Families; entity providing the GTF Coordinator. The two Coordinator positions allow for optimal coordination and collaboration ensuring all aspects of these efforts are seamless.

The new HART grant has financially supported subcontracting with an independent evaluator, ICF Incorporated, LLC, evaluating our HART Project by completing a state-wide Needs Assessment and supporting the development of long-term project outcome measures. In addition, funds have been designated to enhance DCF's data collection system, Provider Information Exchange (PIE), with the ultimate goal at the end of the 5-year project to be fully automated; current indicators being collected manually.

The newly revised HART webpage went live in April 2015. The new site ensures state and national sharing of information and direct connections to the teams doing this work on a daily basis.

<http://www.ct.gov/dcf/cwp/>

The state of Connecticut recently passed legislation that went into effect on October 1, 2014 requiring MDTs to review human trafficking cases - Public Act 14 -186: An Act Concerning Department of Children and Families and Protection of Children allows HT victims classified as "uncared for" so CTDCF's Multidisciplinary Teams (MDTs) can provide immediate services

to victims and training to law enforcement on DMST. A new piece of legislation was submitted for the 2015 session: HB 6849, An Act Strengthening Protections for Victims of Human Trafficking:

- Section 1 expands the services currently provided by the Department of Public Health, including counseling regarding HIV and acquired immune deficiency syndrome, HIV-related testing, and referral services, to victims of trafficking in persons and other commercial sexual exploitation of children acts;
- Section 2 expands the membership of the Trafficking in Persons Council to include public members who work with child victims of commercial sexual exploitation and child trafficking victims;
- Section 3 permits a minor who has incurred a criminal record as a result of being trafficked to expunge the records immediately or, at latest, upon turning 18 years of age;
- Section 4 eliminates the requirement that force or threat of force, fraud, or coercion be used in sex trafficking of a minor under age 18. This section also expands trafficking in persons to include those who have knowingly assisted, enabled, or financially benefited from domestic minor sex trafficking;
- Section 5 expands crimes for which wiretapping can be authorized to include trafficking in persons, promoting prostitution in the first degree, aggravated sexual assault of a minor, enticing a minor, and employing a minor in an obscene performance;
- Section 6 makes an exception for commercially sexually exploited minors under the age of 18 from the listed ineligibility factors for filing an application for compensation, award of compensation and amount of compensation.

This legislation addresses all of the gaps identified by the Shared Hope Protected Innocence Challenge: State Report Cards from 2014. This legislation is currently on the House calendar; public hearings occurred in April 2015.

Trainings on CSEC and DMST have increased in Connecticut including but not limited to: 1) Introduction to CSEC and DMST, 2) Day 1 Basics of CSEC and DMST, 3) Day 2 Responding and Interventions, 4) Demand, 5) Boys and DMST, 6) CT POST training for law enforcement and

7) new foster care model. Over the year more than 40 trainings have been conducted training hundreds across the state for multiple audiences including but is not limited to Child Welfare staff, Probation staff, court personnel, law enforcement at all levels, legal representation at all levels, service providers, schools, medical providers including school nurses, universities including schools of social work and medical students and multiple community organizations including the faith based community. Several Training of Trainers (TOT's) have occurred and/or are scheduled to increase capacity ensuring state-wide coverage: 1) Introductions to CSEC and DMST, 2) Not a #Number, 3) My Life My Choice and 4) POST Certified Law Enforcement Training.

Service provisions for this population have increased now including Rapid Responses and the Survivor Care Program. The Rapid Response is a 1 time intervention with a youth to engage, safety plan and provide basic resources much of which is included in the Backpacks they receive during the intervention. The Survivor Care is a long-term service that is best described as a combination of intensive case management and 1:1 mentoring by a person specifically training in CSEC/DMST. The process of "training up" our service provider network continues allowing CSEC/ DMST referrals based on staff competencies. The new foster care model is in the middle of rollout; 12 agencies across the entire state have been trained and the training for the foster parents is scheduled for the end of May 2015. Specialized mentoring resources exist in two regions in the state; training of all mentoring providers will occur in May 2015 and a specialized training and curriculum will begin. Existing resources are being explored for this population such as Community Housing Assistance Program (CHAP) focused on transitioning youth into post-secondary education and Community Housing Employment Enrichment Resource (CHEER) focused on supporting transitioning youth to gainful employment.

There have been no changes in state law or regulations relating to the prevention of child abuse and neglect that would affect the state's eligibility for the CAPTA state grant.

Citizen Review Annual Reports

No Annual Reports from Connecticut's CRPs have been received to date.

Connecticut's State Liaison Officer:

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Section E. Chafee Foster Care Independence Program

Serving Youth Across the State

Connecticut is a state-administered child welfare agency with six regions. Contracting for services is a centralized function that ensures services are available across the state to all youth. Unique services can also be purchased locally through wrap-around funding if there are local gaps in the service array for youth. Connecticut's Chafee services serve youth through the age of 21. DCF have statutory authority to keep young people voluntarily in the care of DCF past their 18th birthdays and have recently expanded the services that are available to transition-aged youth. There are no systemic barriers in the state that preclude us from serving youth of various ages and at various states of achieving independence. In the 2015-2019 implementation period, DCF will be adopting a new independent living assessment and curriculum that is currently in use by the adult Department of Mental Health and Addiction Services (DMHAS). This assessment will be administered to all youth before they participate in Independent Living Skills training and post-training help prepare youth for success.

DCF utilizes both state and ETV funds to provide services to youth who have left foster care for kinship guardianship or adoption after attaining the age of 16. Through ETV funds, DCF oversees a grant program that provides up to \$5,000.00 per academic year to youth involved in a post-secondary program. In accordance with the Chafee ETV Program, DCF utilizes the

cost of attending an institution of higher education (as defined in section 472 of the Higher Education Act) to determine costs allowable under the Connecticut ETV program. DCF will continue to oversee the state's ETV program in the upcoming planning period.

CFCIP Program Improvement Efforts

The Department has a strong network of Youth Advisory Boards (YABs) that operate in each of its six regions. The YABs are comprised of young people in the Department's care who meet on a regular basis to provide feedback and recommendations about DCF's service array and practices. Representatives from the regional YABs convene quarterly at a statewide meeting with senior leaders at the Department, including the Commissioner.

This past year has seen the efforts of many present and past YAB members' efforts with the signing of the Adolescent in Care Bill of Rights and Expectations in June of 2015. Additional accomplishments include a very successful 4th annual Youth at the State Capitol Day and the releasing of a book of collected stories and poems written by Connecticut's foster youth called "Home, Voices of Connecticut's Foster Youth".

All regional and statewide boards participate in teambuilding and leadership days at our Wilderness School. These experiences seem to result in our having highly cohesive and productive boards. This year, the boards and their membership, have the opportunity to participate in a 5 day Wilderness School experience that will no doubt be life changing for those who participate.

Our youth's commitment to improving the lives of youth in foster care continue with this year's new initiative, to have a DCF Alumni Association available to all youth in and out of care. Through this association, foster youth will be able to connect with and receive support from former youth. Additionally, YABs will focus their attention on the needs of youth transitioning from care and the department will continue to use this forum to gather input from the youth to inform the services provided.

Additional efforts to provide youth in care normative experiences and in compliance with the newly signed Public Act 15-199, Connecticut established the Reasonable Prudent Parent Standard which allow caregivers to make decisions around a child's ability to participate in normal childhood activities without DCF or Court approval. This will undoubtedly allow children and youth in foster care to more easily participate in normative peer activities which. All private provider contracts now require programs to develop a policy, process and protocol for implementing these standards.

How CT provides youth with certain documents when they age out of foster care:

The department provides youth 18 and older who are discharging from care copies of the following documents: educational records; medical records including medical history of family members, to the extent known and obtained from the case records, as the law allows; original birth certificate and an extra copy; original social security card and an extra copy; passport; immigration and/or citizenship papers.

How CT includes youth age 14 and over more fully in case planning:

The department invites and encourages youth to participate and if possible to attend the Administrative Case Review (ACR). Accommodations are made to hold the review at a time and location that is convenient to the youth. At age 16, the department develops a Transitional Plan for each youth in the department's care for the purpose of permanency planning and preparation for discharge from care. The plan is youth-driven and based on the youth's identified needs prior to and at the time of discharge. The Transition Plan is reviewed at the first Administrative Case Review after the youth's 16th birthday and reviewed and revised at subsequent ACR's as long as the youth remains in care. The implementation of CR-CFTM and Permanency Teaming will promote active engagement of youth's involvement in case planning and decision making activities.

Planned use of funds (Chaffee) to support engagement in age or developmentally appropriate activities

The Department builds into the Chaffee grant funding for developmentally appropriate

activities as well as annually providing funding to each Regional Youth Advisory Board for such activities. Regions utilize these funds to sponsor activities such as college fairs, holiday parties and graduation celebrations.

National Youth in Transition Database (NYTD)

This year marks the beginning of the Department's ability to view and analyze NYTD Survey data as the first cohort completed their survey cycle (baseline, 19 and 21 years). Preliminary data suggests that most youth at age 21 have completed secondary education, have received some employment training and/or vocational training and, have high rates of unemployment or are underemployed. Additional survey information indicates more positive outcomes such as the majority of youth report having positive adult connections, health insurance and no children. The Department will continue to analyze this cohort data to see how it can be utilized in adolescent case practice, training and for service development and delivery.

The Department has increased staff efforts to locate and survey youth no longer in foster care and, as a result, has seen more youth participation. NYTD regional staff have begun to document efforts to locate youth as well as take the opportunity to collect and document additional information provided by youth. Youth are asked to voluntarily share their experiences while in care including what was the most helpful or beneficial service and/or experience and what was not. Additionally, youth are asked to share freely any thoughts or ideas that could help guide the Department with staff & service development and or service delivery. The Department will continually collect and review this information along with the NYTD survey data to improve its service delivery.

