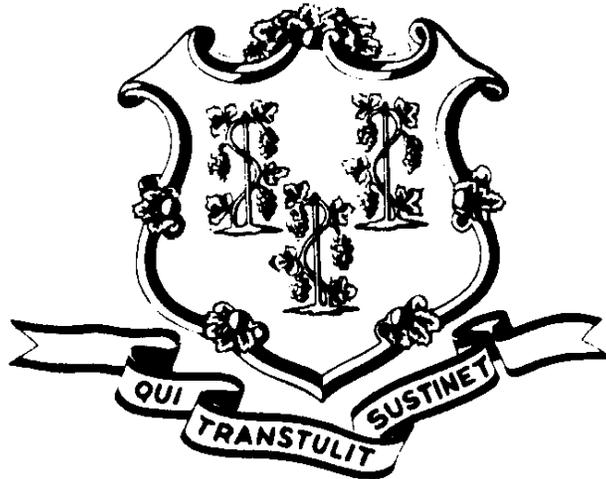


**STATE OF CONNECTICUT**  
**AGENCY PREVENTION REPORT**



**A REPORT TO THE**  
**CHILD POVERTY AND PREVENTION**  
**COUNCIL**

**2012**

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**NOVEMBER 2012**

**Table of Contents**

<b>I.</b>	<b>State Agency Prevention Reports.....</b>	<b>2</b>
	<b>A. Program Summary.....</b>	<b>3</b>
	<b>B. Department of Children and Families.....</b>	<b>8</b>
	<b>C. Department of Developmental Services.....</b>	<b>12</b>
	<b>D. Department of Education.....</b>	<b>16</b>
	<b>E. Department of Labor.....</b>	<b>22</b>
	<b>F. Department of Mental Health and Addiction Services.....</b>	<b>24</b>
	<b>G. Department of Public Health.....</b>	<b>31</b>
	<b>H. Department of Social Services.....</b>	<b>42</b>
	<b>I. Judicial Branch Court Support Division.....</b>	<b>47</b>
	<b>J. Office of Policy and Management</b>	<b>52</b>
<b>II.</b>	<b>Appendix</b>	
	<b>C.G.S. Section 4-67x (g).....</b>	<b>53</b>

# REPORT TO THE CHILD POVERTY AND PREVENTION COUNCIL

## I. State Agency Report

This report implements C.G.S. Section 4-67x (g) which requires each state agency with membership on the Council that provides prevention services to children to submit an agency prevention report to the Council by November 1<sup>st</sup> of each year through 2014. This report must also be included in the Council's annual progress report to the Governor and legislature. This report represents the sixth annual State Agency Prevention Report.

For the purpose of this report, prevention is defined as:

*Policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.*

Prevention programs and services highlighted in this report serve children aged 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at-risk behavior before a problem occurs and promote the health and well-being of children.

Each report includes the following:

- long-term agency goals, strategies, performance-based standards and outcomes and performance-based vendor accountability;
- a statement on the overall effectiveness of prevention within the agency;
- methods used to reduce disparities in child performance and outcomes by race, income level and gender
- a brief description of the purpose of the prevention program;
- the number of children and families served; and
- state and federal funding for fiscal year 2011-2012.

This Prevention Report is comprised of reports from:

- Department of Children and Families
- Department of Developmental Services
- Department of Education
- Department of Labor
- Department of Mental Health and Addiction Services
- Department of Public Health
- Department of Social Services
- Judicial Branch Court Support Services Division
- Office of Policy and Management

The Departments of Transportation, Higher Education, Economic and Community Development, Office of Health Care Access, Commission on Children, and the Commission on Human Rights and Opportunities determined that their prevention programs did not meet the definition of primary prevention, and therefore, no reports from these agencies are included in this report.

# State Agency Prevention Programs - SUMMARY

## State Agency Prevention Programs

This section of the report provides a summary on state agency primary prevention services that provide intensive, comprehensive and family-centered resources and support which reduces or eliminates high-risk behavior and promotes the health and well-being of children and families.

In Fiscal Year (FY) 2012, these agencies expended \$297,402,897 to administer 32 comprehensive primary prevention programs and services that positively impact Connecticut's children and families. The chart below provides a snapshot of the state agency primary prevention programs included in this report.

Summary

Department of Children and Families			
Program	FY12 Funding	Service Level	Description
Early Childhood Consultation Partnership	\$2,347,995	4,061 children and 1,394 teachers	Prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors.
Early Childhood Services	\$520,512	77- 112 families served in Parents in Partnerships and 70 families in Child First	Promotes the development of positive parenting skills and the development of healthy children.
<b>Total</b>	<b>\$ 2,868,507</b>		

Department of Developmental Services			
Program	FY 12 Funding	Service Level	Description
Birth to Three	\$50,194,829	9,333 children and families	Early intervention services to all infants and toddlers who have developmental delays or disabilities.
Family Support Services	\$4,185,378	1,320 individuals including 327 children-Respite Centers; 799 individuals including 345 children – Family Support Services	Services, resources and other forms of assistance to help families raise their children who have intellectual disabilities.
<b>Total</b>	<b>\$54,380,207</b>		

Department of Education			
Program	FY12 Funding	Service Level	Description
Early Childhood Program	\$74,838,095	10,454 children	Expand and enhance access to and availability of school readiness and child day-care programs.
Even Start Family Literacy	\$479,919	53 even start families	Intensive family literacy services to low-income parents and children.
<b>Total</b>	<b>79,318,014</b>		

Department of Labor			
Program	FY 12 Funding	Service Level	Description
Jobs First Employment Services	\$17,741,841	15,742 annual caseload	Provides employment services to families in receipt of time- limited state cash assistance.
Youth Employment Program	\$3,500,000	2,312 youth	Provides employment services for youth aged 14 through 24.
<b>Total</b>	<b>\$21,241,841</b>		

Department of Mental Health and Addiction Services			
Program	FY 12 Funding	Service Level	Description
Best Practices Initiative	\$1,872,736	185,376 children, family members, prevention and treatment professionals	Fourteen statewide funded projects that employ a population-based public health approach to address demonstrated substance abuse prevention needs.
Local Prevention Council Programs	\$552,470	799,519	The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils.
Partnership for Success	\$2,300,000	51,728 clients served by PFS coalition	The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20.

<b>Department of Mental Health and Addiction Services</b>			
<b>Program</b>	<b>FY 12 Funding</b>	<b>Service Level</b>	<b>Description</b>
Regional Action Council	\$1,851,867	1,656,826 children, families, community members and prevention professional	Regional Substance Abuse Action Councils (RACs) are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum.
Statewide Service Delivery Agents	\$1,835,726	426,472 children, families, community members and prevention professional	Four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services.
Tobacco Prevention and Enforcement	\$618,984	1,813 retail inspections and 39,080 printed material	Enforcement and strategies to reduce underage tobacco use.
Tobacco Compliance Check Inspection	\$633,417	1,936 inspections	Enforce and implement the regulation of the federal Tobacco Control Act that restricts the sale and promotion of cigarettes and smokeless tobacco products to minors under 18 years-old.
<b>Total</b>	<b>\$9,665,200</b>		

Department of Public Health			
Program	FY12 Funding	Service Level	Description
Asthma Program: Pediatric Easy Breathing Program for children	\$500,000	6,798 surveyed and 1,813 or 26% with asthma children	A professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma.
Asthma Program: Pediatric Easy Breathing Program for Adults	\$39,332	1,000 surveyed, 225 with asthma	Focuses on adults treated by medical resident physicians in Bridgeport Hospital.
Community Health Centers	\$4,136,759	315,992 clients	Provides comprehensive, community-based, primary and preventive health care.
Family Planning	\$1,020,934	28,917 people with reproductive health services over 50,000 visits, conducted outreach and education to 1,535 at-risk teens	Provides preventive and primary reproductive health care through health care services, information, and education to low-income women of reproductive age.
Immunization Program	\$54,949,669	872,751 children served	Prevent disease, disability and death from vaccine preventable diseases in infants, children adolescents and adults.
Injury Prevention - Childhood Motor Vehicle	\$30,000	255 parents/caregivers and 644 children	Child passenger safety education and child booster seats provided to parents and caregivers.
Injury Prevention Intention Youth Violence	\$50,000	120 at 3 locations with each program location providing a 10 session course	Increase awareness of issues associated with youth violence; recognize and appropriately deal with anger, conflicts, peer-to-peer relationships; increase knowledge regarding the impact of, and risk factors for violent behavior; decrease arguments and fighting; and provide knowledge of appropriate resources for help.
Nutrition, Physical, Activity and Obesity	\$1,205,697	110,000 children and families--SNAP-Ed; 12,660 Preventive Health Services; 889,239 community transformation.	Supports social, emotional, cognitive, and language development in young children while encouraging healthy eating and physical activity. The program trains and motivates teachers, provides materials, and serves as an ongoing resource to promote the implementation of nutrition education and physical activity in the preschool classroom.
Rape Crisis and Prevention Services	\$ 1,003,081	17,793 children, youth, adolescents and young adults; 82 professional training offered to 1,657 professionals	Makes available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation.
Special Supplemental Nutrition Program for Women, Infant and Children	\$57,962,957	14,194 infants, 30,845 children, and 12,293 women	Provides nutrition and breastfeeding education, supplemental food, and referrals for health and social services to eligible women, infants and children.
Tobacco Use Prevention and Control	\$1,079,069	8,900 individuals	Provides local cessation and prevention programs.
<b>Total</b>	<b>\$121,977,498</b>		

Department of Social Services			
Program	FY 12 Funding	Service Level	Description
Nurturing Families Network	\$1,340,000	1,900 families in intensive home visiting and 500 families in Nurturing Parenting groups	Provides parenting education and support to families through three levels of services: screening and short term support, intensive long term home visiting and parenting groups.
Fatherhood Initiative	\$568,173	641 individuals and 15 couples	Provides outreach, awareness and training for parents relating to parenting, healthy relationships and healthy marriages.
Teen Pregnancy Prevention	\$ 2,057,939	690 program participants	Prevents teen pregnancy and welfare dependency through the provision of awareness education and supportive programs and services.
<b>Total</b>	<b>\$ 3,966,112</b>		

Judicial Branch Court Support Services			
Program	FY 12 Funding	Service Level	Description
Educational Support Services	\$646,800	316	Supports families to ensure that children's educational needs are identified and free and appropriate educational services are accessible.
Family Support Centers	\$3,305,232,	1,097	A multi-service "one-stop" service for children and families referred to juvenile court.
<b>Total</b>	<b>\$ 3,952,032</b>		

Office of Policy and Management			
Program	FY 12 Funding	Service Level	Description
Title V Delinquency Prevention Program	\$33,486	N/A	Provides grants to cities and towns for delinquency prevention and early intervention projects.
<b>Total</b>	<b>\$ 33,486</b>		

# Department of Children and Families

- **Early Childhood Consultation**
- **Early Childhood Services**
- **Positive Youth and Family**

**Long-Term Agency Goals:** The Department of Children & Families applies a generalized knowledge of prevention in the design and implementation of all its prevention programs and activities. The programs use existing data and national research as the foundation for designing and implementing appropriate evidence-based programs and practices. Similar to other state and federal agencies, risk and protective factors play an important role in the Department's planning process. For example, the federal Children's Bureau has outlined five protective factors that may diminish the likelihood of maltreatment: nurturing and attachment between family members; knowledge of parenting and child development; parental emotional resilience; social connections for parents; and concrete supports such as food, clothing, housing, transportation, and services. The theory is that parents and caregivers who better understand how to care for their children, have access to more and better resources and feel safe and connected to their community will thrive and be less likely to abuse or neglect their children. The programs described here have been shown through research and evaluation to be effective at addressing at least one of these important factors. Knowing that prevention resources are limited, the Department works diligently to collaborate with other state and community based agencies as well as internally to maximize existing prevention dollars. All of the programs listed are examples of collaborations and partnerships.

**Goals:**

- Prevention/Less Need for DCF Services
- Children to Remain Safely at Home
- Achieve More Timely Permanency
- Improved Child Well-Being
- Transitioning Youth Better Prepared for Adulthood

**Strategies:** Meeting the desired outcomes is best achieved through building agency and local capacity,

public awareness, programs and services, and integrating prevention principles, strategies and resources throughout the department.

**Performance-Based Outcomes:** The Department is working diligently to meet the Exit Outcomes for its Consent Decree. Therefore, the following outcomes are aimed at meeting these court defined measures. A complete list of Outcome Measures can be found at [http://www.ct.gov/dcf/LIB/dcf/positive\\_outcomes/pdf/Two\\_Page\\_Summary\\_Outcomes\\_1\\_22.pdf](http://www.ct.gov/dcf/LIB/dcf/positive_outcomes/pdf/Two_Page_Summary_Outcomes_1_22.pdf)

**1. Prevention/Less Need for DCF Services**

- Fewer investigations
- Fewer open cases
- Fewer delinquency petitions
- Fewer Families with Service Needs (FWSN) petitions
- Increase numbers of families receiving appropriate and effective services
- Fewer re-entries into child welfare system

**2. Children to Remain Safely at Home**

- Fewer removals from home
- Fewer re-entries into care
- Fewer delinquency commitments
- Lower recidivism
- Fewer disrupted adoptions
- Fewer FWSN commitments

**3. Achieve More Timely Permanency**

- Fewer youth aging out with APPLA goal
- Reduce average Length of Stay (LOS) for reunification & Meet Outcome Measure (OM) 7 re: Reunification
- Reduce average LOS for Transfer of Guardianship (T Of G) & Meet OM 9 re: T/G
- Reduce average LOS for adoption & Meet OM 8 re: Adoption

**4. Improved Child Well-Being**

- Fewer school changes
- Improved school achievement
- Fewer placement changes

- Meet OM 14 re: Placements within License Capacity
- Increase of placement with siblings
- Meet OM 6 re: Child maltreatment in Out of Home (OOH) care
- Increase percentage of children placed with relatives
- Timely medical/dental care
- Lower percentage of children in congregate care
- Reduction of children on discharge delay
- Improved performance on OM 15 re: Needs Met

#### 5. Transitioning Youth Better Prepared for Adulthood

- Increased percentage with family/adult connection
- Increased percentage of high school graduates
- Increased percentage engaged in treatment if needed
- Increased percentage with financial literacy
- Increase percentage with sustainable housing
- Meet OM 20 re: Discharge
- Meet OM 21 re: Discharge to DMHAS/DDS

**Measure of Effectiveness:** The findings thus far indicate that programs targeting and strengthening families have been the most effective. Research tells us that the earlier interventions are introduced into children's lives the greater the chance for positive results now and later. National research studies show that very young children are especially vulnerable. The Adverse Childhood Experience Study (ACES) found that adverse childhood experiences are strongly related to the development and prevalence of risk factors for disease and health and social well-being throughout the lifespan. This emphasizes the need for prevention and early intervention programs for very young children and the need to target children in the context of their families and the communities in which they live.