Lastly, review of the NYTD survey data has provided the Department with an opportunity to enhance the electronic data collection and reporting systems that will allow the NYTD staff to more easily identify cohort populations and information to assist locating youth for surveys.

NYTD Independent Living Services data is available but unfortunately, continues not to be used for service delivery improvements nor is it being shared with stakeholders. Data

elements collected for this report are based on several Adolescent Services Payment codes attached to youth that are available in LINK and do not include nor accurately represent many services that are paid for by the department through contracts or by fee for service. DCF provides services through “fee for service” payments as well as through contracts for many independent living services that provide one or more of the elements identified in the "Independent Living Services" data report and these are not reflected in this data, thus negatively skewing the number and type of services youth receive.

While there is a ‘snapshot’ format of the NYTD data, it can be used as a resource to talk with youth, providers, the courts, and other stakeholders about service and youth transitioning out of foster care. The Department continues to address the above issues by providing technical assistance and training to the staff who are assisting youth with completing the surveys so more accurate data can be gathered. Central office staff regularly contacts area office staff to alert them of surveys needing to be completed and assists with questions related to these surveys in order to better capture quality survey data. Additionally, the Department is in the process of redesigning the State SACWIS and this new system will allow for additional services to be captured by linking services to individuals in order to better capture the many independent living services provided to Connecticut foster youth.

Pregnancy Prevention

The Department continues to partner with the Connecticut Department of Public Health as part of their federal Personal Responsibility Education Program (PREP) with the goal to reduce the rates of pregnancy, STD/STI's and HIV among foster youth and at risk youth in Connecticut. The program will continue to focus on providing evidence based interventions to youth in and aging out of foster care, high risk youth in the community as well as youth involved with the juvenile justice system. Program interventions also include providing much needed training to caretakers of foster youth, service providers for youth in and transitioning from foster care as well as educators and providers for youth at risk in the community.

Additionally, this grant allows the Department to continue to offer staff development and

training to our Adolescent Social Work staff as well as to other professionals working with at risk youth, including juvenile justice youth involved with the child welfare agency. It is important for Department staff to continue to receive the latest prevention and intervention information that will allow them to provide the needed information and services to our youth who are at a higher risk for pregnancy, HIV, STD's and STI's.

[Coordinate services with other federal and state programs for youth.](#)

In November 2011, the DCF contracted provider for housing services for families, agreed to allocate existing contract funds to pilot a housing program for youth and young adults homeless or at risk of homelessness but could not re-enter the Child Welfare system due to ineligibility. The Homeless Youth Pilot Program was created a system of care to address the needs of youth aging out of foster care. The pilot's objective was to prevent or end homelessness for young adults struggling to maintain safe and stable housing. In this two-year model young adults have the opportunity to gain employment and/or vocational or higher education while living in their community, are offered case management services, linkages to services including mental health, substance abuse, and medical, along with an opportunity to re-connect with family, friends and build a new network of support and resources to maintain their success and continued growth into adulthood. The program was a great success, with 73 young adults stably housed or self-sufficient and connected to employment and/or educational programs and additional resources and services they need in their community within the first year. Due to the time limitations on the Federal FUP vouchers this program did not access or utilize these vouchers. The program has found that with its ability to assist with housing more flexibly and longer than the FUP voucher would, it was not effective. The program did help parenting youth and young adults access FUP vouchers when eligible as there was no time limit and more effectively provided stable housing.

In SFY 2015, the State Legislature re-instated the original \$1 million from the original 2010 Homeless Youth Project. DCF was also mandated to no longer leverage \$1.5 million in funding from the Supportive Housing for Families program but specify those dollars into a Homeless

Youth Program with its own funding. The program was re-named by young adult program participants to “Start”.

The new funding was allocated between the existing and newly named Start Program to build on the success of the existing program and allow for additional program components such as Crisis Response and Outreach services, to DCF involved youth and non-DCF involved youth ages 16-24. This additional component provided Street outreach for youth and young adults in the Hartford area, Emergency Housing for youth and young adults statewide, Family mediation, Survival aide, including, emergency food, blankets, coats, etc., LGBTQ Specific Services and access to the two-year transitional model.

Also, with the re-instated dollars DCF also allocated \$50,000 to the CT Coalition to End Homelessness to conduct the first annual Homeless Youth Count in 2015. With the support of these dollars Connecticut will be the first state to engage in a statewide effort to count homeless youth. The Count allows for DCF and the Department of Housing (DOH) to gather data on the length and number of episodes of youth homelessness, social networks, family relationships, and reunification with family.

How CT provides youth with certain documents when they age out of foster care:

The department provides youth 18 and older who are discharging from care copies of the following documents: educational records; medical records including medical history of family members, to the extent known and obtained from the case records, as the law allows; original birth certificate and an extra copy; original social security card and an extra copy; passport; immigration and/or citizenship papers.

How CT includes youth age 14 and over more fully in case planning:

The department invites and encourages youth to participate and if possible to attend the Administrative Case Review (ACR). Accommodations are made to hold the review at a time and location that is convenient to the youth. At age 16, the department develops a Transitional Plan for each youth in the department’s care for the purpose of permanency

planning and preparation for discharge from care. The plan is youth-driven and based on the youth's identified needs prior to and at the time of discharge. The Transition Plan is reviewed at the first Administrative Case Review after the youth's 16th birthday and reviewed and revised at subsequent ACR's as long as the youth remains in care. The implementation of CR-CFTM and Permanency Teaming will promote active engagement of youth's involvement in case planning and decision making activities.

[Describe any planned use of funds \(Chaffee\) to support engagement in age or developmentally appropriate activities](#)

The Department builds into the Chaffee grant funding for developmentally appropriate activities as well as annually providing funding to each Regional Youth Advisory Board for such activities.

[The Virtual Academy](#)

The Virtual Academy was established by Unified School District (USD#2) in February 2016 to serve secondary youth in the care (inclusive of Juvenile Justice youth) of Department of Children and Families. This creation was based on 2015 standardized assessment results in the state of Connecticut. The 11th grade results (Connecticut only takes standardized assessments in grades 3-8, and 11) saw over 95% students fail to meet the achievement level in math and over 90% fail to meet the achievement level in reading. The Virtual Academy provides these youth an online opportunity at remedial courses in Math and English Language Arts. There are credit recovery options for all content areas (Math, English Language Arts, Social Studies, and Science), elective course offerings, career pathway classes, and SAT/ACT prep classes. As of June 2016, over 100 youth have accessed the Virtual Academy and its seven state certified teachers across the state. These youth have combine to earn over 40 credits toward their high school graduation.

[Education and Training Voucher Program](#)

(Attachment E)

Annual Reporting of Education and Training Vouchers Awarded 2016

Name of State: State of Connecticut Department of Children and Families

	Total ETVs Awarded	Number of New ETVs
2014-2015 School Year* (July 1, 2014 to June 30, 2015)	178 computers to be distributed + 33 students summer intersession +2 students over budget +3 Students of adoption/guardian (new) <hr/> Total = 216 ETV awarded	New recipients 181 (178 computers + 3 ETV grants = 181)
2015-2016 School Year* (July 1, 2015 to June 30, 2016)	122 computers distributed (August 2015) + 4 ETV grants adoption/guardianship (3 new and 1 repeat award) +1 Special student funding request +44 summer funding requests (2015) +29 summer funding requests (2016) <hr/> Total 200 ETV awarded	New recipients 125 (122 computers + 3 new ETV grants)
2016-2017 School Year Anticipated projections for the next school year	Anticipate 207 computers (2016 cohort) Anticipate 200-250 computer vouchers (2017 cohort); supporting 2 Pupil Services Specialist, 5-10 ETV grants adoption/guardianship 50-75 summer funding vouchers Mailing 54+ ETV applications for grants to eligible youth who have been adopted or subsidized guardianship transfers	

Narrative:

The State of Connecticut Department of Children and Families (DCF), has utilized some of the Education Training Voucher funds to support 2 Pupil Services Post-Secondary Education Consultant positions (one full time, and one part time) since 2006. This year through other funding, the Department has been able to hire one additional part-time Post-Secondary Education Consultant. The third Pupil Services Specialist was a volunteer transfer from within the Department's School District (USD# 2). The Post-Secondary Education Consultants support Social Workers, community providers and foster youth with transitional services and assist with youth who are already in PSE programs transition through adulthood/out of DCF care. The Post-Secondary Education Consultants also continue to support the Department's staff, foster youth and foster/adoptive parents through consultation as well as provide community outreach and training regarding the Department of Children and Families Post-Secondary Education programs, transitional services, retention

and policies.

Data collection and maintenance for PSE in Connecticut DCF has remained an ongoing challenge for the department since the durational position that focused on data collection ended in October 2014. The Department of Children and Families is in the process of purchasing a new computer tracking system for its child protection system Child Welfare Information System (CWIS). A member of Post-Secondary Education Consultant team is involved in the committee and is representing the needs for collecting data and developing a system that includes foster youth in post-secondary education.

The Education Training Voucher (ETV) funds continue to be provided to youth who are currently in the foster care system and enrolled in a post-secondary education program, for youth who have had their guardianship (subsidized or unsubsidized) transferred (after the age of 16) from the Connecticut Department of Children and Families to another caregiver, and for youth who have been adopted after the age of 16 and are enrolled in a post-secondary education institution. From July 2014 – June 30, 2015, 3 new ETV grants were awarded to eligible youth. From July 1, 2015- June 30, 2016 period, the Department provided 4 ETV grants to eligible youth. In April and May 2016, there were 54 applications mailed to this population and 4 returned applications this year (due insufficient forwarded addresses from the US Postal Service) thus far. Any applications that are received prior to June 30, 2016 will be paid and included in the calculation for next year. The deadline for submission of an application is August 15, 2016.