**Methods:** At the ground level, programs such as The Breakthrough Series (a program implemented in Waterbury to look at the issue of overrepresentation of

minorities in the child welfare system) and Better Together (a program to engage families in our work to inform the Department's ongoing efforts) work to concretely address the issue of disparities in outcomes by race, income and gender. At the systems level, two new DCF initiatives, the Differential Response System and the Best Practice Model combine to support the mission of the Department to protect children, improve child and family well-being and support and preserve families. The goal is to provide a framework for how the agency as a whole will work internally and partner with families, service providers, and others to put our mission and guiding principles into action in daily practice and operations. The Department's workforce reflects the populations it serves. In addition, DCF requires all contractors to administer, manage and deliver a culturally responsive and competent program with specifics clearly articulated in every contract.

**Other:** Prevention is just one of the Department of Children and Families' many mandates but it is one of its most important. DCF defines prevention as the promotion of wellbeing for all children and families. This is accomplished by building local and agency capacity, public awareness and funding prevention and early intervention programs and services.

Building capacity is done primarily through training. Since 2005, thousands have been trained in a variety of workshops and conferences on early childhood specific topics, youth substance abuse, depression, suicide prevention, Strengthening Families 10 -14 (a nationally recognized evidence-based curriculum), working with parents with cognitive limitations and shaken baby prevention - to name just a few.

Knowledge is power. It is this belief that drives the Department's Public Awareness campaigns. Getting important and timely information to families, providers and DCF personnel requires constant contacts. Along with the dissemination of letters and brochures to schools, superintendents, police, youth service bureaus, and DCF Area Offices and the information regularly distributed electronically through the Prevention list serve, the new CT Parenting website <http://www.ctparenting.com/> offers parents and other individuals a user friendly internet site for information on a multitude of topics for parents and caregivers.

The Department's prevention programs and services are designed to strengthen children and families.

**Early Childhood Consultation Partnership (ECCP):** The goal of ECCP is to prevent children birth to age 6 from being suspended or expelled from their early care and education setting due to challenging behaviors. ECCP promotes and facilitates the early identification of children in daycare education settings with mental health needs. The focus of this service is the provision of consultation and training to staff in Early Care and Education Settings in order to promote young children's social and emotional wellness in order to prevent behaviors that could result in the child being suspended or expelled from the early care and education setting. The program also provides service to DCF foster homes, safe homes, childcare homes, and parent child residential facilities.

**Number Served:** Since its inception in 2003 the program has served over 18,858 children and over 6,665 teachers and assistant teachers within an estimated 900 of Connecticut's licensed early care or education centers. **In 2011-2012, 4,061 children and 1,394 teachers and assistant teachers were served.**

**Program Cost: FY 2011-2012:** \$2,347,995

**Performance-Based Standards:** ECCP is a data driven program demonstrating its effectiveness through the internal quality assurance and program improvement measures it employs and through external research evaluations and national studies. ECCP is further backed by a 2007 rigorous randomized control evaluation conducted by Walter S. Gilliam, PhD, of Yale Child Study Center. A randomized study compared outcomes for children who were/ were not enrolled in classrooms that received ECCP services. Results indicated significant effectiveness in reducing classroom behavior problems in children, demonstrating changes such as decreased oppositional behaviors and hyperactivity. Program measures such as 6 month follow up data show that 99 percent of children in programs that received consultations were neither suspended nor expelled from their early care or education settings, and that 92 percent of classrooms served demonstrated improvement in the overall quality of classrooms environments.

**Performance-Based Outcomes:**

- Increased number of early childhood education centers and staff who have access to education and support services related to social and emotional wellness.
- Increased the number of caregivers and teachers that are implementing practices supportive of social and emotional health
- Improved ability of educators to observe and document children's behavior and identify behaviors that may be clinically significant
- Improved ability of educators to deliver classroom strategies and interventions targeted to specific children
- Improved ability of educators to initiate discussions with parents regarding children's behavioral difficulties, and to work in partnership with families, in helping to address children's individual needs
- Reduced incidence of suspension and expulsion in young children due to behavioral problem
- Increase coordination between parent /guardians, providers, DCF workers
- Increased capacity of parent /guardians, providers, DCF workers and early educators in the areas of healthy social/emotional development and attachment
- Increased support for children in foster care and for DCF staff

**Performance-Based Vendor Accountability:** ECCP is funded through Connecticut's State Department of Children and Families and is managed by Advanced Behavioral Health (ABH®), a non-profit behavioral health care management company. ABH has been responsible for the development and administration of the ECCP program. ABH subcontracts with 10 non profit behavioral health clinics for 20 Early Childhood Mental Health Consultants to provide statewide coverage. ECCP is backed by a rigorous research evaluation and features a fully manualized service approach, customized central Information System, and an integrated and competency based workforce development and training program. ECCP is now an evidence –based effective practice and nationally recognized as an evidence-based model for other states to follow.

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**EARLY CHILDHOOD SERVICES:** Parent in Partnership (PIP) strengthens parenting through the use of a standardized parenting curriculum for an in-home and community-based support and intervention for high risk families. Child FIRST provides home based assessment, family plan development, parenting education, parent-child therapeutic intervention, and care coordination/case management for high-risk families.

**Number Served:** Parents in Partnership 77-112 families /yr and Child FIRST 70 families/yr

**Program Cost: FY 2011 – 2012:** \$520,512

**Performance-Based Standards:** Promotes the development of positive parenting skills, school readiness skills and healthy development for children, ages birth to six who may be identified as at risk for abuse and/or neglect and having developmental delays in order to increase their ability to function optimally in social and learning environments.

**Performance-Based Outcomes:**

- Families will have less or no DCF Involvement - measured at enrollment and at the end of the program
- Parents/caregivers will show less stress as evidenced by the Parenting Stress Index (PSI)
- Caregiver-parent relationships will be strengthened as evidenced by the Observation of Caregiver-Child Relationship (OCCR)
- The home environment will demonstrate improvement as evidenced by the Home Observation - Physical Environment (HOPE)
- Families will gain a better understanding of stages of childhood development including social and emotional development and children will show improvement in this area as measured by the Ages and Stages-Social Emotional Questionnaires
- Parents will be screened for depression and will show improvement
- Clients will be satisfied with the program

**Performance-Based Vendor Accountability:** Quarterly and Annual reports. Site visit review tool are being developed.

# Department of Developmental Services

- **Birth to Three**
- **Family Support Services**

**Long-Term Agency Goals:** The Department of Developmental Services (DDS) provides services and support to more than 15,858 individuals who have a diagnosis of intellectual disability in Connecticut including 2,567 children under the age of 18. This number does not include approximately 9,300 eligible children who are served in the Birth to Three System. While most children live with their families, approximately 162 children served by DDS live in other residential settings. The department's long term prevention goal is to:(1) provide early intervention to families of very young children with disabilities or delays to ameliorate the delay or to at least prevent secondary disabilities; (2) support families to care for their children in the family home and (3) to prevent out-of-home placement.

**Strategies:** For children enrolled in Birth to Three, family-centered early intervention services are delivered in natural environments as early as possible. Most families who have children with intellectual disabilities over the age of three need extra support to care for their children at home. DDS provides Family Supports to assist families caring for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully raise their children who have intellectual disability. The Department of Developmental Services plans to continue to provide Individual and Family Grants, Respite and Family Support Workers to families. Within available resources, the department serves as many families as possible with these Family Supports.

In addition to the Family Support services offered by the department, DDS continues to implement Home and Community Based Services Waivers which offer services in the community as an alternative to institutional care for children over the age of three. The department continues to expand the range and number of services available under the waivers that assist families to care for their children within the family home. These services include personal services, individualized supports, respite, home and vehicle modifications, family training and consultative services. All children who receive Medicaid fee for services are provided with a DDS case manager. A

help line exists in each of the three DDS regions to assist families who do not have a case manager to access appropriate family support services.

**Performance-Based Outcomes:** For children enrolled in Birth to Three, children are identified as early as possible, children's developmental trajectories are improved, parents feel more confident and competent to foster their children's development, and fewer children need special education services by Kindergarten. For children over the age of three, children are able to live at home longer with their families, receiving appropriate supports and avoiding more costly residential or out-of-home care.

**Measures of Effectiveness:** Because individuals eligible for DDS supports and services have a diagnosis of intellectual disability or autism spectrum disorder, they are likely to require lifetime services. While intellectual disability or autism spectrum disorder in and of itself is not "preventable", strategies are pursued to lessen or delay the need for more comprehensive services throughout an individual's lifetime and to provide supports and services that build skills and independence. The provision of in-home services often delays the need for more comprehensive and thus more expensive residential or out-of-home services. In Birth to Three, family survey outcome data supports that the stated outcomes are being achieved to a great degree.

**Methods:** Any child that meets the DDS eligibility criteria in section 1-1g of the Connecticut General Statutes is eligible for services, irrespective of race, income level, gender or town of residence. Funding for these services is allocated to a child and their family based upon the child's level of need and available appropriations. Birth to Three is an entitlement program and all eligible children may receive services. Data about all children born during a given calendar year (birth cohort) indicate no racial, income level, or town of residence disparities. The prevalence of a wide range of developmental disabilities is greater for males than for females, however, and Birth to Three enrollment is 65% boys. The focus of early intervention services is in teaching the family and other caregivers to facilitate the child's development during naturally occurring routines and activities.

**BIRTH TO THREE:** The Department of Developmental Services (DDS) is the lead agency (17a-248 C.G.S.) for the Birth to Three program, which is also operated under the provisions of Part C of the Individuals with Disabilities Education Act. This is the same federal law that governs special education for children ages 3 to 21.

The mission of the program is to strengthen the capacity of families to meet the developmental and health-related needs of their infants and toddlers who have developmental delays or disabilities. The program ensures that all families have equal access to a coordinated program of comprehensive services and supports that:

- foster collaborative partnerships
- are family centered
- occur in natural settings
- recognize current best practices in early intervention
- are built upon mutual respect and choice

Birth to Three seeks to assist families to ameliorate delays in their infants' or toddlers' development that are identified early or to prevent secondary delays or disabilities. We work with families to ensure that their children are ready for Kindergarten at age five.

The federal law requires that two groups of children receive services 1) those with developmental delays and 2) those with diagnosed conditions expected to lead to a developmental delay without the benefit of early intervention. States are given quite a bit of latitude in defining both of those groups.

Early intervention services must be delivered in natural environments and for children at this age, that is typically the home, (although services can be delivered in any setting that the child and family typically frequent, such as at child care.) Most services are delivered by occupational, physical, and speech therapists along with early childhood special education teachers, although there are many other professionals and paraprofessionals who can be service providers as well.

**Number Served:** In FY 2012, 8,419 referrals were accepted for evaluation. During some portion of fiscal year 2012, 9,333 eligible children and their families received services with an average of 5,000 children enrolled on any given day. Data about children born each year between 2000 through 2008 show that the Birth to Three System has consistently served 10% to 11% of the children born in that year (birth cohort). Data on those children born in 2008 shows that one out of every eighty-five children born that year received autism services sometime before their third birthday.

**Program Cost: FY 2011 -2012:** \$50,194,829

In addition to state and federal funding, the state netted \$1,090,272 from parent fees and \$3,986,381 from commercial insurance in FY 11. (Medicaid billing resulted in \$9,651,913 federal reimbursement for the state's general fund).

**Performance-Based Standards:** There is a single statewide point of access, which is easily marketed to health care providers and other referral sources. Once children are referred, they are evaluated and, if eligible, family service plans are developed within 45 days of referral. All new services are delivered no later than 45 days from the writing of the plan. Individualized Family Service Plans (IFSPs) are reviewed at least every six months and rewritten at least annually. School Districts are notified of all children receiving early intervention services shortly before the child turns three, if the children have not already been referred to the districts. Parents are encouraged to refer their children no later than age 2 ½.

**Performance-Based Outcomes:**

- All eligible children and their families are identified and offered services
- Children receive early intervention services as early as possible
- Children's developmental trajectories are improved
- Families feel more confident and competent to foster their children's development
- Fewer children need special education services by Kindergarten

**Performance-Based Vendor Accountability:** Birth to Three has an in-depth, multi-layered process for assuring the quality of services and the performance of its contractors.

*Data System* - All contractors are part of a real-time data system that enables the state to view their performance on a daily basis. As part of that data system, the contractors have a “performance dashboard” that allows them to monitor their own performance.

*State Performance Plan/Annual Performance Report* - The department submitted a five-year State Performance Plan to the U.S. Department of Education and then submits an Annual Performance Plan each year reporting on progress. Each indicator of performance in the annual plan is also reported for each contractor. Any contractor not in 100% compliance with the Individual with Disability Education Act (IDEA) for any indicator receives a finding of non-compliance which must be corrected as soon as possible but no later than twelve (12) months from written identification. Connecticut’s Annual Performance Report for IDEA Part C has resulted in a determination of “meets requirements” for the past five consecutive years.

*Self Review*- In addition, every two years, each Birth to Three contractors submits self-review looking at their performance over a wide variety of indicators. That review is submitted electronically to DDS central office staff who verifies the data and the contractor is required to prepare an improvement plan for any items that are either not in compliance with the law or performance items that need improvement. Twice a year, the state ranks contractors on one or more specific indicators chosen by a stakeholders group. Low-performing contractors receive an on-site monitoring visit by a team composed of state staff, a program director from a different agency, and parents. The team focuses on the indicator that was low but then delves much deeper into issues of quality. The team reviews child records, interviews staff, and interviews parents. The monitoring report is issued and any findings of non-compliance are made. Corrections of non-compliance findings or items needing improvement are added to the contractor’s existing improvement plan. Any finding of non-compliance must be corrected as soon as possible, but no later than twelve (12) months from written identification.

*Dispute Resolution.* The last check on contractor performance is procedural safeguards for parents. Each written complaint received is investigated and may result in one or more findings that must be corrected by the contractor. The same is true for any administrative hearings, although they have been held infrequently. All of these accountability processes are detailed in the Birth to Three Quality Assurance Manual on [www.birthe23.org](http://www.birthe23.org) under “Publications”.

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**FAMILY SUPPORT SERVICES:** The Department of Developmental Services (DDS) provides Family Supports that assist families to care for their children who have intellectual disabilities in their homes. Most families who have children with intellectual disabilities need extra support to help them keep their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families successfully raise their children who have intellectual disabilities. Family Supports include Respite Services provided by DDS and DDS Family Support Workers. Family Supports help children grow up in a nurturing family home where they are more likely to live healthy, safe and productive lives. DDS Respite Centers provide 24-hour care for extended weekends in comfortable home-like environments.

Family Support Workers provide temporary in-home and community support to DDS consumers who live at home with their families. These supports are provided by DDS staff who have skills needed to work with children who have intellectual disability and their families. The types of supports and services provided include in-home and community supports, respite, skill building, implementation of behavior programs, activities to promote health and wellness, transportation to medical appointments, and support with transitions to adult programs.

**Number Served:** The department has 11 Respite Centers which served a total of 1,320 individuals statewide in FY 12, including 327 children. During FY 12, DDS family support workers provided services to more than 799 individuals statewide, including 345 children.

**Program Cost: FY – 2010-2012:** \$4,185,378

**Performance-Based Standards:** The goal of DDS Family Supports is to provide a range of supports for families of children with intellectual disabilities so they can stay together and keep their children in the family home. DDS prioritizes family supports based upon the level of need of the child and the family; for instance, a child who is a high priority on the waiting list for residential services is also a high priority for services at respite centers.

**Performance-Based Outcomes:** Specific outcomes in measuring the success and effectiveness of Family Supports provided by DDS include the number of children and families served and the number and percentage of children who live in family homes compared to children in out-of-home placements.

**Performance-Based Vendor Accountability:** Family Supports are provided by DDS staff through the department's programs and are not contracted services. Family Support programs are operated based upon DDS policies and procedures specific to those services. The procedures are described in the eligibility criteria, priority for services, and service operational guidelines. DDS regional offices maintain data on the numbers of children and adults served. DDS has a centralized process to review requests for out-of-home placement for children. The department's Children's Services committee meets monthly to review any requests to place a child under age 18 out of the family home. The committee reviews alternative supports that have been put in place, makes recommendations for additional supports that may be successful in keeping families together and makes recommendations to the Commissioner regarding the appropriateness of placements.

# Connecticut State Department of Education

- **Early Childhood Program**
- **Even Start Family Literacy Program**

**Early Childhood Program:** To significantly increase the number of accredited and/or approved spaces for young children in order to provide greater access to high-quality programs for all children; To significantly increase the number of spaces for young children to receive full-day, full-year child care services to meet family needs and to enable parents to become employed; and to establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families. All programs must receive National Association for the Education of Young Children (NAEYC) or Head Start accreditation within three years of initial funding and must maintain such accreditation for continued funding to ensure high-quality programs for all children. Communities must offer a range of options regarding the length of program day and year in order to meet the needs of families. Families are offered a sliding fee scale as a means of providing affordable high-quality early education programming. The program serves resident children in priority school districts and competitive grant municipalities who are ages 3 and 4 years of age and children age 5 years of age who are not eligible to enroll in school.

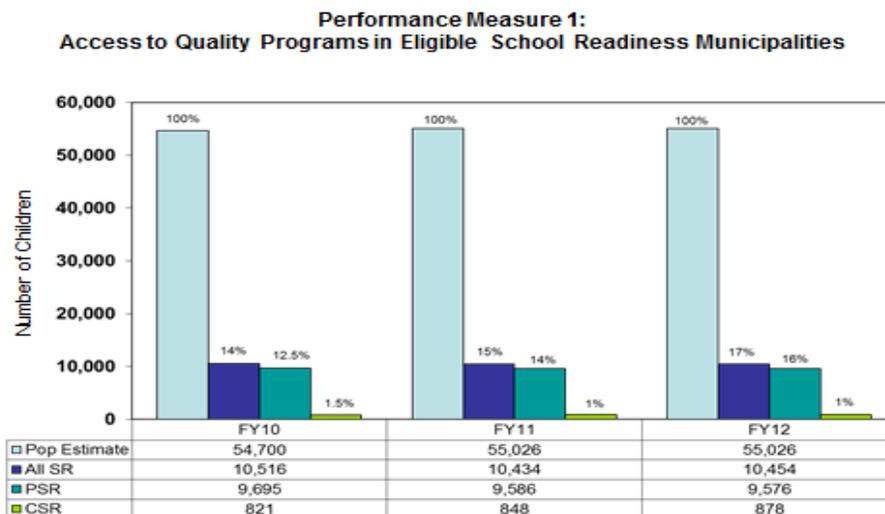
**Number Served:** A total of 65 towns/school districts in Connecticut served 10,454 children in priority and competitive school readiness programs.

**Program Cost FY 2012:** \$74,838,095

**Performance-Based Standards:** Quality preschool services are available for 100 percent of eligible children in priority school districts. By 2015 every School Readiness classroom will have a teacher with an early childhood associates or bachelor’s degree or higher. By 2020 every School Readiness classroom will have teacher with an early childhood bachelor’s degree or higher. All of the School Readiness Programs are accredited or approved under the recognized systems.

**Performance-Based Outcomes:** Quality early childhood programs ameliorate the risk factors that lead to achievement gaps. Two components that contribute to program quality are: teachers with early childhood specific training; and systematic monitoring across multiple program components.

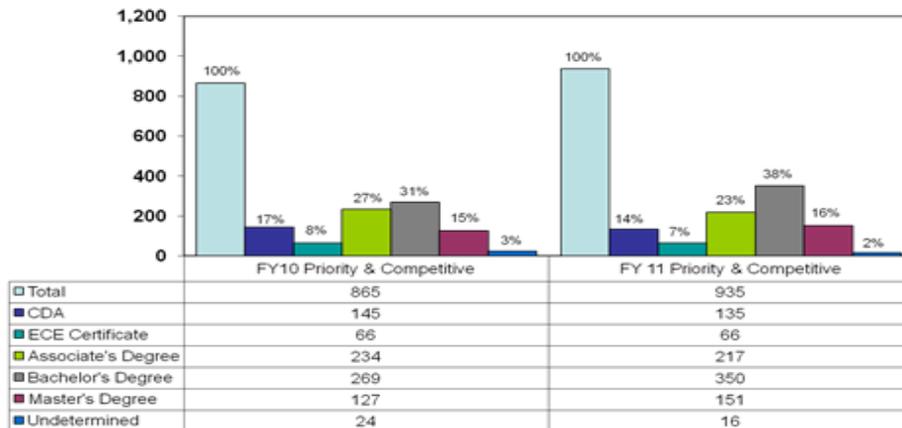
**Performance Measure 1:** Access to quality early childhood programs in eligible municipalities.



This graph shows a comparison of the School Readiness-funded space capacity over the past three years in relation to the preschool population estimates, for eligible 3-4 year olds, in the 65 School Readiness Municipalities. The School Readiness municipalities show a slight increase in capacity to serve more preschool children. Level funding continues to prohibit significant increases in meeting the need for preschool services across the state.

**Performance Measure 2:** Progress of teacher qualifications toward a Baccalaureate degree.

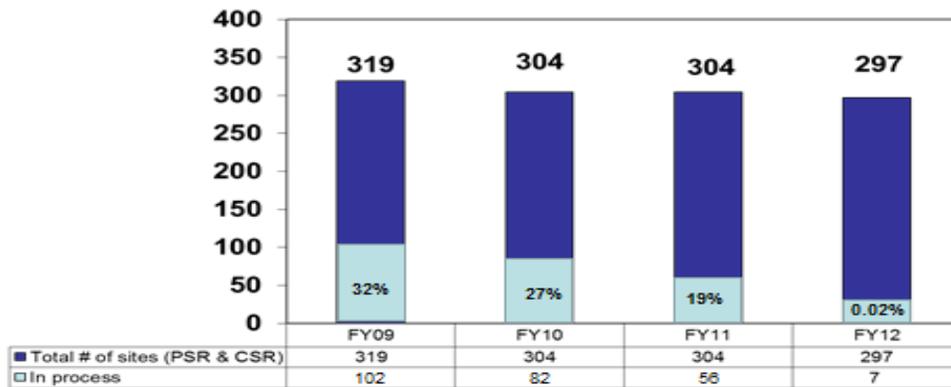
**Performance Measure 2:  
Progress of Teacher Qualifications Toward Baccalaureate Degree in  
School Readiness Programs**



Working collaboratively with the Early Childhood Professional Development Registry, the State Department of Education (SDE) can now report real-time data for this measure. Therefore, FY 10 and FY 11 data are available for this report. Since the Registry is unable to report teacher data at the classroom level, the CSDE further disaggregated teacher information from the Registry to provide an accurate picture, matching teacher to classroom. The CSDE found 305 School Readiness sites with 935 teachers. There does not seem to be significant progress toward attaining higher level teacher qualifications. However, there has been a major reduction in the number of teachers in the “undetermined” category due to more accurate credential verification. It is expected that the recent legislative change to mandate approval of college programs offering an early childhood type degree, and the timeline for teachers to reach the bachelor level by 2020, will shift movement toward attaining degrees.

**Performance Measure 3:** Progress toward quality standards.

**Performance Measure 3:  
Progress Toward Quality Standards**



There was a significant effort this year for programs to become NAEYC accredited. There are 297 School Readiness sites in Connecticut. 288 of these programs are participating in the NAEYC accreditation system; 99.98 percent of which hold accreditation and .02 percent are in process of achieving such status. There are 9 programs that hold Head Start status not pursuing NAEYC accreditation. The NAEYC and Head Start systems align with the School Readiness quality components and are therefore adopted as the School Readiness quality monitoring system. These systems address multiple program quality components such as health, curriculum, family, assessment, physical environment, teaching, leadership, and community partnerships.

**Performance-Based Vendor Accountability:** School readiness programs are based on ten quality components and provide supports and services for collaboration with community agencies, health, nutrition, parent education and services, transition to kindergarten, professional development that includes training in emerging literacy and diversity, family literacy, child and program evaluation, a sliding fee scale and a non-discriminatory admissions process. The plan to implement these supports and services is described by each school readiness program in their application. The program’s adherence to the quality components is reported through the Connecticut School Readiness Preschool Program Evaluation System (CSRRPES), as well as state monitoring visits and community liaison site visits. These reports focus on the program’s implementation of the services and emphasize collaboration with outside service providers in order to support the individual needs of families in the context of their community.

**Even Start:** To break the cycle of poverty and illiteracy for low-income families. In FY 2012, Even Start moved from a federally funded program to a Connecticut State funded program to continue provide intensive family literacy services involving parents and children in a cooperative effort to help parents become full partners in the education of their children and assist children in reaching their full potential as learners. Even Start helps break the cycle of poverty and illiteracy by improving the educational opportunities of families most in need in terms of poverty and illiteracy by integrating early childhood education, adult literacy or adult basic education, and parenting education into a unified family literacy program. Local programs are implemented through cooperative projects that build on high-quality existing community resources, creating a comprehensive range of services for low income children and parents.

Even Start helps children and families achieve the academic standards set forth by the state and uses instructional programs that are based on scientifically-based reading research to:

- enrich language development, extend learning and support high levels of educational success for children birth to age seven and their parents;
- provide literacy services of sufficient hours and duration to make sustainable changes in a family;

- provide integrated instructional services for families, where children and their parents learn together to develop habits of life-long learning; and
- support families committed to education and to economic independence.

**Numbers Served:** Even Start in Connecticut operated with three programs serving high-need areas of Middletown, New London, and Torrington. Programs served 53 families (54 Even Start adults and 60 children) through all Even Start components. The number of programs supported has dropped significantly each year from a previous service level of 10 programs in FY 2003. One program operational in FY2011 closed due to lack of funding, leaving the remaining three programs.

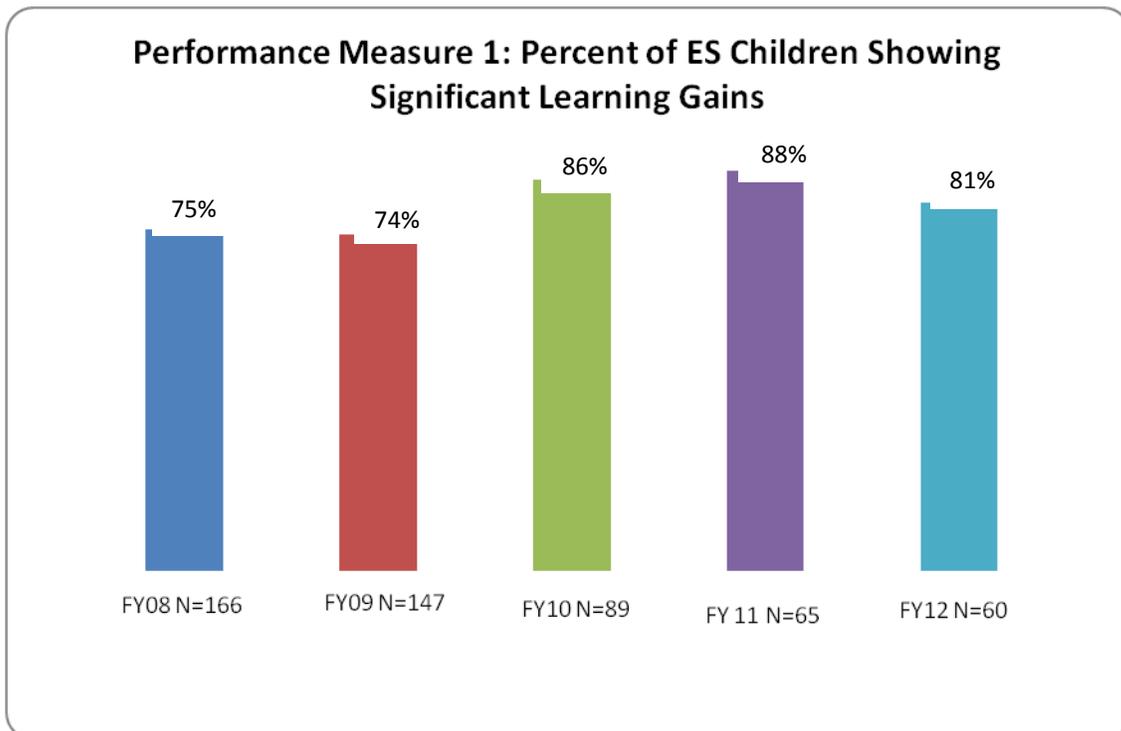
**Program Cost: FY 2011-2012** \$479,919

**Performance-Based Standards:**

1. It is expected that 50 to 65 percent of the Even Start children birth through k-bound will meet the reading readiness standards for their age group.
2. It is expected that 40 percent or more of the adults will meet adult literacy goals in adult Basic Education or English as a Second Language reading and 60 per cent of the adults in a high school diploma or General Educational Development program will make progress toward attaining a high school diploma or its equivalency.
3. It is expected that 40 to 60 percent of the parents will meet standards for skill development in family literacy such as reading to child, encouraging child to read with them at home, etc.