During the year July 2014 - June 2015, CT DCF covered summer tuition expenses for 44 youth foster youth who took summer courses. From July 1, 2015 - June 2016, the Department of Children and Families awarded and additional 29 foster youth ETV grants for summer tuition expenses. It is anticipated that foster youth enrolled in a post-secondary education institutions will again be offered the opportunity to have summer course tuition grants offered again in the summer of 2017.

In July 2014- June 2015 year, there were 2 foster youth who requested and were granted ETV

funds for post-secondary education expenses. In July 2015- June 2016 there was 1 youth who requested and received special permission to utilize ETV funding for post-secondary education expenses outside of their annual budget.

The Department continues to purchase computers, printers and supplies for foster youth that have graduated from high school and are enrolled in a Post-Secondary Education program. For the cohort of foster youth graduating high school in June 2014, the Department purchased and distributed a total 178 computers. The foster youth who were in the June 2015 cohort, the Department purchased and distributed 122 computers to eligible youth. The Department is planning to purchase and distribute 207 computers, printers and supplies for eligible youth in the 2016 cohort. In the cohort of 2016, there are currently 183 post-secondary education plans that have been reviewed for foster youth who will graduate from high school and attend post-secondary education in the fall 2016. There are another 24 foster youth who have not finalized their post-secondary education plans as of yet, but are anticipating graduation and enrollment into post-secondary education also in the fall 2016. The Department will again purchase computers, printers, and supplies for a total of 207 foster youth this year. It is anticipated that the cohort for 2017 is estimated to be 200+ youth.

In 2015, the Post-Secondary Education Consultants reviewed academic profiles of 230 youth in the foster care system. This school year (2015-2016) the Department Post-Secondary Education Consultants reviewed 183 post-secondary education plans of youth in care who are high school seniors or earning a GED. In addition, there are 24 more foster youth who still need to have a Post-Secondary Education Plan reviewed by the PSE Consultants. From July 1, 2014 – June 30, 2015 the Department awarded a total of 216 ETV grants (with 181 being new recipients). From July 1, 2015- June 30, 2016 the Department has awarded 200 The ETV grants with 125 being new recipients thus far.

Section F. Updates to Targeted Plans

Adoption Recruitment/Retention/Support Activities

Foster and Adoptive Parent Recruitment activities throughout the state:

- Town sporting events: soccer, baseball, football/cheerleading;
- Preschool programs;
- PTA (Parent Teacher Association) meetings;
- Town recreation center activities;
- Hair dressers/barbers – back to school haircuts;
- Radio Interviews;
- WIHS Radio Interviews;
- Bus tail advertisements
- WATR Radio Interviews;
- Statewide Parent Teacher Association Council guest speaker;
- Open Houses;
- Big E – Connecticut Day (September of each calendar year), front foyer exhibit space;
- Heart Gallery Display (photos and brief biographies of youth);
- Social Media posts about foster care and adoption needs, highlights, etc.: Facebook, Twitter, CT Parent web site;
- 211 Information Line; staff phone operators have information about foster care and adoption needs in CT to share with callers who are interested in learning how to become a foster/adoptive parent or a resource for a child.

In 2009, a recruitment and retention plan was developed to increase the number of African American and Hispanic foster and adoptive parents. In addition, recruitment and retention plans specific to the communities of and populations served by the Department's local area offices set forth specific goals and targets for the recruitment of culturally, racially and linguistically diverse homes.

In 2009 and 2010, in conjunction with AdoptUsKids, DCF conducted a "market segmentation" plan. This plan was supplemented and expanded by the DCF Office of Research and

Evaluation (ORE), which helped further refine the data and added a geo-mapping component to create a more comprehensive picture of foster care needs in Connecticut. The data divides the Connecticut population into clusters and then determines which clusters best represent the profile of our current successful foster families in Connecticut. Based upon this data, four segments were identified as providing the greatest foster care recruitment opportunities. This data, while helpful in focusing our work, did not provide the next necessary next step which was to develop a communications plan that would allow us to reach out to perspective foster families with a targeted message on the need for foster families and the benefits of being a foster family. During 2014 and early 2015, the Department has made some shifts to focus greater resources on targeted, specialized and extreme recruiting. This approach is designed to be more thoughtful and intensive, shorten the timeframes to identify families for specific youth, as well as to be more strategic in outreaching to people who are most likely to become foster or adoptive parents. This work will continue to evolve throughout 2015.

During calendar year 2014, the Department successfully licensed 742 new foster and adoptive homes. The breakdown of those new licenses is as follows:

- Foster homes - 113
- Adoptive homes - 72
- Special Study homes - 116
- Independent homes - 25
- Relative homes - 416

The Department will continue to move towards placing children with relative/kin throughout 2015.

In 2014, the Department started Caregiver Support Teams in all six regions. There are 676 slots statewide. Utilization as of April 2015 is at 330 slots, which is up from 227 in January, 2015. The caregiver support team provides much deserved in-home supports to both kin and non-kin family based placements.

The Heart Gallery

Since 2003, the Heart Gallery continues to bring awareness to the Connecticut public about children in state care that need a permanent family or lifelong family connection. In November 2005, it was expanded to be on display continuously throughout the year in a minimum of two (2) locations. The Heart Gallery has been featured in venues such as the State Capital, children's museums, theaters, art galleries, community centers, libraries, malls, churches, hospitals, and commercial spaces throughout Connecticut.

From 2005 to early 2014, 320 children have been featured in the Heart Gallery, and 116 children have been adopted. Currently, there are 8 youth featured in the Heart Gallery. In 2014, 11 new youth were featured in the Heart Gallery. Also in 2014, 21 children left the Heart Gallery because the Department found either family placements with relatives or non-kin foster families (18 youth), because they aged out (2 youth), or because youth needed congregate care treatment (1).

GOOGLE and technology based recruitment:

DCF continues to recruit on the web via the purchase of a Google ad. Key words entered into a Google Search including "adoption" and other related phrases connecting a viewer directly to the Department's website. This recruitment strategy brings a monthly average of 15 families calling the CT Foster and Adoptive Parent Kid Hero line who express an interest in becoming licensed for adoption. The following results from January 1, 2014 to December 31, 2014 are as follows:

- Total of 386,703 page views
- 68,992 unique visitors
- 96,338 site visits
- 30.5% (117,946) are "new visitors"
- 60.40% (268,758) are "returning visitors"

The visitors viewed an average of 4.01 different pages per visit and spent an average of 2 minutes and 44 seconds on the site. As a result of the "Google" ads, in 2014 a monthly average of 150 families called the CT Association of Foster and Adoptive Parent's Kid Hero

line, inquiring about the process to adopt a child.

The Department has a contract with the nationally recognized AdoptUsKids, where DCF features waiting children on the AdoptUsKids web site. DCF Permanency Exchange Specialists use this web site, the Department's website, and A Family for Every Child's website/Heart Gallery, and other web based sites highlighting the children for whom they provide specific recruitment.

DCF continues to recruit on the web via "Google" ads. Key words entered into a "Google" search including "adoption, adopting in CT" and other related phrases connect a viewer directly to the Department's website CTfosteradopt.com.

Photo-listing:

The Department utilizes web based sites for the purpose of securing permanent adoptive resources. DCF features waiting children on the AdoptusKids web site. DCF Permanency Exchange Specialists are the contact person for children for whom they provide specific recruitment on this web site and on the Department's website.

Wednesday's Child:

Until 2014 the Department recruited adoptive families for waiting children by featuring a child, sibling group, or a successful adoptive family on a "Wednesday's Child" television segment. WTNH, Channel 8 in New Haven CT continues to provide this service, funded by New Haven based, Casey Family Services and the Connecticut Association of Foster and Adoptive Parents. WTNH aired the Wednesday's Child segments during their noon and evening news programs each Wednesday. The program was managed by the DCF Adoption Resource Exchange. 135 children were featured and 51 children were adopted. In addition to children being featured, an additional 46 segments aired including 31 segments of testimony from successful adoptive families. Other segments included highlights from November's National Adoption Day celebrations and other adoption related stories. This initiative is no longer operational. However, in 2015 the Department began a regular segment on WFSB's Better Connecticut program for youth who are in need of a home.

Wendy's Wonderful Kids:

A private foster care agency (Klingberg Family Center) was awarded the Wendy's Wonderful Kids (WWK) contract sponsored by the Dave Thomas Foundation in 2006. Via a service agreement with DCF they provide services to achieve permanency for children in state foster care programs nationwide. The WWK social worker has a caseload of 15-20 children and youth in need of permanency. They work with the APRE Supervisor for referrals for their program. This resource was expanded in 2014 and there are now 4 Recruiters in CT doing this work. The program operates at a consistent capacity of 60 active cases statewide.

Child-Specific Adoption Recruitment:

As a part of a child's individual recruitment plan, emphasis is placed on recruitment from a child's perspective; looking first at the child's natural network of important people in his/her life, whether those people are family, kin, or viewed as important as seen from the child's perspective. Emphasis on the need to focus on recruitment within the child's family or origin, kin and community remains constant. A child's case record is thoroughly reviewed as a part of this process. Additional efforts are made targeting areas which are most likely to touch a child's life, finding connections from within a child's community or based on a child's request or interest. Outreach includes: photo displays, child specific presentations or articles and newsletters highlighting specific children include: collaboration with four (4) cable access shows, five (5) children's museums, six (6) newsletter/ magazine or newspaper submissions, various town Parks and Recreation Departments, True Colors initiative and community bulletin boards. Recruitment for children of color has been conducted through collaboration with the Delta Sigma Theta Sorority, Meriden Black Expo, the First Cathedral of Bloomfield, the State of Black CT Alliance (SBCTA), Puertorriqueñísima Radio and the Faith, Family and School Conference.