**Performance –Based Outcomes:** After federal funding for this program was cut at the close of FY 2011, Even Start became fully funded by the state of Connecticut in FY 2012. Funding for this program was set at the FY2011 level of \$479,919. Even Start families at all three programs operational during FY2012 continue to make solid gains.

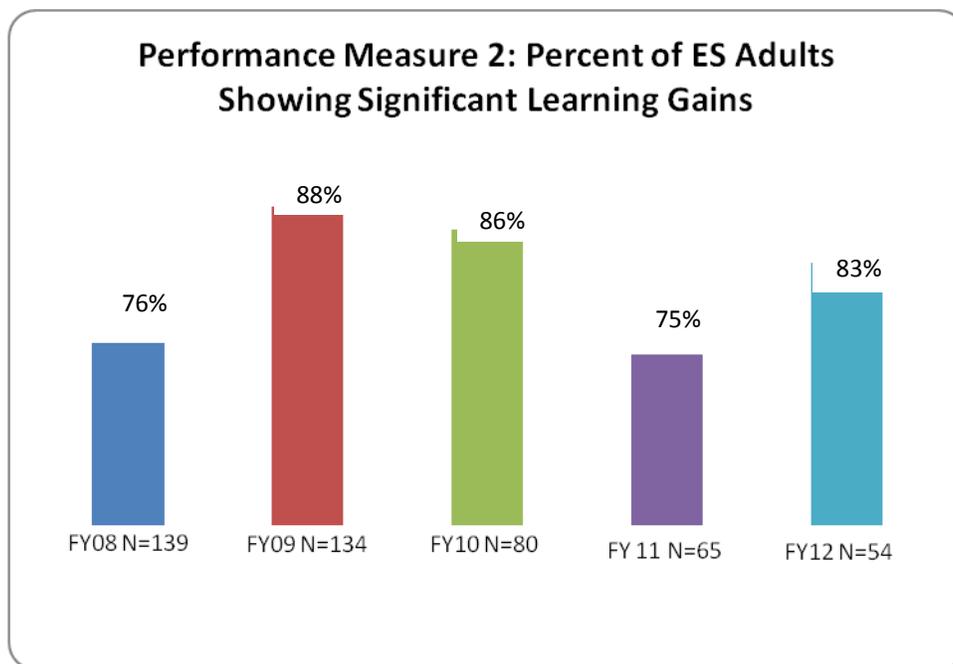
**Performance Measure 1:** Percent of Even Start children meeting standards in reading/reading readiness skills.



Even Start program performance data over five years show that on average, 81percent of the children met or exceeded standards in reading readiness for their age group (birth to kinder-bound). Children participated an average of 55 hours per month in early childhood classrooms, interactive literacy activities and during home based instruction. This year, over 83% of the children were infants and toddlers and were assessed every four months using the Ages and Stages Questionnaire (ASQ). Other assessments used for older children include: Phonological Awareness Literacy Screening (PALS), the Peabody Picture Vocabulary Test (PPVT), Concepts About Print, and the Developmental Reading Assessment (DRA).

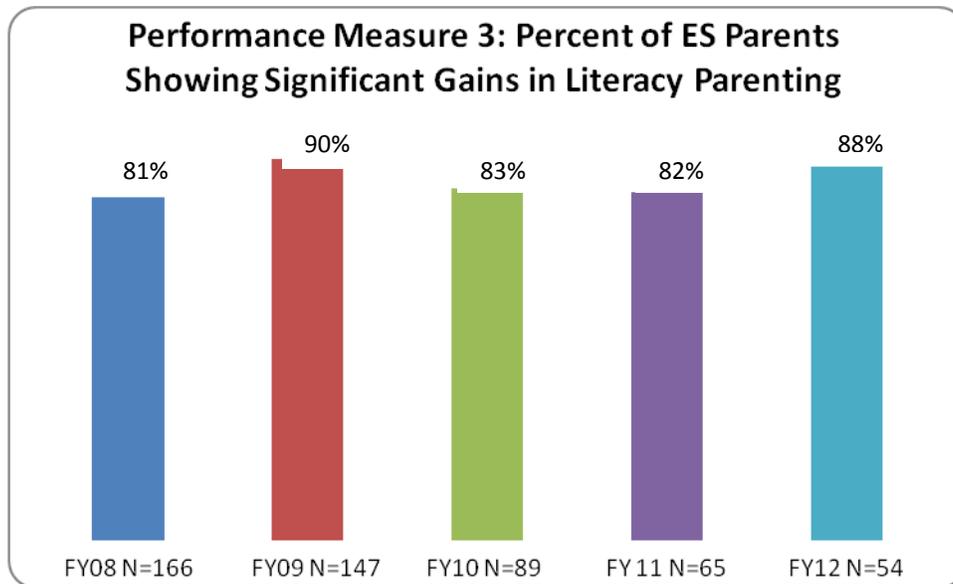
Although research data are not available for Connecticut, research from other states indicates that children who receive Even Start services outperform children who do not participate in Even Start. These studies suggest that Even Start children score significantly higher on measures of reading readiness and are twice as likely as non-Even Start children to be reading at or above grade level (Link, D.E. and Weirauch, 2005)

**Performance Measure 2:** Percent of Even Start parents showing significant learning gains or earning a high school diploma.



Over the past five years, adults in Even Start have consistently made significant gains. Every year, the program has exceeded its expected standard by more than 30 percent. The average percent of adults making significant progress during the year on their goals is 82 percent, exceeding the overall standard for adult literacy by 40 percent or more. These are impressive gains on measures of high school completion and English language acquisition.

**Performance Measure 3:** Percent of Even Start parents demonstrating gains in family literacy skills.



Results show that in the past five years, on average, 88 percent of the parents were observed to learn and apply parenting skills related to family literacy. Parents participate in parenting education classes, interactive literacy activities (with their child), and home-based instruction visits averaging 13 hours per month. Parents are encouraged to work directly with the child during interactive literacy activities and home-based instruction under the guidance of Even Start staff or collaborators. Parenting education classes are aligned with what children are learning in their early childhood classroom. Concepts underscored in parenting education are enhanced through application during interactive literacy activities and home-based instruction.

*Performance-Based Vendor Accountability:* Even Start is required to contract for local program evaluation. All programs must report on attendance and outcomes. They receive 3-5 visits per year from the evaluator who monitors the quality of Even Start components. To ensure quality, programs must develop local objectives that are measurable and meet standards. Local evaluation visits include participant record reviews, observations of components (protocol developed for each component), ECERS and ITERS reviews of early childhood classrooms, review of lesson plans, and conduct focus groups and interviews with participants and staff.

References:

Link, D.E. and Weirauch, D.M. (2005). *Questioning the validity of the evidence against family literacy programming: A critical analysis of the National Even Start Evaluations. Literacy Harvest/ Family Literacy forum, 12, 33-38 New York: Literacy Assistance Center.*

# Department of Labor

- **Jobs First Employment Service**
- **Connecticut Youth Employment Program**

**Long-Term Agency Goals:** The Department of Labor (DOL) is committed to protecting and promoting the interests of Connecticut workers. In order to accomplish this in an ever-changing environment, the DOL assists workers and employers to become competitive in the global economy using a comprehensive approach to meeting the needs of workers and employers, and the other agencies that serve them.

Within the context of DOL's long term agency goals, the DOL has two programs that target families and children: Jobs First Employment Services (JFES) and CT Youth Employment Program. The goals of the JFES program are to enable all families who receive time-limited state cash assistance to become and remain independent of welfare through employment by the end of the 21-month durational limit on cash assistance. The goal of the CT Youth Employment Program (CYEP) is to provide low-income youth aged 14 through 24 years with meaningful paid work experiences.

**Strategies:** To meet the goals of the JFES program, parents on cash assistance are provided with employment-related assessments, job counseling, case management, vocational education, adult basic education, subsidized employment and support services to enable them to become employed before their cash assistance ends. TFA recipients often have multiple and/or severe barriers to participating in the program and obtaining and retaining employment. The program offers intensive, home-based case management which provides in depth assessments and

assistance obtaining the services necessary to overcome the barriers to employment.

To meet the goals of the CYEP program, low-income youth are provided with job-readiness training, career exploration and guidance, exposure to the world of work and paid work experience.

**Measure of Effectiveness:** The DOL measures the effectiveness of these programs by collecting and reporting on obtained employment information on these two groups. The JFES program issues monthly figures on the number of JFES participants who are employed by vendor and statewide. The number of participants with earnings higher than the TFA payment standard and the Federal Poverty Level are also issued monthly. JFES contracts with vendors contain performance standards and contractors' performance are measured and issued once the wage file information is available.

CYEP measures effectiveness by collecting data on the number of youth to participate in a paid work experience and compare these numbers to the vendors' goals as stated in their contracts. DOL also collects data on the number of youth to participate in job-readiness training and to receive support services. Compliance monitoring is conducted at all five regional Workforce Investment Boards (WIBs). This includes a review of financial management, consisting of financial reporting, cost allocation methodology, cash management, allowable costs, payroll controls, audit requirements, procurement and property controls. Also, WIA eligibility verification for youth is reviewed by sampling client files throughout the state.

**Jobs First Employment Services:** Provides employment services to families in receipt of time-limited state cash assistance. These services assist TFA recipients to prepare for, find and keep employment so that they can become independent from welfare.

**Number Served:** 15,742 annual caseload

**Program Cost: FY: 2011-2012:** \$17,741,841

**Performance-Based Standards:**

- Number of participants to obtain employment during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the cash benefit that they receive during the State Fiscal Year
- Number of participants and percentage of JFES caseload to obtain employment with wages higher than the federal poverty level for their family size during the State Fiscal Year

**Performance-Based Outcomes: SFY 12 complete employment data will not be available until January 2013.**

SFY 11 data is: total annual caseload 16,490, 6,437 or 39% of the caseload obtained employment; 5,449 or 33% of the caseload earned wages above temporary family assistance benefits; and 1,793 or 11% of the caseload earned wages above the federal poverty level.

**Performance-Based Vendor Accountability:** Indicators of performance toward achieving these standards at contractor and statewide levels are determined and issued monthly. Contracts with program vendors and subcontractors include these performance base standards. Standards are measured using the DOL wage data when it is available (normally six months after the end of a program period). Until the recent recession, all vendors consistently met these standards.

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**Connecticut Youth Employment Program:** State funded subsidized employment program for low-income youth aged 14 through 24 years. The Youth Employment provides employment opportunities, work-readiness training and supportive services. In some instances, academic remediation is also provided.

**Number Served:** 2,312 youth served through the Summer. Services were continued to more than 350 youth in year-round services.

**Program Cost: FY – 2011-2012:** \$3,500,000

**Performance-Based Standards:** As established in the contract, the number enrolled and successfully completed the program and the wages paid.

**Performance-Based Outcomes:** FY 2011 –2012 – 2,312 youth served and 2,192 successful completions. Services were continued to more than 350 youth in year-round services.

**Performance-Based Vendor Accountability:** Workforce Investment Boards (WIBs) solicit employers and worksites either directly or through subcontracts with municipalities and community-based organizations. WIBs ensure employers comply with applicable wage and workplace standards. The Department of Labor monitors program operations for proper and timely payment of wages, to ensure funds are spent primarily on wages, and program objectives are met.

# Department of Mental Health and Addiction Services

- **Best Practices Initiative**
- **Local Prevention Council**
- **Partnership for Success**
- **Regional Action Council**
- **Statewide Service Delivery Agent**
- **Tobacco Prevention and Enforcement**
- **Tobacco Compliance Check Inspection**

**Long-Term Agency Goals:** The goals of the Department of Mental Health and Addiction Services (DMHAS) include:

- Reduce the incidence of problem behavior and improve the health and well-being of Connecticut's citizens.
- Achieve quantifiable decreases in substance abuse rates across the state.
- Establish a quality care management system to achieve defined goals, service outcomes and the continued improvement of the integrated DMHAS health care system.
- Maintain a broad array of programs and practices that are data informed and will respond to changing needs as the prevention system grows.
- Increase workforce capacity to provide culturally competent and integrated services to persons whose needs are challenging or not well met.
- Create a resource base to support DMHAS' prevention services goals, expansions, and fiscally sound system investments

**Strategies:** The Departments' strategies include:

- Assess the prevention needs for youth, families and communities across the state
- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Develop, maintain and increase partnerships with state and local agencies to implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Implement program standards to monitor the service system
- Increase funding of evidence-based programs that focus on families, early childhood and youth development

- Explore resources to implement the prevention data infrastructure, policy and program recommendations
- Provide training and technical assistance to increase the cultural ability of prevention program providers to work effectively with youth and parents from culturally, economically and geographically diverse populations

**Performance-Based Outcomes:**

- Increased number of evidence-based programs for youth, families and professionals that focus on youth suicide prevention, tobacco and alcohol use prevention
- A more refined quality assurance process that assesses effectiveness and fidelity of implementation of prevention programs
- An integrated state plan that supports families and communities in youth and early childhood development
- Increased partnerships with state and local agencies
- Increased number of providers trained and receiving technical assistance on cultural competency
- Increased cost-effectiveness and community readiness to implement prevention programs

**Population Outcomes**

- Reduction in the drug/alcohol use
- Reduction in suicidal behavior among youth and young adults
- Increased employment or school retention
- Decreased criminal justice involvement
- Increased social connectedness

**Program Outcomes**

- Increased enforcement of alcohol, tobacco and other drug laws
- Reduction in retailer violation rates for tobacco sales to minors
- Reduction in access to alcohol, tobacco and illegal drugs by minors

**Measure of Effectiveness:** DMHAS continues to document gains in the federal health outcome measures, namely:

- A reduction in cigarette and other tobacco use rates among 12-17 year-olds, as well as

recent use of illicit drugs across all ages (2008 NSDUH report)

- Although alcohol and marijuana use remains above the national average, the state has seen a reduction in alcohol use rates over the past year among ages 12-20 and 21 and over
- The number of tobacco merchants selling tobacco products to minors has decreased to 11.3% in 2011 from a high of 70% in 1996
- The percentage of funded prevention programs that are evidence-based has increased to 73% in 2009 from 65.5% in 2008. The percentage of expenditures spent

on evidence-based programs and strategies has also increased.