The DCF Permanency Exchange Specialist reviews the child's DCF case record aka "case mining" identifying adults who are and were linked to the child youth in the case history. The PES works various adults who are currently connected to the child i.e.: the child's caregiver, DCF Social Worker, clinicians, teachers, etc. Consultants work directly with the

child/youth when at all possible for their input throughout the process. Once a family comes forward, the specialist takes a lead role in working and supporting the family until they are able to join a TIPS-MAPP training.

Child specific recruitment activities in 2012-2015 include some of the following; photo displays, child specific presentations, articles and newsletters, collaboration with four cable access shows, community bulletin boards, children's museums, magazine and newspaper articles and ads, events sponsored by True Colors. Child specific recruitment for minority children assigned to the ARE has occurred through collaboration with Puertorriquenisima Radio and the Latino Way. In 2014, these staff in addition those from private Therapeutic Foster Care agencies were trained in Extreme Recruitment techniques.

While You Wait Events:

Since 2005, DCF's Adoption Resource Exchange staff, continue to manage ongoing training opportunities for pre adoptive families called "While You Wait". Topics include: understanding legal risk issues in adoption, open adoption, managing behaviors which result from the effects loss and trauma experienced by children placed via the state's foster care system, adopting adolescents, and other related parenting topics related to adoption. Multiple sessions are planned for each year. These are held across the state on a regular basis in collaboration with DCF area office foster care and adoption units and CT Association of Foster and Adoption Parents staff. The events/activities listed above are supported through state funding.

DCF Adoption/Permanency Resource Exchange child specific recruitment activities:

In 2014, the Permanency Exchange Specialists from APRE provided child specific recruitment for 20 children and youth in need of adoptive families.

16 were youth ages 12-17

4 were under the age of 12

8 are African American or Latino children/youth

10 are Caucasian children/youth

2 are Bi-racial

- 5 have significant medical needs
- 10 have significant developmental disabilities
- There was 1 sibling group of two children

Child specific and targeted recruitment include public photo displays, child specific presentations, articles and newsletters, community bulletin boards, children's museums, magazine and newspaper articles and ads and events sponsored by True Colors. Child specific recruitment for minority children assigned to the ARE has occurred through collaboration with Puertorriqueñísima Radio. This work continued in 2014 and into 2015.

Technology Based Recruitment Activities in the Adoption Resource

Exchange/Permanency Resource Exchange:

Since 2013, the APRE broadened the scope of technology based recruitment to include postings on the agency's Facebook page, Twitter account and the most predominantly used, Heart Gallery web site. Additionally, outreach and partnerships with statewide foster care community collaborative allows the photos and demographic write-ups of waiting children to be showcased on a variety of internet sources. E-mail "blasts" are sent out to the statewide PTA association and various professional company newsletters and quarterly reports. The Department has continued the contract with the nationally recognized AdoptUsKids, where DCF features waiting children on their national website. DCF Permanency Exchange Specialists use this web site, as well as "A Family for Every Child" website located in Oregon to highlight the children for whom we are currently most in need of families. This work continued in 2014 and into 2015.

Minority Family Recruitment:

DCF has continued to develop its Minority Family Recruitment initiative. The Department is targeting professional organizations that have large minority memberships (e.g., sororities, fraternities, Urban League, NAACP, Jack and Jill, Connecticut Hispanic Bar Association, Black Social Workers Association, etc.). The goals for this endeavor continue to be:

- Increase the numbers of licensed African-American and Latino Foster/Adoptive parents in the state of Connecticut.

- Achieve permanency and finalization of adoptions for older African-American and Latino children in the agency's care.
- Increase knowledge of and favorable opinion about DCF foster care and adoption in African-American and Latino communities.
- Obtain research, including engage in surveying and focus groups, on adoption attitudes, practices, trends and beliefs in the African-American and Latino communities.

The Department has begun outreach to organizations that represent the broader socio-economic diversity that exists in communities of color and specifically the African American and Latino populations. The intent of the outreach was to establish 5 community forums around the State. These forums were intended to have community leaders, activists, politicians, and family members come and have a discussion with the Commissioner and other members of the Department about the philosophies, barriers, and strategies to increase placement of children with relatives as well as with people of their own race and ethnicity from their own community. One forum occurred during the year and the Department has charged The Continuum of Care Partnership Foster Care Working Group to address this issue and assist in implementing these forums.

Foster/adoptive provider training:

Up until 2015, prospective foster and adoptive families received 35 hours of pre-licensing training using the PRIDE curriculum. In 2015 DCF contracted with the Children’s Alliance to implement a new trauma-informed statewide training curriculum for foster and adoptive parents called: Trauma Informed Partnering For Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP). TIPS-MAPP will be utilized by the Department and private Child Placing Agencies (CPAs) to create more uniform training practices across the State.

Prospective foster and adoptive families receive 30 hours of pre-licensing training using the TIPS MAPP. This curriculum is designed to help prospective foster and adoptive families develop five abilities that are essential for foster parents to promote children's safety,

permanence and well-being. After completion of the program foster and adoptive parents will be able to:

- meet the developmental and well-being needs of children and youth
- meet the safety needs of children and youth
- share parenting with a child's family
- support concurrent planning for permanency
- meet their family's needs in ways that assure a child's safety and well-being

These trainings are held on a regular, ongoing basis, across the State, occurring in a variety of community settings. The trainings are often held in the evening or on the weekend.

Department staff and private therapeutic foster care (TFC) providers convene the TIPS-MAPP trainings. Child care is typically provided to aid families' attendance. In 2014, some regions began piloting additional pre-licensing training curriculum to supplement the required training. This includes a component on Health and Wellness.

The Department is in the process of reviewing the post-licensing requirements and options to ensure that foster parents are able to meet the expectations and develop the competencies they need to care for the children in their homes.

Additional achievements/progress in foster and adoptive parent recruitment and training in 2014 and early 2015 has included:

- Expanded our partnership with the Dave Thomas Foundation, Wendy's Wonderful Kids (WWK). Three more recruiters were added to Connecticut at no cost to DCF (Connecticut has had one recruiter through this Foundation since 2006). This will allow for more focused and child specific recruitment for our most challenging youth. The WWK caseloads stand consistently at capacity of 60 active cases statewide.
- Central Office, DCF Regional staff, partnering state agencies, and private providers have participated in a state sponsored "Lean" process focusing on foster care licensing process. This week long event resulted in concrete suggestions intended to reduce the

number of steps required for families to become licensed (i.e., eliminating redundant steps) and reducing the time it takes for families to become licensed. During late 2014 and early 2015 the Department implemented the recommendations generated by the workgroup. These include: 1) improved consistency and standardization of our initial inquiry process through enhanced utilization of our foster and adoptive parent advocacy agency, CT Association of Foster and Adoptive Parents (CAFAP) so they are now the repository for all initial inquiries up through the families' attendance at an Open House in the Regional Office. 2) Updating foster care policy, creating a practice guide and streamlining the forms used. 3) Eliminating home study review by a Program Manager when no concerns are present. 4) Refining the background check process to significantly reduce the amount of time it takes to obtain the requisite checks. The work continues to implement all of these recommendations and continue to assess and refine other aspects of our work.

- Partnered with the Connecticut Association of Foster and Adoptive Parents (CAFAP) to implement a centralized training web list for families.
- Central office staff had duties re-structured and they were deployed half time to the regions to absorb permanency related work. These staff help in family search/engagement, case mining, and family outreach. These Central Office staff, along with private foster care providers and DCF Regional staff, were given training in Extreme Recruitment and Child and Family Teaming from national experts.
- Our contracts with private providers who offer post adoption support to families was adjusted so that the services can be given to transfer of guardianship families. Families who have guardianship of youth will have the same supports in place as families who have adopted.
- Developed a site audit process for therapeutic foster care agencies and the audits will ensure that recruitment and retention plans are in place.

- Central Office staff partnered with CAFAP and DCF Regional staff to expand a foster parent/youth satisfaction survey.
- DCF Regional offices received consultation from the CWSG on their local recruitment and retention plans and goals.
- The Department shifted the oversight of the community collaboratives to the regions. This allows for recruitment to be coordinated at a local level and tailored to local needs.
- The Department consolidated our lengthy hardcopy version of our foster parent manual into a streamlined collection of web links for families. We also translated this into Spanish.
- The Department re-opened the slots for Multidimensional Treatment Foster Care in one DCF region with one private provider. This is a foster care program designed to serve youth in the juvenile justice system. Families will be recruited for specific youth in our care.
- The Department has adjusted written contracts for congregate care providers; these contracts now include clear expectations for family engagement. The hope is that this will increase permanency for youth who reside in group care.

Permanency Planning Services Program (PPSP):

The Permanency Planning Services Program (PPSP) provides core contracts with 17 child-placing agencies in Connecticut. In addition to providing specialized recruitment services, an array of other permanency services include the following: services to legally free a child or sibling group, pre-placement planning for the child or sibling group, assessment and a written home study for a potential adoptive family, transition and placement planning, post placement supervision, post finalization services, assessment services in reunifying a child

with family, and assessment services after a child has returned to their identified family. All of these assist the Area Office staff in actualizing the child's permanency plan. Services are accessed by the use of a service agreement with the private child placing agency. In 2014, supports were expanded to cover transfer of guardianship families.

Out-of-State Permanency Placement Services Program (PPSP):

DCF Central Office staff provide ongoing assistance to DCF Area Office staff in identifying out-of-state private agency resources and negotiates contracts with out of state agencies upon Area Office request. The availability to quickly access supportive services for families, particularly across state lines, enhances the Department's ability to facilitate adoptive and relative placements for children. The Department utilizes web based sites for the purpose of securing permanent adoptive resources. DCF features waiting children on the AdoptusKids web site. DCF Permanency Exchange Specialists are the contact person for children for whom they provide specific recruitment on this web site and on the Department's website.

[Health Care Oversight and Coordination Plan](#)

Substantive meetings with the DCF Health Standards and Practice Committee (HSPC) led to a focus on several initiatives and partnerships with some members of the HSP Committee aimed at improving health outcomes for children served by DCF. These initiatives included partnering with the Department of Social Services who oversees Medicaid in CT to secure a 'claims health profile'; partnering with Child Abuse Pediatricians (CAPs) on enhanced education of staff, FP and community stakeholders aimed at prevention and early identification of child abuse; partnering with CT Dental Health Partnership, the state's Dental health ASO on an initiative to enhance oral health; and partnering with CT's Affiliation of Foster and Adoptive Families (CAFAF) to expand and enhance caregivers understanding of health needs of children in foster care.

In the last year there have been several changes in DCF's infrastructure that have expanded opportunities to focus on health. Led by DCF's Director of Pediatrics with support from the Director of Nursing, the Division of Health and Wellness continues to work to develop

systems of care that best support DCF, especially Regional and Area Office staff and enhances health outcomes for the children and families we serve.

In September 2015, the RRG nurses were moved from reporting to AO/Regional leadership to the Division of Health and Wellness. Supervised by the Department's Director of Nursing, the team identified several key objectives including 1) build a nursing infrastructure and 2) standardizing nursing practice. The vision for RRG infrastructure is to ensure that each of DCF's 6 regions have a nurse supervisor (APRN/nurse consultant) who oversees nurse/s in each AO. Specific strategies to best support this vision include working with existing APRNs who assumed these supervisory positions to develop their skills as supervisors. Work is also underway to promote/hire additional nurses and nurse supervisors to ensure sufficient resources and capacity to support the model envisioned. Initiatives aimed at standardizing nursing practice include: standardizing nursing consultations to ensure prompt and appropriate engagement of nurses; dissemination of Critical Incidents and other key reports directly to nurses to ensure a 'medical lens' early in a case; the development of standards for nursing documentation; and attention to professional development. Attention has also been paid to the implementation of a standardized orientation for new nurses including an ongoing mentoring experience with RRG nurses to support and promote retention.

Additional efforts to promote attention to health include 1) expanded partnering between DCF Divisions; 2) consideration of expansion of the RRG to include Health Advocates and Regional Psychiatrists; and 3) transitioning of the Nursing Community of Practice (COP) to a Health COP. The latter is considered an important vehicle for the promotion and implementation of initiatives focused on health. Composed of representatives from key groups throughout DCF, this strategy aims to expand responsibility for health by promoting cross agency engagement and ownership in the selection of strategies and commitment to initiatives focused on health that will assist in our achieving our mission.

Health & Wellness Policy and Practice Guide: Translating Policy into Practice:

DCF continues with initiatives aimed at implementation of the Departments Health and

Wellness policy and practice guide entitled “Standards and Practice Regarding the Health Care of Children in DCF’s Care”. Education of stakeholders remains a key strategy and much has been accomplished over the past year. This work includes efforts to ensure consistency of messages as well as a graduated learning experience that builds knowledge and reinforces messages regarding best practice in health. Specific education initiatives include the following:

- Training of AO staff: DCF nurses continue to work to support and educate staff and community providers through individual case consultation. Other ongoing efforts include partnerships with DCF’s Academy of Workforce Development in the provision of education as part of routine training of social workers in preservice and investigators in in-take training. The Health and Wellness Division has also partnered with CT’s Child Abuse Pediatricians (CAPs) on an education initiative focused on child abuse prevention and early identification. Strategies include 1) ongoing quarterly training by CAPs to DCF nurses on topics impacting children in care and case review and 2) RRG Nursing/CAP partnerships in education to specific AO/Regions they serve. The DCF nurse training is aimed at enhancing capacity and how to best prepare nurses to support AO and community providers. Initiatives with AO/Regions will focus on prevention and early recognition of child abuse and include a review of the fundamentals with attention to key issues identified through research as well as experiences in CT. CAPs will also use AO/Regional cases to reinforce strategies for prevention in addition to providing strategies and information which will promote appropriate and prompt consultation with RRG nurses/CAP.

Health Advocates have also partnered with DSS’ ASO for dental care, CT Dental Health Partnership on the “Health Mouths, Healthy Kids” initiative, a project aimed at promoting oral health. Initially launched in 2014, the project will be reissued in fall of 2016 with a renewed focus on AO engagement to enhance outcomes. The team is currently working to develop materials which highlight the importance of oral health and factors which make children and families we serve vulnerable. As with all Division education initiatives, attention will be paid to consistent messages and best practice. Project elements include 1) partnering of Health Advocate with AO

leadership to determine best approach for the office; 2) power point templates and materials that can be personalized to capture AO specific information including data; 3) ongoing partnership with CT DHP; and 4) education of other key groups including community providers and foster parents. Project activities will also be informed by claims data obtained through an MOU with CT DHP, DSS' ASO for dental health which provides both population and individual level data. Measures of oral health include receipt of recommended cleaning and examination as well as initiation of oral health care.

- Training of Foster Parents and Caregivers including relative/kin: In partnership with both internal and external stakeholders, the Health and Wellness Division has enhanced and subsequently launched several educational initiatives for caregivers. Attention has been paid to ensuring consistent messages with a focus on three core courses, 'Fostering Health for Children in Foster Care', 'Strategies and Resources for Managing Health Care', and 'Medically Complex Certification'. Courses are designed to provide sequential learning and augment one another. Additional courses are offered to supplement knowledge. Software ensures that materials for most courses are available for both in-person and on-line learning maximizing access. This same software also facilitates the collection and recording of information about participants and feedback. Course schedules as well as links to on-line courses are available through CAFAF and support FPs in meeting their education requirements. The core courses and other initiatives are described here:

- Basic education of all foster parents. The Health and Wellness Division has successfully launched the revised "Fostering Health for Children in Foster Care" curriculum that ensures that all foster parents receive education about health including information about the health of children entering care as well as an overview of DCF health practice. Developed through ProProf software, the revised curriculum is available for both online use and in-person presentation. An in-person training is included as part of pre-licensure requirement and a Spanish version will be available early in FY 2016. The recently launched online version ensures that the curriculum is available to all

caregivers including existing foster parents as well as kin and relative placements. The ProProf software technology ensures that we can track completion and also permits evaluation and collection of feedback essential to QI/QA. Requiring on-line completion of evaluation through a ProProf linkage ensures that information from in-person trainings can also be captured to track completion as well as QI/QA.

- Training of Relative / Kin who will be caring for children with complex medical needs: As part of our initiative aimed at promoting available and enhanced education, DCF revised and launched our curriculum for relatives and kin who assume responsibility for children with complex medical needs. Intended to supplement “Fostering Health for Children in Foster Care”, this new training “Strategies and Resources for Managing Health Care” focuses on providing relative / kin with information about resources in DCF and the community, as well as tools that can assist them with managing a child’s complex medical needs. It includes information about DCF’s Health Advocates who with the nurses can support families in accessing information and resources.
- Medically Complex Certification Course for foster parents interested in caring for children with complex medical needs: DCF continues to provide enhanced and targeted education to individuals interested in caring for children DCF serves who have complex medical needs. Based on a 4 tiered classification, the course led by nurses in the Complex Medical Unit of the Health and Wellness Division, explores the unique needs of this population and explores components which contribute to a child’s medical complexity. A revised curriculum is currently being developed and will be implemented in early FY 2016. The new certification embraces sequential cumulative learning. Families interested must complete both ‘Fostering Health for children in Foster Care’ and ‘Strategies and Resources for Managing Health Care’ courses as well as participate in a one day ‘Medically Complex Certification’ course. The day is focused on providing an overview of this unique population as well as tools to help prepare families to care for a child with complex medical needs. It

includes a framework for considering how a child's condition may impact multiple domains of their everyday life including nutrition and physical activity, emergency, education, social and emotional development, trauma and more. In addition to courses, prior to a child's placement, caregivers who will be caring for a child designated as having complex medical needs receives training about that child's specific health care needs entitled "child specific medical training" (CSMT) and age-appropriate CPR.

- Training for Congregate Care providers: Health and Wellness Division has partnered with DCF licensing to review and enhance congregate care standards and best align them with DCF practice.

DCF's Enhanced Multidisciplinary Evaluations (MDEs)

DCF's Multidisciplinary Evaluations continue to ensure that children entering care receive a comprehensive screen of their physical, behavioral and dental health needs as well as assess both education and trauma within 30 days of placement. Successful implementation of the enhanced MDE model has allowed the Department to focus on refining the model and maximize its effectiveness as a tool for case planning. Strategies to address more qualitative aspects include attention to MDE clinics themselves and AO/Regional DCF office practice as well as attention to broader ongoing QI/QA mechanisms. These different elements are described here and include plans for addressing opportunities identified:

- MDE clinics continue to meet the needs of the Department and to provide examinations within 30 days of a child's entering care. Data from the MDE clinics provides details about their success including measures of scheduling, report completion and distribution, and the completion of trauma screens. Data as well as feedback from bi-monthly MDE Committee meetings informs MDE practice.

The MDE program continues to partner with the CONCEPT trauma grant team to enhance trauma screening of children entering care. As part of this work,

the MDE clinics continue to complete the MDE trauma screens and where indicated recommend referral for therapeutic intervention children and youth entering care. Work is currently underway on a trauma screen for younger children with pilots underway in several Pediatric practices. Once completed, the plan is to add this screen to MDE clinic practice.

- In addition to routine MDE committee meetings, the MDE PDOC has been meeting with AO/Regions to review their AO/Regional specific MDE protocols, explore strategies for improving practice and identify opportunities for enhancing the utilization of the MDE in case planning. Meetings include dissemination of lessons learned from other offices as well as tools that may assist with data and monitoring.
- Data attests to the successful implementation of the enhanced MDE model and allows attention to qualitative components including quality of the report and AO practice. Ongoing routine monitoring of MDEs is accomplished through a number of QI/QA processes. These include ongoing data collection (robust data submitted monthly by MDE clinics) and survey of MDE consumers collected by MDE clinics. Additional QI/QA tools soon to be launched include a MDE customer survey and a peer review process of MDE the report's "Summary and Recommendations".