**Methods:** DMHAS provides Prevention services aimed at increasing the health & wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. To address disparities, DMHAS contracts with several statewide and regional technical assistance resources to ensure that all products, activities and services are culturally competent and developed and implemented with fidelity.

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**BEST PRACTICES INITIATIVE:** Fourteen (14) statewide funded projects that employ a population-based public health approach to address demonstrated substance abuse prevention needs. Contractors conduct activities focusing on the prevention of community problem substance use utilizing the five-step Strategic Prevention Framework. Approximately 50% of their overall funding for the initiative is used to reduce underage drinking and related consequences in youth ages 12-20 with the remaining funds used to reduce other problem substance use identified through a regional needs assessment process.

**Number Served:** A total of 185,376 children, family members, prevention and treatment professionals, as well as other adults were served in SFY 12.

**Program Cost: FY 2011-2012:** \$1,872,736

**Performance –Based Standards:** DMHAS requires programs under the Best Practices Initiative to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

**Performance-Based Outcomes:** Contractors under this initiative are expected to:

- Assess the risk and protective factors associated with problem substance use and related consequences in targeted communities using relevant epidemiological and other data
- Build community capacity to understand and implement prevention strategies utilizing existing substance use prevention coalitions of community leaders, key stakeholders and representatives of underserved populations
- Update DMHAS-approved prevention plans for problem substance use and related consequences that describes evidence-based environmental interventions/strategies to reduce problem substance use consumption
- Implement evidence-based interventions/strategies to reduce problem substance use consumption, and
- Evaluate changes in problem substance use consumption and consequences in the target population.

**Performance –Based Vendor Accountability:** Program contractors for this initiative complete a strategic plan of community needs and resources, evidence-based programs and strategies to address them and evaluation information and measures. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Contractors are required to use the federal guidance document for identifying and selecting evidence-based programs which assures program fidelity and fit. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an

opportunity to discuss any program changes and challenges. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

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**Local Prevention Council Programs:** The Local Alcohol, Tobacco and Other Drug Abuse Prevention Council Grant Program (LPCP) initiative supports the activities of local, municipal-based alcohol, tobacco, and other drug (ATOD) abuse prevention councils. The intent of this grant program is to facilitate the development of ATOD abuse prevention initiatives at the local level with the support of chief elected officials. The specific goal of this grant initiative is to increase public awareness focused on the prevention of ATOD abuse, and stimulate the development and implementation of local substance abuse prevention activities **primarily focused on youth through 120 local municipal and town councils serving the 169 towns and cities in Connecticut.**

Local Prevention Councils (LPCs) are advisory and coordinative in nature and reflective of each community's racial/ethnic, political, and economic diversity. Councils include representation from professionals working in the prevention field in general and ATOD abuse prevention in particular. Additionally, council membership includes a cross-section of the community which it serves including city/town agencies, organizations, communities and ethnic groups, parents, media, business, senior citizens, health care sector, etc., concerned with prevention issues. The LPCP initiative is designed to: 1) support the on-going prevention activities of established councils; 2) support specific prevention projects of local councils; and 3) support activities that increase public awareness of the problem of ATOD use and abuse.

**Number Served:** A total of 799,519 elementary and high school students, parents and family members, school faculty and staff, were served in SFY 12.

**Program Cost: FY 2011-2012:** \$552,470

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**PARTNERSHIP FOR SUCCESS:** The Partnership for Success (PFS) Initiative uses a public health approach in over 30 municipalities and statewide across college campuses to decrease alcohol consumption in youth ages 12 to 20. Programs under this initiative build on existing resources to implement environmental strategies known to be effective in reducing youth alcohol use rates, such as curtailing retail and social access, policy change, enforcement, media advocacy, and parental and merchant education. The initiative is intended to measure changes in underage drinking utilizing student survey and social indicator data. The target populations are: school aged children 12 to 17 years old, college students 18 to 20, and those adults who influence these youth including parents, family members, care-givers, schools, communities at large and the agencies, organizations and institutions within those communities.

**Number Served:** 51,728 individuals were served by PFS coalitions between July 2011 and June 30, 2012.

**Program Cost: FY –2011-2012** \$ 2,300,000

**Performance-Based Standards:** DMHAS requires programs under the PFS Initiative to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

**Performance-Based Outcomes: Contractors under this initiative are expected to:**

- Assess risk and protective factors associated with underage alcohol consumption and related consequences in the target community using relevant epidemiological and other data.

- Build community capacity to understand and implement prevention strategies utilizing existing alcohol prevention coalitions of community leaders, key stakeholders and representatives of underserved populations
- Develop a community strategic plan that describes community methods to address the underage alcohol consumption using environmental strategies
- Implement evidence-based or innovative environmental intervention(s)/strategies to reduce underage alcohol consumption, and
- Evaluate reductions in past 30 day use of alcohol by the target population. Evaluate community changes in underage alcohol consumption risk and protective factors through changing data and new information on alcohol-related problems in the community.

**Performance-Based Vendor Accountability:** Program contractors for this initiative complete a five-step planning process to guide their prevention activities. The steps include: 1) assessing population needs; 2) building capacity to address the needs; 3) developing a comprehensive strategic plan that articulates a vision for organizing programs, policies and practices to address the needs; 4) implementing evidence-based programs, practices and policies identified in step 3; and 5) monitoring implementation and evaluating effectiveness. Contractors also complete an action plan which identifies and codes the action steps for implementing their plan, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

**Regional Action Council:** Thirteen (13) sub-regional planning and action councils that have responsibility for the planning, development and coordination of behavioral health services in their respective region.

Regional Substance Abuse Action Councils (RACs) are public-private agencies comprised of community leaders. Its purpose is to establish and implement an action plan to develop and coordinate needed services across the behavioral health continuum. These services are generally described as a continuum of care which includes community awareness and education, prevention, intervention, treatment and aftercare. The members of the Regional Action Council serve as volunteers assisted by professional staff. Members include representatives of major community leadership constituencies: chief elected officials, chiefs of police, superintendents of schools, major business and professional persons, legislators, major substance abuse service providers, funders, minority communities, religious organizations and the media.

**Number Served:** A total of 1,656,826 children, family and community members, and prevention professionals were served in SFY 12.

**Program Cost: FY 2011-2012** \$1,851,867

**Performance Based-Standards:** DMHAS requires all contractors to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

**Performance-Based Outcomes:** Performance outcomes for the RACs are as follows:

- 100% of towns in sub regions are funded through Local Prevention Councils
- 25% of funding efforts are focused toward underage alcohol initiatives resulting in a reduction in use across sub regions
- 25% of funding efforts are directed towards the prevention of underage tobacco use resulting in a violation rate of less than 20% among tobacco retailers in the sub region

- The development of a Priority Needs Assessment on the substance abuse continuum of care from prevention through treatment and recovery in the sub region
- The development of SPF Sub-Regional Profiles to include alcohol, prescription drugs, heroin, cocaine, marijuana and other substances of note

**Performance-Based Contractor Accountability:** Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

**STATEWIDE SERVICE DELIVERY AGENT:** The Statewide Services Delivery Agents (SSDA), also known as the DMHAS Resource Links, are four entities funded by DMHAS to support prevention efforts across the state by building the capacity of individuals and communities to deliver prevention services. Their target populations include local communities, individuals, and agencies providing prevention programming; regional and statewide service agencies; societal organizations and institutions, e.g. corporate, medical, religious and recreational entities. The Statewide Service Delivery Agents utilize multiple strategies like information and public awareness, education, community development, capacity building and institutional change, and social policy to promote the health and well being of all Connecticut’s residents across the life span. Within the last two years these SSDAs have provided distinct services to move Connecticut’s prevention system to align with the blueprint of the Strategic Prevention Framework (SPF).

The Statewide Services Delivery Agents consists of the following entities:

1. Connecticut Clearinghouse - is a comprehensive information resource center that makes available thousands of books, tapes and printed reports, and provides electronic access to the latest information on substance abuse, mental health and a variety of other issues.
2. Multicultural Leadership Institute, Inc. - is an agency dedicated to promoting culturally and linguistically proficient services regarding the prevention of ATOD and other related problems among African origin and Latino populations.
3. Governor’s Prevention Partnership - is a statewide organization comprising of public/private partnerships designed to change the attitudes and behaviors of Connecticut youths and adults toward substance through its School, Campus, Workplace and Media Partnerships.
4. Prevention Training Collaborative - is to provide prevention practitioners and others in the field of prevention the training needed to obtain and maintain certification status and provide support to individuals looking to increase their knowledge and skills in the prevention area.

**Number served:** A total of 426,472 children, family and community members, and prevention professionals were served in SFY 12.

**Program Cost: FY 2011-2012:** \$1,835,726

**Performance-Based Standards:**

1. DMHAS requires contractors to adhere to Prevention Program Operating Standards. These standards establish a minimum level of program operation intended to reflect quality and articulate a service philosophy that promotes health and builds strengths. The purpose of the standards is to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS.

**Performance-Based Outcomes:**

- Improvement in the health and wellness of gay, lesbian, bisexual, trans-gendered and questioning clients
- Increase in the number of DMHAS providers with approved cultural competency plans
- Increase in the number of Hispanic and African American staff in substance abuse agencies across the state
- Increase in the number of school and community based mentoring programs
- Reduction in the state rate for underage drinking
- Increase in the number of resources aimed at alcohol, tobacco and other drug prevention
- Increase in the capacity of prevention contractors to implement evidence-based programs, policies and practices

**Performance-Based Vendor Accountability:** Program contractors for this initiative complete program information and measures during the biannual contract renewal process. An action plan that sets the stage for the collection of process measures necessary for federal reporting is also completed. It identifies and codes the action steps for implementing goals and objectives, the staff hours required to implement activities and the numbers to be served by each activity. Progress reports are also required and consist of bi-monthly narrative and process data submitted electronically. The report generally allows contractors to share information with DMHAS regarding program participants and services that are delivered and helps staff to track compliance with contractual obligations as well as provides an opportunity to discuss any program changes. An annual site visit by DMHAS staff is conducted to validate program activities, assess continuing contractor capacity, determine technical assistance needs, and substantiate eligibility for continued funding.

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**TOBACCO PREVENTION and ENFORCEMENT:** The federal government requires that states enforce and enact laws and implement strategies that reduce underage tobacco use. DMHAS employs a variety of strategies and activities to comply with the federal mandate.

These include:

1. Legislation & Law Enforcement: passing and enforcing youth tobacco access laws.
2. Sampling Method & Survey Design: obtaining scientifically valid and reliable measure of tobacco retailer compliance with laws.
3. Inspection Protocol & Implementation: following approved inspection protocols for conducting random, unannounced inspection of tobacco retailers.
4. Merchant Education: producing and distributing educational and awareness materials for a merchant education program.
5. Community Education & Media Advocacy: increasing public awareness on youth tobacco issues through youth forums and focus groups, community mini-grants and a statewide hotline for information and complaints.
6. Community Mobilization: forming coalitions to mobilize community support.

**Number Served:** During FY 2012, 1,813 retail inspections were completed to assess compliance with state tobacco laws and 39,080 print materials were developed and distributed to tobacco merchants to raise awareness and increase compliance with the laws.

**Program Cost: FY 2011-2012:** \$ 618,984

**Performance-Based Standards:** DMHAS must comply with the federal requirements to enforce the state tobacco laws and maintain the tobacco retailer violation rate at or below 20%. Failure to do so will result in a 40% cut to the federal Substance Abuse Prevention and Treatment Block Grant allocation.

**Performance –Based Outcomes:** Increase in age of first use for tobacco products

- Decrease in tobacco use rates among youths ages 12-17
- A rate of no more than 10% of merchants across the state who sell tobacco products to minors

**Performance-Based Vendor Accountability:** Tobacco merchant inspections are completed in strict adherence with federal Substance Abuse Mental Health Services Administration (SAMHSA) guidelines. Annual reports on these

inspections and their results, changes in the state's tobacco laws, coordination and collaboration activities are submitted and available for public review and comment on the DMHAS website

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**TOBACCO COMPLIANCE CHECK INSPECTION:**

Enforce and implement the regulation of the federal Tobacco Control Act that restricts the sale and promotion of cigarettes and smokeless tobacco products to minors under 18 years-old.

**Number Served:** 1,936 inspections of retail tobacco establishments were conducted in FY2012 to assess compliance with youth access and advertising regulations of the Tobacco Control Act.

**Program Cost: FY 2011-2012:** \$633,417

**Performance –Based Outcomes:**

- Increase in age of first use for tobacco products
- Decrease in tobacco use rates among youths ages 12-17
- A rate of no more than 10% of merchants across the state who sell tobacco products to minors

**Performance-Based Vendor Accountability:** The FDA requires that: inspections be conducted in a variety of location, outlet types and communities; evidence be properly tagged and bagged; and, inspections recorded on the Tobacco Inspection Management System (TIMS).

# Department of Public Health

- **Asthma Program: Easy Breathing Children**
- **Asthma Program: Easy Breathing Adults**
- **Community Health Centers**
- **Family Planning**
- **Immunization Program**
- **Injury Prevention – Childhood Motor Vehicle**
- **Injury Prevention Intentional Youth Violence**
- **Nutrition, Physical Activity and Obesity**
- **Rape Crisis and Prevention Services**
- **Special Supplemental Nutrition Program for Women, Infant and Children**
- **Tobacco Use Prevention and Control**

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## **ASTHMA PROGRAM: PEDIATRIC EASY BREATHING PROGRAM:**

The Connecticut Children's Medical Center (CCMC) Asthma Center is conducting Easy Breathing, an asthma clinical management program. The program has successfully expanded beyond the original five communities to provide statewide coverage. The Easy Breathing program is a professional education program that trains pediatric providers to administer a validated survey to determine whether a child has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. Easy Breathing is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

**Number Served:** 6,798 patients surveyed for asthma with 1,813 (26%) diagnosed with asthma

**Program Cost: FY 2010-2012:** \$500,000

**Performance-Based Standards:** The contractor conducts quarterly site visits with the Regional Program Coordinators to review and rectify data issues, training needs and/or implementation problems. The contractor submits quarterly narrative and surveillance data to DPH. Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute. The contractor trained 10 new practices in Easy Breathing and retrained 6 other practices. The contractor trained 341 providers.