The MDE customer survey will be completed by AO staff and will capture information about the quality of the MDE report. Developed in ProProf software, the survey takes 3-5 minutes and is delivered as a link in the email accompanying the completed MDE report to the Social Worker and RRG Nurse. Questions in the survey include assessment of usefulness of the information received in informing case planning; quality of the recommendations; and adherence to MDE protocol regarding inclusion of only child specific information. The ProProf platform facilitates the collection of information from the survey and its use in planning.

Ongoing challenges to best practice regarding the MDE report's "Summary and Recommendations" component has prompted the development of a peer review process. Currently under development, a team composed of MDE clinic clinicians will develop a tool for 'assessing the quality' of the Summary and Recommendations component of the MDE. Informed by DCF including clinical PDs, system PDs, RRG nurses and education consultants, the goal is to have MDE clinicians utilize a tool to review de-identified reports thus promoting best practice and by doing this, learn from one another. Additional plans for the committee include the development of a protocol for training new MDE providers.

- Results of the rigorous MDE QI/QA process will be used to inform immediate practice but also inform future RFPs for the service.

Care Coordination and Community Partnerships

DCF continues to work on efforts to enhance outcomes for children in care through improved coordination and collaboration with health care providers in the community. A strategy that reflects recognition that the majority of children in DCF care remain in their community and are best served by providers familiar with them and their families. Current activities are described here:

- Partnering with AAP to promote and fully develop medical and physical health components of the MDE
- Continued work on pilots with AO/Regions on the development of models of health practice consistent with DCF Standards and utilizes best practice to enhance outcomes for children in care. Partners include FP and providers
- DPH Medical Home Care Coordination Collaboratives (HCCC). DCF recently joined the State Level Care Coordination Collaborative, a grant-supported initiative aimed at

increasing the number of children and youth with special health care needs who receive a patient / family centered medical home approach to comprehensive, coordinated service and approaches. Building on the Department of Public Health's Medical Home Initiative and their Regional Care Collaboratives, this statewide initiative seeks to increase state's capacity to coordinate policy, program development and collaborative partnerships across agencies. Through this participation, DCF aims to improve integration of internal and external care coordination efforts. Efforts are already underway to partner with other Collaborative members on a plan to facilitate care coordination for families involved in DCF's Family Assessment Response (FAR) who may benefit from attention to health and ongoing support.

DCF continues to participate on the Regional Collaboratives which are in various stages of development across the state. They include: East Region, South Central Region, North Central Region, Northwest Region and Southwest Region. Routine DCF representation includes AO social workers, RRG nurses, Health Advocates and members of Central Office Medically Complex Unit staff with some variation specific to a case in review. Special attention is paid to supporting children who are transitioning to families and to maintaining placements.

Health Information and Documentation

Recognizing the importance of health information to informing practice and planning, DCF continues work on initiatives aimed at improving access and availability of reliable health information. These efforts include:

- Standardization of nursing / health documentation: The Nursing Standards and Practice Workgroup took the lead in the development of a guideline for nursing documentation. Approved by the full RRG staff, this standard will be applied to all nursing documentation, support best practice and facilitate communication with AO/Region staff.
- Ongoing involvement in planning for new SACWIS / CCWIS system:

Representatives from DCF Health and Wellness continue to participate in meetings to inform planning for the development of the health components of the new SACWIS system. Attention continues to be paid to 1) ensuring the creation of a health summary; 2) documentation and tracking of identified health standards and components of care; 3) access to a comprehensive immunization summary; 4) support of the health passport including a provider portal for completion of forms relating to health and a mechanism to alert staff (social worker and/or RRG nurse) to the new information ; 5) ensuring access to data at both population and individual level to inform planning and 6) mechanisms to alert Health and Wellness staff including RRG nurse/Health Advocate, etc. and prompt their review.

- Share Point: The Division of Health & Wellness continues to develop the Health and Wellness Share Point site that will provide access to information about programs and valuable links to resources. Included is information about Medically Complex Unit, Medication Administration, Health Advocates, MDE, Congregate Care Medical Review and RRG Nursing and information about all the Health Passport forms and information.

- Claims health profile: Recognizing the importance of health information to informing planning and safety for children upon their entry into care, DCF has partnered with DSS on an initiative to create a claims health profile for children entering care. Developed with CT Health Network, DSS' ASO for health, and DSS, the claims health profile provides a snapshot of health and is provided within 24 hours of request. Information collected include:
 - Identification of PCP and one year of claims diagnoses
 - Identification of any other providers and two years of claims diagnoses
 - Pharmacy information including medication, date last filled, prescriber and pharmacy
 - Immunization information based on two years of claims
 - Inpatient admissions including hospital, dates and diagnoses for two years

- Emergency department visits including dates and diagnoses for two years

Work is currently underway to determine how best to operationalize the use of the claims health profile and incorporate it into practice. Most immediately it will be included as a component of the “Model of Health” pilot, which will identify how it can best be utilized by AO and steps needed for successful integration into ongoing CPS practice. Lessons learned from the “Model of Health” pilot will inform a statewide approach and experience with the claims health profile will also inform its integration into SACWIS.

Development of a Data Plan and Dashboard for Health

DCF Health & Wellness Division continues to work to enhance access to data to inform planning at both the individual and population levels. Current activities include attention to effective use of currently available data from MDEs, claims health profile, dental health initiative and CMCU.

The claims health profile will provide an opportunity to capture information about the health of children entering care. Initially captured manually, the goal is to work with DSS to establish an interface with CHN in the new CCWIS systems that would permit automatic completion and importing of the claims health profile. We also plan to expand the MOU with CHN to include access to health claims information for all children in care with goal of identifying diagnoses as well as key health measures.

As part of the data plan, continued attention will be paid to measures that provide for some baseline or comparison and where possible allow attention to possible racial or ethnic disparities. This includes review of currently available data and measures within DCF through PIE, LINK, Court Monitor reports and ROM reports.

Centralized Medication Consent Unit (CMCU)

Established in 2007, the CMCU is staffed by child psychiatrists and APRNs who are responsible for making decisions on all psychotropic medications recommended by a provider for a DCF-committed child/youth. In addition the unit maintains the policies, practice requirements and guidelines regarding the use of all psychotropic medications in DCF-committed children. These guidelines and requirements are developed in collaboration with the Psychotropic Medication Advisory Council (PMAC), a DCF-organized council composed of public and private physicians, clinicians, nurses, family members and pharmacists. PMAC meets regularly to: recommend psychotropic medication dosing and monitoring guidelines and requirements; collect and review adverse drug reaction reports; and conduct routine pharmacy utilization reviews. In 2015, all DCF Area Offices received updated training on the CMCU and the role of the DCF staff. In addition a survey of providers was conducted to receive feedback on how to improve the system. 90% of the providers rated their overall level of satisfaction with the CMCU process as very good or excellent.

Data from the CMCU database:

1. The total number of unique youth on any psychotropic medication has been reduced from a high of 1135 in 2011 to 752 in 2015.
2. Reduction in the total number of concurrent psychotropic medications has been reduced from 8 in 2009 to 5 in both 2014 and 2015. In 2015, 2.18% of all youth committed to DCF were on four or more concurrent psychotropic medications.
3. Use of two or more anti-psychotic medications was reduced from 52 unique youth in 2012 to two youth in 2015 on two anti-psychotics. That is equal to 0.81% of all youth committed to DCF in 2015. Both youth had further reductions in their medications and there has now been zero youth on concurrent anti-psychotic medications for twelve consecutive months.
4. Focus on children age five and under has reduced the total use of medications and in 2015 no child in this age group was on more than two psychotropic medications including ADHD medications.

5. Data for the use of psychotropic medications is monitored by race/ethnicity however because of the low numbers of youth on two anti-psychotics or age five and under on any psychotropic medication, no statistical significance can be made.

Next Steps:

1. Continue to actively address the use of two or more anti-psychotic medications concurrently and four or more psychotropic medications concurrently by children/youth committed to DCF.
2. Continue to closely monitor the requests and use of psychotropic medications by children age five and under. Work collaboratively with regional staff to insure that non-medication alternatives are fully integrated into the clinical treatment plans.
3. Develop the process to monitor the use of PRN medications. This will require a modification of the database.
4. Integrate the Adverse Drug Report protocol used by the CMCU with the Quality Assurance Unit's monitoring process.

Disaster Plan

The state's disaster plan protocol was activated in January 2015 for a blizzard. All foster homes and licensed facilities were contacted before the storm to ensure they were equipped with supplies, generators, etc. DCF facilities were fully prepared and staff stayed overnight to ensure coverage during the storm. Careline remained operational. There were no disruptions to DCF operations as a result.

DCF's Business Continuity Plan will require updating this year to account for changes in administrative structure.

Training Plan

No changes to Plan have been identified. See Section 5.

1. CAPTA Annual State Data Report Items

Information on Child Protective Workforce

The official job classifications developed by the State of Connecticut, Department of Administrative Services for child protective service professionals include:

- Social Worker Trainee
 - Minimum requirements for this classification, which is the routine entry level job, is possession of a Bachelor's Degree in Social Work or a closely related field. Closely related field is defined as applied sociology; child development; child welfare; clinical psychology, counseling; human development and family studies; marriage and family therapy; nursing; social and/or human services; education; criminal justice. In practice, the Department screens applicants for this classification and prioritizes applicants with either a BSW or MSW for interview.