**Performance-Based Outcomes:** Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Institute of Health's Asthma Guidelines was reported as follows: **for patients with persistent asthma, 86% of patients had a an Asthma Action Plan and 94% of patients with persistent asthma were prescribed inhaled corticosteroids. This is an excellent measure of adherence to NAEPP treatment guidelines.**

### **Performance-Based Vendor Accountability:**

Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district
- Documentation of monitoring each participating district for adherence to required program activities
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness

- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, race/ethnicity
- Evaluation results of the effectiveness of the Easy Breathing Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly).

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**ASTHMA PROGRAM: ADULT EASY BREATHING PROGRAM:** Bridgeport Hospital continued Easy Breathing for Adults. This Program is based on pediatric Easy Breathing with the focus being on adults treated by medical resident physicians in Bridgeport Hospital's Primary Care Clinic. Easy Breathing for Adults is an asthma clinical management program. The program has successfully integrated training for medical residents to implement Easy Breathing. The Easy Breathing program is a professional education program that trains medical resident providers to administer a validated survey to determine whether a patient has asthma, to conduct an assessment to determine asthma severity, to utilize treatment protocol guidelines for determining proper therapy, and to develop individual treatment plans. Easy Breathing is an asthma recognition and management program that is implemented by primary care providers that documents adherence to the National Asthma Education and Prevention Program Guidelines (NAEPP) standards for asthma care.

**Program Cost: FY 2011-2012:** One contract for Adult Easy Breathing at Bridgeport Hospital was funded for the amount of \$39,332.

**Number Served:**

1,000 patients surveyed for asthma with 225 (22.5%) diagnosed with asthma.

- 52 providers were trained in Easy Breathing
- 56% of patients had an AAP
- 66% of patients with persistent asthma were prescribed inhaled corticosteroids

**Performance-Based Standards:** The contractor conducts weekly meetings with the Physician Champion and conducts monthly meetings with all Easy Breathing clinic staff to review and rectify data issues, training needs and/or implementation problems. The contractor submits quarterly narrative and surveillance data to DPH. Indicators are the number of providers trained in Easy Breathing. The contractor trained 52 medical resident physicians, attending physicians and RNs/LPNs in the Bridgeport Hospital Medical Clinic.

**Performance-Based Outcomes:** Improved asthma diagnosis and medical management by primary care providers for better patient control and self-management based on the National Institute of Health's Asthma Guidelines was reported as follows: for patients with persistent asthma, 56% were prescribed inhaled corticosteroids. This is an excellent measure of adherence to NAEPP treatment guidelines. In addition, 66% with persistent asthma received a written treatment plan per the NAEPP guidelines.

Indicators are guideline adherence for prescribing inhaled corticosteroids for those with persistent asthma and patient education and provision of patient written treatment plans to enable patients to effectively manage their asthma symptoms before they become acute.

**Performance-Based Vendor Accountability:**

Documentation of DPH oversight conducted under this contract with the contractor and subcontractors through audits, site visits, quarterly and annual aggregate reports as follows:

- Documentation of technical and professional assistance provided,
- Description of the contractor-created, locally managed data quality control program and the actual assistance provided for the management of the Easy Breathing data system, generation of reports at each district,
- Documentation of monitoring each participating district for adherence to required Program activities,
- Documentation of review of all survey and treatment plan data from each district for consistency and appropriateness,

- Documentation of the results of data analysis that include demographics of children surveyed in each community for asthma, by age, race/ethnicity, and number of newly diagnosed children by age, race/ethnicity,
- Evaluation results of the effectiveness of the Easy Breathing Program in each participating community by analyzing the following process measures and outcome measures over time (quarterly).

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**COMMUNITY HEALTH CENTERS:** The purpose of the Community Health Center program is to assure access to comprehensive primary and preventive health care services and improve the health status of the underserved and vulnerable populations in Connecticut. Thirteen health care corporations receive partial funding through the Connecticut Department of Public Health to provide comprehensive preventive and primary health care services through Community Health Centers located in over 150 satellites throughout the state. As safety net providers, they deliver health care to individuals enrolled in Medicaid and Medicare as well as the underinsured and uninsured from birth through old age. Twelve of the 13 corporations are Federally Qualified Health Centers (FQHCs) that receive funding authorized by Section 330 of the Public Health Service Act. The remaining community health center (CHC), referred to as an FQHC “look-alike,” meets all the requirements to be considered a FQHC, but does not receive Section 330 funding.

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The CHCs serve as the medical home and family physician for many of the poor, underserved, vulnerable, and those at risk for poor health status who live in communities throughout Connecticut. They offer comprehensive, community-based, primary and preventative health care that includes: pediatric, adolescent, adult and geriatric health care; prenatal and postpartum care; supportive services, such as translation, transportation, case management, health education; social services and culturally sensitive healthcare. Depending on availability, many offer dental care; mental health and addiction services; school based health care; and outreach programs. These services are available to individuals regardless of their ability to pay.

**Number Served:**

315,992. This number includes those clients seen for primary and preventive care, oral health care, and health care access. The Uniform Data System (UDS) data from the U.S. Department of Health and Human Services Health Resources and Services Administration is what is utilized for most reporting.

**Program Cost: FY 2011-2012:** \$4,136,759

**Performance Based Standards:**

All 13 CHCs submit quarterly and annual reports to DPH. The UDS report, which the section 330 funded health centers submit annually to the federal government, is utilized for data for 12 of 13 CHCs. The “look-alike” utilizes a modified form of reporting to the federal government that is also used by DPH.

**Performance Based Outcomes:**

- Number of pregnant women beginning prenatal care in the first trimester.
- Number of children with second birthday during the measurement year with appropriate immunizations.
- Number of women 21-64 years of age who received one or more Pap tests during the measurement year or during the two years prior to the measurement year.
- Number of diabetic patients whose HbA1c levels are less than or equal to 9 percent.
- Number of adult patients 18 years and older with diagnosed hypertension whose most recent blood pressure was less than 140/90.
- Children and adolescents aged 3-17 with a BMI percentile, and counseling on nutrition and physical activity documented for the current year.
- Patients aged 18 and over with (1) BMI charted and (2) follow-up plan documented if patients are overweight or underweight.

- Tobacco users aged 18 or older who have received cessation advice or medication.
- Patients aged 5 through 40 diagnosed with asthma that have an acceptable pharmacological plan.
- Number of births less than 2,500 grams to health center patients.
- At least 80% of children served between the ages of 24 and 35 months will be immunized.
- At least 80% of adolescents will receive a behavioral risk assessment for substance abuse and sexual activity, and a nutrition assessment.
- At least 80% of men and women between the ages of 20 and 64 years will receive a cardiovascular risk assessment, and appropriate cancer screenings.
- At least 60% of adults aged 65 and older will receive a cardiovascular and cerebrovascular risk assessment, cancer screenings, a behavioral health risk and a nutrition assessment, and a flu shot.

**Performance Based Vendor Accountability:**

Review of reports including reports the CHCs submit to the federal government; periodic site visits to the contractor; medical record audits on site visits; communication and collaboration with CHC contractors and the Community Health Center Association of Connecticut (CHCACT).

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**FAMILY PLANNING:** Twelve Family Planning Centers are funded by the Connecticut Department of Public Health (DPH) through a contract with Planned Parenthood of Southern New England, Inc. (PPSNE). The purpose is to provide a Family Planning Program for primary prevention through comprehensive reproductive health care services in those areas of Connecticut with a high concentration of low-income women of reproductive age and with a high rate of teen pregnancy. The health care services include clinic services, cancer screenings outreach activities, health education programs, pregnancy testing, distribution of condoms, HIV counseling and testing, and referrals and follow-up.

**Number of Clients Served:** The program provided 28,917 people with reproductive health services and close to 50,000 visits, conducted outreach and education to 1,535 at-risk teens. The majority of these teens were at risk for sexually transmitted disease, HIV and pregnancy because they were already teen parents, or they were in a drug and/or alcohol treatment program, alternative incarceration program, or other social services program which indicated a past history or likelihood of risky behavior. The contractor distributed approximately 400,000 free condoms.

**Program Cost FY 2011-2012:** \$1,020,934

**Performance Based Standards:** The contractor met or exceeded all outcome measure goals except for one. Seventy four percent of the program’s clients received services regardless of the ability to pay (this includes patients paying according to a sliding fee scale and those covered by Medicaid). Based on sample chart reviews, 95% of female patients receiving a preventive reproductive health exam received a Pap test (Goal 90%); 99% of female patients with a reproductive health exam received a clinical breast exam (goal 90%); 89% of female patients with a reproductive health exam received screening for Chlamydia trachomatis (goal 85%); and 79% of clients with a reproductive health exam received AIDS education, non-specific behavioral counseling and, upon request, information on testing sites (goal 80%).

**Performance Based Outcomes:**

- Number of clients receiving services this period regardless of ability to pay (were unable to pay all or part of cost).
- Number of patients receiving a comprehensive annual preventive reproductive health exam during the reporting period.
- Number of female patients with a preventive reproductive health exam who received a Pap test.
- Number of clients with a preventive reproductive health exam who received a clinical breast exam.
- Number of female patients receiving a preventive reproductive health exam during the reporting period who received a screening for Chlamydia Trachomatis.
- Number of clients with a preventive reproductive health exam who received AIDS education, non-specific behavioral counseling and, upon request, information on testing sites.

- Number of clients surveyed who reported overall satisfaction with visit and satisfaction with key areas (friendliness of staff, comfort of waiting, skills of medical personnel).

**Performance Based Vendor Accountability:** Contractor accountability is monitored through site visits with random medical record reviews, observations, and staff interviews, review of quarterly and annual report data and contractor participation and updates on various Maternal and Child Health Committees.

**IMMUNIZATION PROGRAM:** The prevention of disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, vaccination, monitoring of immunization levels, provision of vaccine and professional and public education.

**Number Served:** Children from birth through 18 years of age. Total CT population 0-18 years of age served for CY 2012 is 872,751.

**Program Cost: FY 2011-2012:** \$54,949,669

**Performance-Based Standards:** Immunization coverage is one of our principal performance-based standards. The program uses data from the National Immunization Survey (NIS) conducted annually by CDC estimates vaccination coverage among children aged 19-35 months old nationally and for each state and our statewide immunization registry called CIRTS to measure immunization coverage rates for children in CT.

**Performance –Based Outcomes:** According to the 2011 National Immunization Survey (NIS), Connecticut’s 2011 NIS coverage (excluding Hib vaccine) for 4 doses of DTaP, 3 polio, 1 MMR, 3 hepatitis B, 1 varicella and 4 PCV (4:3:1:0:3:1:4) was 79%. Based on this information, CT was ranked 7th among all 50 states with highest immunization coverage rates. The 4:3:1:0:3:1:4\* vaccine series is based on NIS data that excludes the Haemophilus influenzae type b (Hib) vaccine. The 2011 NIS survey included children born January 2008 through May 2010.

According to our Connecticut Immunization Registry and Tracking System (CIRTS) immunization registry data which looked at the records of 34,316 two-year-olds born in 2008, 4:3:1:2:3:1.4\* coverage is 79%. The 34,136 children represent 85% of the 40,230 births recorded in CIRTS for 2008

\*Please note the vaccine series that include Hib reflect the Hib supply shortage and the February 2008 to July 2009 deferment of the Hib booster dose.

**Performance-Based Vendor Accountability:** Funding provided to 11 health departments representing the largest municipalities in Connecticut to increase immunization levels among children residing in their communities by conducting the following activities to improve vaccine/immunization delivery, tracking, outreach, referral, education and assessment.

Specific Program Outcomes and Measures

Outcomes	Measures
1. Children 0-24 months of age who reside in the contractor’s service area who are enrolled in CIRTS have been age-appropriately immunized against vaccine- preventable diseases	1. At least 85% of children 24 months of age who reside in the contractor’s service area, and who are enrolled in CIRTS have been age-appropriately immunized against vaccine preventable diseases
2. Children 0-24 months of age referred to the IAP Coordinator for outreach are successfully identified and referred for appropriate care, and/or their records are updated in CIRTS.	2. At least 90% of children 0-24 months of age who are referred to the IAP Coordinator for outreach are successfully identified and referred for appropriate care, and/or their records are updated in CIRTS.

**INJURY PREVENTION- CHILDHOOD MOTOR VEHICLE:** Child passenger safety education and child safety and booster seats are provided to parent/caregivers with a special emphasis on low-income families. The geographic service area is statewide. The Maternal and Child Health Block Grant funds the services through a contract with Safe Kids Connecticut.

**Number served:** Through Maternal and Child Health Block Grant funding, the program provided 18 child passenger safety workshops, serving 255 parents/caregivers and 644 children during SFY2011.

**Program Cost FY 2011-2012:** \$30,000

**Performance-Based Standards:** Training programs are based on national safety curricula developed by child passenger safety experts, and are regularly reviewed to insure that they meet current “best practice” standards. Nationally certified child passenger safety instructors or technicians deliver the training and educational programs and work with families to ensure that child safety seats and booster seats are correctly installed and used.

**Performance-Based Outcomes:** Percentage of parents/caregivers aware of correct use of appropriate occupant protection systems.

**Performance-Based Vender Accountability:** Contractor is required to submit periodic reports on program activities and outcome measures. The Injury Prevention Program monitors selected training programs and closely with the Contractor and other partners to identify provider organizations and to insure that low-income families receive program services.

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**INJURY PREVENTION – INTENTIONAL YOUTH VIOLENCE:** Youth violence prevention programs contracted by the Connecticut Department of Public Health (DPH) focus on increasing knowledge and changing behaviors that are manageable within the limited resources available to the programs. Program goals include increasing awareness of issues associated with youth violence; recognizing and appropriately dealing with anger, conflicts, peer-to-peer relationships; increasing knowledge regarding the impact of, and risk factors for violent behavior; decreasing arguments and fighting; and providing knowledge of appropriate resources for help.