- Social Worker
 - Applicants for the Social Worker classification must either have completed the Social Worker Trainee requirements, which includes serving two (2) years at the level of a trainee, or successfully completed the competitive examination for Social Worker. Requirements to sit for the Social Worker examination are: Master's Degree in Social Work or a closely related field (as identified in the Social Worker Trainee requirements above) OR a Bachelor's Degree in Social Work or a closely related field (as identified in the Social Worker Trainee requirements above) plus two (2) years' experience in the self-directed use of case management techniques and counseling to sustain or restore client functioning. Applicants must have successfully passed the exam and appear

on a certified exam list for consideration by the Department for hire.

Applicants at this level are also prioritized by possession of a BSW or MSW.

- Social Worker Supervisor
 - Minimum requirements for entry to the Social Worker Supervisor examination are: Master's Degree in Social Work or a closely related field as defined in the Social Worker Trainee requirements above plus two (2) years' experience in the self-directed use of case management techniques and counseling to sustain or restore client functioning OR a Bachelor's Degree in Social Work or a closely related field as defined in the Social Worker Trainee requirements above) plus three (3) years' experience in the self-directed use of case management techniques and counseling to sustain or restore client functioning. Applicants for this promotional opportunity must be on the certified exam list for permanent appointment to this class.

Data on the education, qualifications, and training of such personnel

The educational requirements for staff are minimally a four-year degree in Social Work or a related field as indicated above. Internal prioritization has resulted in the majority of new hires to these classes since 2012 possessing either a BSW or MSW. Qualifications are in accordance with those required to sit for the competitive exams for each classification as cited above. Training of personnel, aside from their post-secondary degree occurs internally and is tracked by the Academy for Workforce Development.

How skill development of new and experienced staff is measured

Training evaluations are distributed at the end of each training offered through the DCF Academy in an effort to gather specific information regarding overall feedback, relevance and application of class content. The DCF Academy also accepts and encourages requests for one-to-one training to be provided to staff when skill development or another area of concern arises.

New employees continue to take a pre- and post-examination at the beginning and end of their pre-service training series. Academy staff have recently enhanced the post-examination

to ensure it accurately reflects current competencies and practices from classroom content. Students are given components of an actual case to review. Upon review, they are asked to develop the following tools and documents: a genogram, a Structured Decision Making Family Strengths and Needs Assessment, and a modified case plan document. The oral component of the exam focuses on the group supervision process. This oral presentation allows them to gain more comfort presenting cases in a concise and factual manner.

Academy staff also partner with supervisors and managers of new employees to coordinate the learning process. Bi-monthly meetings are held to discuss skill development and to trouble-shoot any barriers to the learning process. Transfer of learning activities are also built into the pre-service training programs to ensure content is applied to practice.

[DCF Regional Direct Care Workforce 2/28/2016](#)

	TOTAL	TM	TF	WM	WF	BM	BF	HM	HF	OM	OF
C&F Administrator	8	3	5	3	3	0	2	0	0	0	0
Area Director 2	6	2	4	1	3	1	1	0	0	0	0
Program Director	32	9	23	5	16	0	4	4	3	0	0
Program Manager	96	26	70	15	40	3	16	6	13	2	1
Social Work Supervisor	336	85	251	47	133	24	71	12	41	2	6
Social Worker	1185	271	914	142	413	85	305	37	182	7	14
Social Worker Trainee	138	43	95	18	40	15	27	10	27	0	1
Social Work Case Aide	105	35	70	8	27	15	18	12	24	0	1
Total	1906	474	1432	239	675	143	444	81	290	11	23

Caseload Report Guide

CT DCF Electronic case management system ([LINK](#)) utilizes assignments to determine how many points, if any, each Worker assigned to a case receives depending on their role. The following is a summary of the [LINK](#) caseload reporting process:

The assignment combinations listed below in fig 1 generate **ONE** caseload point for each open assignment. There are 132 different combinations of Type/Responsibility/Role in the Assignment Category table. **ONLY** these fourteen assignment combinations will generate a

caseload point.

Any worker with an open assignment of **CPS OOH, N/A, Primary** where no lead assignment exists, will also receive a point for each case participant with an open, approved placement.

Any worker with an open assignment of **Permanency Services, N/A, Primary**, where no lead assignment exists, will receive a point for each case participant with an open, approved placement.

If an open **Lead Worker** assignment outlined in **fig. 1.1** exists for a case participant who is in an open, approved placement, then that worker will receive **ONE** point. We have added an assignment combination of **CPS In-Home, N/A, and Primary** that is to be used to designate **In-Home** cases. This assignment combination will carry **ONE** case point and no additional placement points.

Fig 1.1 - Assignment Category Table

Assignment Type	Assignment Responsibility	Assignment Role	Case Points	Placement Points	Maximum Points	Percentage Utilization
Adolescent Services	N/A	Primary	1	0	20	5.0%
Adolescent Services	N/A	Lead Worker	1	0	20	5.0%
CPS In-Home	N/A	Primary	1	0	15	6.7%
CPS OOH	N/A	Primary	1	1	20	5.0%
CPS OOH	N/A	Lead worker	1	0	20	5.0%
ICO	N/A	Primary	1	0	49	2.0%
ICO	N/A	Lead worker	1	0	49	2.0%
Family Assessment Response	Area Office	Primary	1	0	17	5.9%
Family Assessment Response	Area Office	N/A	1	0	17	5.9%
Investigation	Area Office	Primary	1	0	17	5.9%

Investigation	Area Office	N/A	1	0	17	5.9%
Permanency Services	N/A	Primary	0	1	20	5.0%
Permanency Services	N/A	Lead	1	0	20	5.0%
Probate	N/A	Primary	1	0	35	2.9%
Probate	N/A	Lead	1	0	35	2.9%
Voluntary	N/A	Primary	1	0	49	2.0%
Voluntary	N/A	Lead	0	1	20	5.0%
FWSN	N/A	Primary	1	0	49	2.0%
FWSN OOH	N/A	Lead	0	1	20	5.0%
<i>Last amended March, 2012</i>						

Juvenile Justice Transfers

According to the Department of Children and Families' SACWIS system, during state fiscal year 15/16 there were 26 youth who while under the care of the department were committed as delinquent into the custody of the department. This is defined as a youth transferring from one of the following statuses: 96 Hour Hold, Order of Temporary Custody, and Commitment Abuse/Neglect/Uncared For, Commitment Mental Health, Commitment/FWSN or Statutory Parent to either Commitment Delinquent or Commitment Dual status subsequent to a delinquency adjudication.

2. Sources of Data on Child Maltreatment Deaths:

DCF & CT Medical Examiner Partnership

In an effort to be more responsive to the needs of the children and families of Connecticut following a traumatic and or fatal incident involving a child/youth. The Department of Children and Families has partnered with the Medical Examiner's office of Connecticut; to open lines of communication in order to be more responsive to the needs of a family in need

following a tragic event involving a child/youth. A notification will be provided to the Department following the untimely death of any child or youth under the age of 18 years of age. Upon notification, DCF will assess the event and determine an appropriate response to aid the family during this traumatic event.

Through the Department's centralized intake process under the Careline, the Office for Research and Evaluation's (ORE) Risk Management Unit (RMU), receives notice of all child fatalities and critical injuries reported to the Department.

RMU maintains a database of all such information. In addition, an electronic dunning process has been developed to connect with the DCF Region/Area Offices regarding any needed updates to the case information (e.g., investigation disposition, police actions, etc.) The Department has recently established a process with the State Medical Examiner such that on at least a monthly basis, child fatalities known to that office are sent to the Director of the Careline. Such information is reviewed by the Careline Director and shared with RMU for input into the database. These data are regularly run for internal use, but are also posted at least annually on our [website](#).

Next, the DCF Office of the Ombudsman is now charged with overseeing the Special Qualitative Review (SQR) process. This process is used, at the direction of the Commissioner's Office, to assess areas of strength and challenge with respect to Practice, Policy and System regarding a fatality, usually those that appear to be maltreatment, on an open case or a case that was open within the last 12 months. The SQR process is joined by the Comprehensive Fatality Review Process, which is led by ORE to support a rolling evaluation of fatalities reported to the Department.

Careline (CL) has begun to track all instances of child fatalities and collects data regarding age, nature of the incident, hospital and the region they derive from. This information has been shared with the deputy commissioner for statistical reporting.

Careline has also begun to look at the Critical Incident logs in its current state and see how

we might begin to assess trends for the types of cases we are seeing in order to develop training modules to increase our staff's ability to manage demand.

We are currently working with Risk management and ORE in an effort to stream line our process of reporting, so that there is one central repository of information that gets disseminated regarding Critical incidents and Fatalities to all needed parties.

The Connecticut State Department of Children and Families (DCF/Department) is providing comprehensive case analysis and timely systemic consultation in the aftermath of a child fatality and/or life-threatening critical incident. The Fatality Review process and structure is a function of the Division of Quality Assurance, and is led by the Division's Director. The Department's senior leadership team has determined that child fatalities and life-threatening incidents on open cases and cases closed within one year will be examined by a multidisciplinary Special Review team. The Special Review's emphasis on education and teaching is designed to provide practical feedback and information for professional learning, organizational development and staff support within and across helping systems. The multidisciplinary approach offers a consistent methodology that focuses on relevant fact-finding, and identification of key dimensions in case practice determined to be excellent, acceptable or in need of improvement.

At the Commissioner's discretion, any fatality or critical incident can be examined by the Special Review team. The DCF Special Review team collaborates on a routine basis with the Statewide Child Fatality Review Panel (CFRP) that is Co-Chaired by the Chief Medical Examiner and Child Advocate. The CFRP examines the death of all children and youth under the age of eighteen, including those that are not involved with the child welfare system. The Panel submits data to NCANDS, as does the DCF Careline.

Special Review reports are anchored in the Department's family-centered, trauma-informed and community-based *Mission, Guiding Principles and Practices*. Reports highlight related literature and research across discipline, and link the facts of the case with key findings and recommendations that consider the following core areas:

1. The current goals and status of the Department's Strategic Plan and Organizational Structure;
2. Implementation of family-centered, trauma-informed and community-based services;
3. Quality of supervision and implications for training/workforce development;
4. Relevant policies and procedures; and,
5. Coordination and communication with larger systems (courts, community agencies, healthcare providers, schools, other state agencies, and so forth.

Special Review Reports and processes have led to significant changes in policies and practices within and outside of the child welfare system during the past year, and during the past decade. Although each case is uniquely influential, key changes in policy and practices include:

1. Safe-Sleep education, awareness and protocols;
2. Work with young children 0-3 and their families;
3. Education of Emergency Room and Pediatric personnel on identification of child abuse and neglect;
4. Suicide prevention, early intervention and treatment;
5. Interplay of intimate partner violence, mental health impairments and substance abuse;
6. Engaging with young parents and multi-stressed families across generation;
7. Case Practice Review of our Differential Response System;
8. Juvenile Justice and the dynamic intersection of community involvement, education, public safety and rehabilitation;
9. The profound impact of trauma on clients, communities and professionals; and,
10. Community transitions to and from congregate settings.

During the past year, community partners participated in several Special Reviews of fatalities and critical incidents; expanding learning, enhancing relationships and increasing a transfer-of-learning to other similarly-situated cases. These fruitful activities have led to an increase in cross-program training, multidisciplinary case consultation and more effective service

delivery. In the next year, the Special Review process and structure will include expansion of learning forums to the DCF Area Offices, Communities of Practice, Facilities, Regions, and local professional networks.

Child Fatalities and SACWIS

Introduction

The purpose of this document is to describe how an employee of DCF with appropriate permissions to the SACWIS system will enter the information into SACWIS to indicate a maltreatment death due to abuse or neglect has occurred and subsequently how the data is extracted and submitted in the NCANDS reports.

The CT definition of a “Maltreatment Death” is so defined as: when at least one allegation of abuse or neglect related to the death has been substantiated by DCF against a caregiver. NCANDS defines a maltreatment fatality “as a child dying from abuse or neglect, because either (a) the injury from the abuse or neglect was the cause of death, or (b) the abuse and /or neglect was a contributing factor to the cause of death.

The following DCF Policies are used in the process:

34-2-7 – Operational Definitions of Child Abuse and Neglect

34-2-2 – Investigation Process

34-2-6 – Critical Questions to Answer

34-3-6 – Determination and Conclusion

The definition of Substantiated is “Reasonable cause to believe that child abuse or neglect has occurred”.

Data Entry Process

From a data entry perspective the process starts when a user enters a CPS report into LINK (**Fig 1**).

The next relevant data entry point is reflected in (**Fig 2**) when an investigation worker enters the allegation such as physical abuse with a description of death and marks the outcome as substantiated. There is also a confirmation process that asks if the victim is deceased when death is chosen (**Fig 2b**)

The other two areas where a death recording can initiate is in the placement ending /discharge reason screen (**Fig 3**) and in the inactivation of case participants in the case maintenance screens (**Fig 4**).

In an effort to ensure that the LINK case record is consistent, edits have been applied to areas of LINK where a child’s death may be recorded that prompt the worker to also record the actual date of death on the Person Management window.

When the death of a child is recorded in either Investigation **Allegations, Placement End/Discharge Reason, or Case Participant Deactivation**, that action or approval will not be allowed until a Date of Death is entered in the Person Management window **(Fig 5)**.

NCANDS Reporting Process

On an annual basis the federal reporting team lead will run automated jobs run programs to extract data from the agency's SACWIS system "LINK". The lead will then provide the data to the LINK Program and Customer Support Team (PCSU) for review and validation.

The NCANDS logic is program to extract the following as a fatality any child where the following conditions are met:

- A CPS Report alleging child maltreatment was received and accepted,
- An investigation resulting from that report was conducted and concluded that year,
- Allegations of maltreatment were substantiated,
- The child died, the proximate cause of death determined to be the maltreatment the child sustained

The NCANDS job uses COBOL and SQL to extract data from the ALLEGATION and PERSON tables in the SACWIS DB2 Database.

The NCANDS extraction batch will only transmit data when there is a substantiated allegation of death due to maltreatment. It will not transmit if the death data was entered but there is no corresponding substantiation. Also noteworthy is that the data is only transmitted for the FFY where the investigation has concluded and not the date of death which can have an effect on the date the death is reported.

Recording the Death of a Child

CPS Reports

Fig 1

CPS Report

Report Number: 186624 Name: KATHERINE KLEIN Date: 12/27/2000 15:49:39 Worker: GAYLE MURPHY R/T: 24 Hours

Participant Basic Allegation **Decision** Response

Status

Worker
Name: GAYLE MURPHY Accept Not Accept Pending **OK**

Supervisor
Name: GAYLE MURPHY Accept Not Accept Pending **Text** ▼

Is Substance Abuse a Factor in This Report? Generate Critical Incident Notice Safe Haven Baby?
 Generate Police Report Shaken Baby Indicators? Drug Endangered Child ?
 Response Time: 24 Hours High Risk Newborn? **Screening**

Reasons for Non-Acceptance

Child is Over 18 Perpetrator is Neither Caretaker Nor Given Access to Child
 Insufficient Information to Investigate Does Not Meet Statutory Definition of Abuse/Neglect/At Risk **Cancel**

Investigation Allegations

Investigations with an allegation of Death (i.e. Physical Abuse - Death, or Physical Neglect - Action/Inaction resulting in Death). Upon clicking Approve, a pop up asks if the victim is actually dead ("An allegation of death has been selected. Is the victim actually dead?"). If answered Yes, the investigation cannot be approved until a date of death is entered into **Person Management**.

Fig 2.

Investigation

Name: KLEINKAUF, KATHERINE Number: 131927 Status: Closed Initial Response Time: 24 Hours CPS Date: 12/27/2000 CPS Time: 15:49:39

Participants Basic **Allegations** Services Contacts Results Appeals

Multiple CPS Reports

Report#	Alleged Victim	Alleged Perpetrator	Perpetrator Relationship	Confirmation
186624	Crum, Racheal	MILLS, JOHN		Substantiated
	CAN Code: Physical Abuse	Desc: Death		
	Central Registry: Disclosable			
186624	Redway, Kyal	MILLS, JOHN		Substantiated
	CAN Code: Physical Abuse	Desc: Death		
	Central Registry: Disclosable			

Other Noted Concerns

Program Neglect Program Concern Regulatory Violation

OK
Cancel
Add...
Options ▼

Fig 2b.

Gender	DOB	Race ▲	Marital Status	Role(s)	SHBaby
Female	00/00/0000	Wht		RP	No
Female	07/09/1998	Wht		AV-HM	No
Female	00/00/0000	Wht		PC-RI-HM	No
Male	00/00/0000	Wht		AP-HM	No
					No

Allegation of Death

 **An allegation of Death has been selected. Is the alleged victim deceased?**

Status is

Placement End/Discharge Reason

Ending a Placement for Reason of **Death of Child**. If a placement is ended for reason of Death of Child, the placement ending cannot be approved until a date of death is entered in person management.

Fig 3.

Service

Placement Information

Placement Begin Date: 12/14/2010

Placement End Date: 12/14/2010

Is this a Non-Conforming Placement?

Placement Ending

Placement Ending

Actual End Date: 06/06/2011 Same Day Placement

Placement End Reason: Death of Child

Is the End of This Placement a Discharge from All Placements? Yes

Message

 **A date of death must be entered to deactivate this person. Please update the Person Management window to include the date of death to complete this request.**

Fig 4.

Inactive Case Participants

In the Case Maintenance window, there is a change to the **Inactive/Removed Participant** list - the **Legal Status** label has been changed to **Reason** and will display the most recent reason for deactivation. If the participant is reactivated, the current Legal Status will again display.

Maintain Case

Case
Last/ Provider: B-Boy Number: 286038 Status: Open Closed Reopen
First: Sunday Initial: Suffix: Open Date: 05/08/2011

Participants | Address | Case Contacts | Closing

Basic
Case Type: Family Description: Sngl Prnt(Female) With Unrelate

Participants
Active Case Participants

Name	Status	DOB	Gender	Relationship	Legal Status
Unique B-Baby	Active	01/13/2004	Female	Reference Person	Not Committed

Inactive/Removed Case Participants

Name	Status	DOB	Gender	Relationship	Reason
Sunday B-Bone	InActive	07/14/1979	Female	Parent's Paramour	Death
Nanny Bfore	InActive	01/01/2000	Male	Non-Relative	Whereabouts Unknown
Ronald Ketter	InActive	02/13/1976	Male	Birth Parent	No Longer Involved With Family

Fig 4 b.

Deactivation of a Case Participant

If a Participant is deactivated due to Death, a date of death must be entered in the person management window.

Link Message Manager

i A date of death must be entered to deactivate this person. Please update the Person Management window to include the date of death to complete this request.

OK

Fig 5.

3. Education and Training Vouchers: See Section E

4. Inter-Country Adoptions

Eight children who had been previously adopted from another countries came into DCF care in 2014.

5. Monthly Caseworker Visit Data

The Department will submit our monthly caseworker visitation data by 12/15/16 as required.

**State of Connecticut - Department of Children and Families
Maintenance of Effort**

Child and Family Services Plan for June 30, 2016 submission

	FY 2014	FY 1992
Program Type	State Expenditures	State Baseline
Family Preservation	61,303,754	12,983,241
Family Support	72,685,294	5,278,088
Totals	133,989,047	18,261,329

State share of Title IV-B, subpart 2 expenditures for comparison to 1992 base as required for evidence of compliance with non-supplantation requirements in Section 432 (a) (7) (A) of the Social Security Act