**Number Served:** 120 at 3 locations with each program location providing a 10 session course

**Program Cost FY 2011-2012:** \$50,000

**Performance-Based Standards:** Youth violence prevention program participants are able to identify nonviolent alternatives to fighting.

**Performance-Based Outcomes:** Ninety-five percent of program participants are able to identify nonviolent alternatives to fighting.

**Performance-Based Vender Accountability:** Contracted programs are required to report on program activities, process and outcome measures. Programs use questionnaires, surveys and/or observation to assess outcome measures including violence prevention related survey instruments from Measuring Violence-Related Attitudes, Behaviors and Influences among Youths- Centers for Disease Control and Prevention publication

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**NUTRITION, PHYSICAL ACTIVITY and OBESITY:** The NPAO program receives federal funds to provide nutrition education to low-income individuals in Connecticut, and many projects focus specifically on children and parents. The successful, evidence-based “Feeding My Family, Loving Their Future” curriculum is utilized in over

120 Head Start and School Readiness programs across the state. The curriculum supports social, emotional, cognitive, and language development in young children while encouraging healthy eating and physical activity. The program trains and motivates teachers, provides materials, and serves as an ongoing resource to promote the implementation of nutrition education and physical activity in the preschool classroom. In addition, the program uses “Supermarket Smarts” parent workshops to inform parents on how to make healthy food choices within a limited budget and to promote a positive mealtime environment.

The NPAO program also awards federal funds to between 20 – 30 Local Health Departments/Districts and Counties using Preventive Health and Health Services Block Grant and Community Transformation Grant funding. These funds are awarded to carry out various policy, system, and environmental change strategies which increase community-based opportunities to improve access to healthy foods and safe environments for physical activity and, ultimately, reduce chronic diseases and health disparities.

**Number Served:** Number Served: SNAP-Ed (110,000 children and families); Preventive Health and Health Services (PHHS) Block Grant (12,660) and Community Transformation Grant (889,239 families and children)

**Program Cost: FY 2011-2012:** \$1,205,697

**Performance-Based Standards:**

Nutrition Education:

- By September 30, 2012, 50% of Head Start/School Readiness preschoolers who participate in *Loving My Family, Feeding Their Future* will increase their fruit & vegetable preference by 25%.
- By September 30, 2012, 50% of Head Start/School Readiness preschoolers who participate in *Loving My Family, Feeding Their Future* will engage in at least 60 minutes of physical activity per week.
- By September 30, 2012, 50% of teachers who attend a *Loving My Family, Feeding Their Future* teacher training will plan to increase their fruit & vegetable consumption by ½ cup daily.
- By September 30, 2012, 50% of parents who attend a *Supermarket Smarts* workshop will be able to identify 3 tips to save money at the supermarket.
- By September 30, 2012, 50% of parents who attend a *Supermarket Smarts* workshop will report a willingness to prepare fruit & vegetable recipes at home.

Reduce Excess Dietary Fats:

- By September 30, 2012, at least 50-75% of program participants can accurately identify at least three dietary practices to reduce fat intake and promote heart health.
- By September 30, 2012, at least 25-40% of program participants report, at program end, taking action to reduce dietary fat intake.

Block Grant Physical Activity:

- By September 30, 2012, at least 70-85% participants report, at program end, can correctly identify recommended levels of physical activity to promote heart health.
- By September 30, 2012, at least 60-75% the participants report, at program end, their intent to continue exercising three or more days per week, 30 minutes per day.

Policy and/or environmental changes:

- By September 30, 2012, each participating Health Department/District shall implement two to four policy and/or environmental changes to promote healthy nutrition habits.
- By September 30, 2012, each participating Health Department/District shall implement two to four policy and/or environmental changes to increase access to, or the availability of, areas in which people can engage in physical activity.
- By September 30, 2012, each participating County shall implement a needs assessment and policy scan in preparation to implement two to four policy and/or environmental changes to promote healthy nutrition habits.
- By September 30, 2012, each participating County shall implement a needs assessment and policy scan in preparation to implement two to four policy and/or environmental changes to increase access to, or the availability of, areas in which people can engage in physical activity.

**Performance –Based Outcomes:**

- Ten LHDs implemented 18 policy and/or environmental changes increasing physical activity, and improved nutritional practices at the community level.
- Five Counties conduct a needs assessment and policy scan in preparation to implement two to four policy and/or environmental changes to increase access to, or the availability of, areas in which people can engage in physical activity and promote healthy nutrition habits.
- Pre- and post-tests; oral assessments; interactive game questions; program staff and teacher observations.
- Individual teachers and parents responses; group activity responses; interactive activities; discussions.
- Children task response to stated objectives, skill demonstration and informal feedback.
- Teachers and parents task response to stated objectives, skill demonstration (e.g. meal planning and food purchasing), informal feedback and perceived change in skills.
- Children’s perceived ability to change; reported change (e.g. reported change in children’s intake of vegetables by teachers); food records; food frequency instruments; physical activity questions.
- Teachers and parents’ perceived ability to change; reported change.

**Performance-Based Vendor Accountability:**

- Number of SNAP-eligible children and parents reached through direct nutrition education.
- Number of Head Start and School Readiness programs participating in the program.
- Number of *Loving Your Family, Feeding Their Future* “train-the-trainer” workshops delivered to Head Start and School Readiness teachers.
- Time Head Start and School Readiness teachers provide nutrition education in the classroom and at mealtime.
- Time of technical assistance delivered to ensure fidelity of the nutrition education program.
- Number of nutrition education materials and resources disseminated.
- Number of *Supermarket Smarts* workshops delivered to Head Start and School Readiness parents.
- Number of community partnerships/collaborations formed and enhanced to reach SNAP-eligible children and parents.
- Number of collaborations with agencies to prevent duplication of services, gain updated knowledge of new programs and tools, and facilitates effective management of the programs.
- Service and Evaluation Plans submitted.
- Quality Assurance Plans submitted.
- Quarterly narrative and expenditure reports.
- Participate in site visits as appropriate.
- Staffing plans, including responsibilities of funded or in-kind staff to meet proposal objectives.
- Number of community wellness coalitions that demonstrate community support, mobilization, and buy-in.
- Number of agencies, organizations and municipalities that serve in a leadership capacity.
- Documentation of community assessment, policy scan and report of recommendations for policy, system and environmental change strategies implementation.
- Submission of comprehensive evaluation plans to include defined outcome and process measures.
- Demonstration of plan implementation and project sustainability.

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**RAPE CRISIS and PREVENTION SERVICES:**

The Rape Crisis and Prevention Services Program provides funding to support free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation to sexual assault victims and their families. Services also include community education, primary prevention activities, training to health care providers, schools, law enforcement, social services providers and the community regarding sexual violence prevention, and coordination of services. The program goal is to end sexual violence and ensure high quality, comprehensive and culturally competent sexual assault victim services by offering primary prevention and victim crisis intervention services statewide through the following member service areas: Bridgeport, Danbury, Meriden/Middletown/New Haven, Milford, New Britain/Hartford, Stamford, Torrington, Waterbury, and Willimantic/New London.

**Number of Clients Served:** A total of 17,793 children, youth, adolescents and young adults in school settings participated in rape prevention and education sessions. A total of 3,784 clients were served based on their town of residence, and 82 professional trainings were offered to 1,657 professionals.

**Program Cost FY 2011-2012:** \$1,003,081

**Performance Based Standards:** Standards of accountability are measured based on the following outcomes: clients are able to access the needed and appropriate services from a choice of service options, clients are provided acute care and safety at time of contact, and clients are able to access long-term support services. The Rape Crisis Prevention Services met and/or exceeded all outcome goals.

**Performance Based Outcomes:**

- Clients are able to access the needed and appropriate services from a choice of service options. 90% or more of clients requesting referrals will receive them within 3 days.
- Clients are provided acute care and safety at time of contact. 90% or more of clients requesting immediate emotional assistance will receive such assistance by phone or in person; 90% or more clients who request that an advocate meet them at the hospital will be met by an advocate.
- Clients are able to access long-term support services. 90% or more of clients requesting individual counseling will receive an appointment within three days; 70% of clients requesting group counseling will receive an appointment within thirty days.

**Performance Based Vendor Accountability:**

Contractor accountability is monitored through site visits; communication and collaboration with the contractor (Connecticut Sexual Assault Crisis Services, Inc. (CONNSACS) and its member centers); and with review of quarterly and annual report data. The contractor also performs pre and post-test surveys within primary prevention curricula.

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**SPECIAL SUPPLEMENTAL NUTRITION PROGRAMS FOR WOMEN INFANT and CHILDREN:**

The Connecticut Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) serves pregnant, postpartum and breastfeeding women, infants, and children up to five years of age. The program provides services in five (5) major areas during critical times of growth and development in an effort to improve birth outcomes and child health: 1) Nutrition Education and Counseling; 2) Breastfeeding Promotion and Support; 3) Referral to outside health and social services; 4) Referral from Health Care Provider to ensure clients have a medical home; and 5) Vouchers for healthy foods prescribed by the WIC Nutritionists (WIC food packages). Eligibility is based on both income (up to 185% of the federal poverty level) and nutritional need, based on a complete assessment of health and dietary information. Active enrollment in Medicaid (HUSKY A) qualifies applicants for categorical eligibility in the WIC Program. The WIC Program's promotion and support of breastfeeding, and efforts to prevent childhood anemia, also contribute to childhood health and school readiness. WIC clients are seen in WIC offices at least every three (3) months, but can be seen monthly if identified as high risk. Currently, WIC services are provided to approximately 57,333 participants monthly through a service provider network of 12 local agency sponsors at 76 service sites statewide. Local agency sponsors include hospitals, community health centers, city and town health departments, and community action agencies throughout the State. The Department of Public Health also has agreements with 665 food stores, pharmacies and farmers that are authorized to accept and redeem participants' checks in exchange for WIC approved supplemental foods.

**Number served 2011-2012:** Average monthly participation: 57,333 (12,293 women, 14,194 infants and 30,845 children (From 12 months to 5<sup>th</sup> Birthday).

**Program Cost 2011-2012:** \$57,962,957

**Performance-Based Standards:**

Federal and state regulations include a number of prevention related standards that the local agencies must meet, including timeframes for enrolling program applicants; requirements regarding the early and continuous enrollment of

pregnant women; policies to ensure that all pregnant women are encouraged to breastfeed, unless medically contraindicated, and provided breastfeeding information and support; requirements to provide information regarding the risks associated with drug, alcohol and tobacco use during pregnancy; and to ensure that children are screened for anemia and lead poisoning by their health care provider.

**Performance-Based Outcomes:**

- **Maternal Weight Gain (MWG).** Pregnant women participating in the WIC Program for a minimum of 6 months gain appropriate weight: Target:  $\geq 70\%$ . Current statewide average: 67.2%; range (12 WIC regions): 54.5% – 83.9%.
- **Low Birth Weight (LBW).** Incidence of low birth weight among infants whose mothers were on the WIC Program for at least 6 months during pregnancy: Target:  $\leq 6\%$ . Current statewide average: 6.0%; range (12 WIC regions): 2.4% – 8.6%.
- **Breastfeeding Initiation.** Infants whose mothers were enrolled in the WIC Program during pregnancy breastfeed: Target:  $\geq 60\%$ . Current statewide average: 65.6%; range (12 WIC regions): 48.1% – 91.2%.
- **Breastfeeding Duration.** Infants enrolled in the WIC Program breastfeed for at least 6 months: Target:  $\geq 25\%$ . Current statewide average: 27.0%.
- **Childhood Anemia.** Prevalence of anemia among children enrolled in the WIC Program for at least one year: Target:  $\leq 9\%$ . Current statewide average: 6.6%; range (12 WIC regions): 3.5% – 8.6%.

**Performance-Based Accountability:**

- Local agencies that sponsor WIC Programs must submit annual program plans that identify measurable outcome and process objectives, and specify action plans and evaluation methods.
- The state WIC office tabulates and provides outcome data to the local agencies on a quarterly basis for their use in program planning and evaluation.
- The state WIC office conducts on-site performance evaluations of each local agency at least once every two years.

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**TOBACCO USE PREVENTION AND CONTROL:**

The Tobacco Use Prevention and Control Program follows guidelines and recommendations put forward by the Centers for Disease Control and Prevention (CDC) in their document “Best Practices for Comprehensive Tobacco Control Programs.” This program works to address all areas in tobacco control including educating the public about the risks associated with the use of tobacco products and the hazards of exposure to secondhand smoke. Areas of focus include preventing initiation among youth and young adults, promoting quitting among all tobacco users, eliminating exposure to both second- and third-hand smoke for all state residents, and identifying and eliminating tobacco-related disparities among population groups including those of low socioeconomic status, individuals with mental illness, gay/lesbian/bisexual/transgender, and pregnant women; all of whom are disproportionately affected by tobacco use.

**Number Served:** Community-based tobacco use cessation programs funded during the period along with the telephone-based tobacco use cessation quitline served at least 8,900 Connecticut residents, with many of those services being targeted to individuals with low socio-economic status.

**Program Cost 2011-2012:** \$ 1,079,069

**Performance-Based Standards:** Our standards include the reduction and elimination of use of all forms of tobacco, to prevent or at least delay tobacco use initiation, and to reduce resident’s exposure to second and third-hand smoke. All funded programs must adhere to CDC’s best practices guidelines and use evidenced-based curricula. All programs include education regarding the prevention of tobacco use initiation and the harmful effects of second- and third-hand smoke.

**Performance-Based Outcomes:**

- At least 75% of program participants will reduce their tobacco use;
- At least 75% of program participants will make changes to protect the health of non-smokers.

**Performance-Based Vendor Accountability:**

Contractors are required to collect data at several intervals during the period of service in order to assess program effectiveness, including pre-and post-program surveys. Contractors must submit periodic progress reports detailing their program activities including their self-evaluation and the results of their outcome measures. In addition, an independent evaluator is on contract to evaluate these programs.

# Department of Social Services

- Children’s Trust Fund
  - Fatherhood Initiative
  - Teenage Pregnancy Prevention
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**Long Term Agency Goals:** The Department of Social Services’ (DSS) goals are informed by relevant data secured from a variety of sources. The data that is collected facilitate the creation and implementation of programs and services that address the *root causes of poverty and the concomitants of poverty*. The Department’s goals include:

- Increase access to affordable sound housing stock for income eligible children and families.
- Increase awareness about availability and access to food/good nutrition for income eligible children, individuals and families.
- Increase awareness about and access to preventive and curative health care for income eligible children, individuals and families.
- Increase the number of children, from infancy to three, who are “ready to learn” by providing child care/parenting education that help infants and toddlers develop characteristics and skills in confidence, risk taking, how to socialize and get along with others, trust that are essential in school success.

## Strategies:

- Program and contract staff will have the most up to date local, regional, and national data related to clients’ needs, poverty and its concomitants as well as knowledge and awareness of objectively determined effective program/service outcomes for targeted low income/income eligible children and families that will be used to inform/plan, develop, and contract for services for clients, with external agencies/organizations.
- In addition to actually enumerating level of program participation, within the next 12 months contractees will be required to provide objective outcome measures that demonstrate effectiveness of programs/services based on documented client progress and client feedback.

- Quarterly reviews/evaluations of client outcome data will be provided by contractees.
- Make information about the Department’s programs and services for low income children and families available through many access points public libraries, doctors’ offices, health care centers, neighborhood markets and stores, malls, schools, hospitals, other agencies/organizations, child care/day care, etc., in order to increase awareness and program participation.
- Engage in ongoing recruitment of health care providers/physicians in order to increase access to health care for income eligible children, individuals and families.
- Enhance contractual relationships with community action agencies to ensure awareness and supportive access for clients to programs/services provided by DSS, via various community based locations.
- Whenever possible, dispatch staff to provide information about the Department’s programs/services such as speaking at community events, participating in community fairs, and convening focus groups for purposes of providing, collecting program/service related information.
- Introduce a formal mechanism to collect program participant/service recipients’ feedback related to the receipt and use/usefulness of services provided.
- In DSS funded child care settings, place greater emphasis on helping parents understand the relationship between child rearing practices and “readiness/ability” to learn as well as the value of good nutrition for optimal growth, development, and learning.
- Train and support staff in modifying contracts based on objectively determined clients/program participants’ outcome data.
- Take advantage of funding opportunities that can be used to increase the number of sound adequate housing for income eligible children and families.
- Develop and implement a person-created intake and support system that optimizes access and

program information for clients twenty-four hours a day seven days per week.

**Measure of Effectiveness:** The effectiveness of prevention is best measured longitudinally; the Department is in the process of formalizing a data collection and analysis approach that addresses this issue.

**Methods:** Current data collection processes do not lend themselves to performance measures and outcomes based on race, income level, language proficiency, and gender. The Department plans to rectify this within the next 18 months.

**Other:** As the Medicaid, housing, TANF agency, lead agency for persons with disabilities, subsidizer of child care, and the administrator/manager of the Supplemental Nutritional Assistance Program, the Department provides programs and services that by their very nature address the health and safety needs of children, individuals, and families. There is no doubt that it succeeds in doing so; however, in the coming months and years, DSS will collect data in ways that clearly demonstrate the extent to which current programs are succeeding in preventing intergenerational poverty, the concomitants of poverty, and poor health conditions.

The Department's Children's Trust Fund provides an excellent example of research based programs that are primary prevention.

**Long-Term Children's Trust Fund Program**

**Goals:** The goal of the Children's Trust Fund is to prevent child abuse and neglect and to ensure the positive development of children. The funds appropriated to the Children's Trust Fund are used to support community efforts that assist families. The community programs are designed to engage families before a crisis occurs to actually keep abuse and neglect from happening. This strategy is working. The programs supported by the Children's Trust Fund are making a difference in the lives of children and their parents while reducing the number of families that enter the state child welfare system.

**Strategies:** To achieve its goals the Trust Fund:

- Conducts research to better understand and assess areas of risk for child abuse and neglect, finds the most effective ways to assist families, and develops strategies for improving the skills of service providers.
- Funds broad-based prevention efforts in communities that have been shown to address known risk factors for child abuse and neglect, including poverty, substance abuse, domestic violence, and social isolation.
- Funds programs that include a strong focus on matters that effect the well being of children including improving parent-child bonding and interaction, parenting skills and family relationships, health care access, and developmental monitoring.
- Offers a range of program services to meet the needs of all families.
- Trains human services staff in prevention approaches and strategies to engage and

assist culturally diverse and vulnerable families.

- Supports a network of agencies that work together to support families around their multiple needs.
- Increases public awareness and participation in efforts to prevent child abuse and neglect.

**Performance-Based Standards:** Across all programs the Trust Fund is looking for statistically significant change that can be tied to program efforts. Contractor performance standards for the Nurturing Families Network are assessed annually by comparing each contractor's outcomes with the statewide aggregate outcomes on all evaluation and process measures. The statewide aggregate outcomes serve as the minimum performance standard for this purpose. Sites are encouraged to achieve the outcomes of the highest performing sites.

**Performance-Based Outcomes:**

- Reduced rate and severity of child abuse and neglect
- Improved parent –child interaction and parenting skills
- Connection to health care providers, high immunization rates
- Gains in household stability, education, employment
- Less financial hardship, access to more resources
- Enhanced family relationship and parent well-being
- Increases in developmental monitoring and access to services
- Enhanced child well being over time

**Measures of Effectiveness:** Several studies conducted by the University of Hartford Center for Social Research show that programs supported by the Trust Fund are successfully providing support and assistance to high-risk families and are achieving their goals. The studies show that these programs are reducing the incidence and severity of child abuse and neglect and helping parents to take hold of their responsibilities and become better caregivers.

Highlights of the 2010 report on the Nurturing Families Network follow:

- The annual rate of abuse and neglect is 2%. This rate is very low when compared with rates of 20-25% reported in studies with similarly high-risk mothers who did not receive home visitation services.
- Mothers were more likely to have graduated from high school and be employed and live independently.
- Mothers made significant improvement on the Community Life Skills scale, indicating they were more connected to others in the community and were adept at accessing available resources.
- Rates of preterm and low birth weight babies for the high risk mothers compared favorably with the state and national rates for the general population.
- 96% of participating children were fully immunized and 98% had a pediatric care physician.
- The domestic violence rate dropped significantly from 2.4% at program entry to 1% at the end of the year. All of the mothers who reported domestic violence at program entry were not in violent relationships 1 year later.

The evaluation demonstrates that the NFN program is effective in reducing the incidence of child abuse and neglect and improving the well being of both the parents and children who participate in the program.

**Performance-Based Accountability:** A continuous quality improvement team has been established to review practice guidelines, training needs and program protocols for the larger Trust Fund programs. The policies are written into a manual that guides program implementation efforts at each site. The Trust Fund staff monitors site compliance and effectiveness in implementing the program in accordance with these policies.

The Trust Fund staff works with each contractor to develop an Individualized Program Plan. The plan identifies areas in need of attention or improvement and strategies for achieving the identified goal. The sites are responsible for reporting on their progress implementing the plan and the results of their efforts.

**Methods:** The Trust Fund uses intensive home visiting, developmental surveillance and early identification of developmental delays and behavioral problems, parenting groups and parent engagement to reduce racial and economic disparity.

**Intensive multi-focused home visiting:** Several studies have found that home visiting services reduce disparities in child performance and outcomes by race and income level. One study, conducted by the Missouri Department of Elementary and Secondary Education, found that children enrolled in preschool - whose families participated in a home visiting program - scored significantly higher on all measures of intelligence, achievement, and language ability than children in the comparison group whose families did not receive home visiting services.

The parents who participated in the home visiting program were mostly young, poor, undereducated, single heads of household. Their children shattered the conventional wisdom that they would perform poorly in school. The children did as well as the national norm for children their age - with roughly 15% exceeding the national norm. The children outperformed a comparison group of children from wealthier and more stable families not considered at risk for poor outcomes.

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**Nurturing Families Network (NFN):** NFN has 5 components: Intensive home visiting for new parents who are at high risk for child abuse and neglect. The program focuses on nurturing parenting, child development, and maternal and child health and community resources. Nurturing parenting groups that assist parents in developing appropriate expectations of their children and enhance their parenting skills. Nurturing Connections that brings new parents together with volunteers and others in the community who can help them adjust to the demands of having a baby.

Two new components have been added to the NFN including home visiting tailored to the needs of fathers and men. Also the program is offering in-home cognitive behavioral therapy to treat maternal depression. Evaluation data on these new efforts is not available at this time.

**Number Served:** Services are provided at 42 community locations throughout the state. In 2011-2012, NFN served about 1,900 families in intensive home visiting and 500 families in Nurturing Parenting groups.

**Program Cost: FY 2011-2012:** \$1,340,000

**Performance- Based Standards:**

- Maternal Health/Behavioral Outcomes
- Infant and Child Health and Mortality
- Child Development
- Parenting Skills and Stress
- School Readiness
- Crime and Domestic Violence
- Child Abuse and Neglect
- Economic and family well being

**Performance-Based Outcomes:** The annual rate of abuse and neglect is 2%. This rate is very low when compared with rates of 20-25% reported in studies with similarly high-risk mothers who did not receive home visitation services.

- NFN mothers made statistically significant gains in life course outcomes during their participation in the program.
- Mothers were more likely to have graduated from high school and be employed
- Mothers were more likely to live independently.
- Mothers made significant improvement on the Community Life Skills scale, indicating they were more connected to others in the community and were adept at accessing available resources.
- Rates of preterm and low birth weight babies for the high-risk mothers compared favorably with the state and national rates for the general population.
- 96% of participating children were fully immunized and 98% had a pediatric care physician.
- The domestic violence rate dropped significantly from 2.4% at program entry to 1% at the end of the year. All of the mothers who reported domestic violence at program entry were not in violent relationships 1 year later.
- Parents participating in groups are significantly less stressed and have more realistic attitudes of their children.

**Performance- Based Vendor Accountability:** Vendors must agree to participate in an evaluation. Submit monthly data, review results and develop a written plan to address areas needing improvements.

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**Fatherhood Initiative:** Outreach /awareness education and training for parents related to parenting, healthy relationships, and healthy marriages. Also, support services that connect parents/program participants to programs and services that address their emotional and socio-economic needs.

**Number Served:** 641 participants

**Program Cost: FY 2011-2012:** \$568,173

**Performance- Based Standards:**

- Increase in effective communication skills (between partners/parents)
- Increase in knowledge about responsible parenting
- Increase in the ability to secure and retain employment
- Decrease in the potential for child abuse and neglect

- Increase in responsible parenting
- Identify and assess potential for spouse/partner/child abuse
- Targeted intervention strategies for parents with cognitive limitations

**Performance-Based Outcomes:**

- Results of pre and post-test of training offered for each program participant
- Decrease in child/partner/spousal abuse
- Improved communication between parents/partners
- Improved parent-child relationships
- Increase in marriage between partners (couples)

**Primary Prevention Outcomes:**

- Decrease in child poverty
- Prevention of child abuse and/or neglect
- Collaboration with DCF to prevent the occurrence/reoccurrence of child abuse/neglect among parents referred to DCF for services.

**Performance –Based Vendor Accountability:** Grant access to Yale researchers who are evaluating the program; evidence of dissemination and collection of pre-pos test of curricula; observable use of the 24/7 Curriculum developed by the National Fatherhood Initiative and approved/required by the federal government; report number of program participants; evidence of recruiting and retaining program participants; attend and participate in mastering curricula related to assessing domestic violence and working with parents with cognitive limitations; and evidence of a program plan for each participant in which all services and rationale for the service/referral is included.

**TEEN PREGNANCY PREVENTION:** This program aims to prevent teen pregnancy and welfare dependency through the provision of awareness education (delay in sexual activity, safe sex practices, personal growth and development, etc.) and supportive programs and services.

**Number Served:** 690 program participants

**Program Cost FY 2011-2012:** \$2,057,939

**Performance-Based Standards:** Ongoing documented participation in either the Carrera or Service Learning Teen Pregnancy Prevention Model. Absence of reported and/or lack of observable pregnancies.

**Performance-Based Outcomes:** Absence of pregnancies among male and female program participants.

**Performance-Based Vendor Accountability:** Demonstrated implementation and use of either the Carrera or Service Learning model; participants’ attendance; and evidence of participants’ involvement in program activities, both

# Judicial Branch Court Support

**Long Term Goals:** The prevention goal of the Judicial Branch, Court Support Services Division (CSSD) is to divert children from juvenile court involvement and penetration into the criminal justice system.

**Strategies:**

- Divert children from the judicial process through non-judicial supervision services and referrals to appropriate community-based agencies and diversion programs.
- Identify needs and risk factors of children and families through the use of valid risk/need screening and assessment instruments, and refer children and families to programs and services that address their needs in order to prevent further juvenile court involvement or penetration into the criminal justice system.
- Collaborate with schools, community partners, provider agencies, and other state agencies to support local and state efforts designed to prevent or eliminate at-risk behaviors and to promote the health, well-being, and success of children.

**Performance-Based Outcomes:**

- Reduction in juvenile court intake (Families with Service Needs-FWSN, and Delinquency referrals)
- Juveniles engaged in criminogenic need-based treatment
- Reduction in 24-month re-arrest rates for juveniles on probation or supervision
- Fewer delinquency commitments

**Measures of Effectiveness:** CSSD has adopted a results-based accountability framework to measure the effectiveness of its strategies. Data is collected on outcome measures and reportedly quarterly to management, line staff, judges, attorneys, and contracted service providers as part of a continuous quality improvement effort. In addition, CSSD conducts, through both internal and contracted resources, evaluations of targeted strategies and/or programs. Performance measures include:

- Performance Measure 1 – Juvenile Court Intake: Intake fell 30% from 15,857 in FY 2007 to 9,982 in FY 2012, despite the inclusion of 16 and 17 year olds in the juvenile court system, beginning January 1, 2010 and July 1, 2012, respectively.

- Performance Measure 2 – Juveniles Engaged in Criminogenic Need-based Treatment: Research suggests that completion of targeted treatment is connected to lower recidivism rates. The starting treatment rate in 2009 was 67% and rose to 97%, for 2012. The treatment completion rate in 2009 was 20% and has risen to 74%, for 2012.
- Performance Measure 3 – Reduction in 24-month Re-arrest Rates: The rate of re-arrest (recidivism) at 24-months after the start of a period of probation or supervision has remained consistent over the last four years and is beginning to show progress in the right direction. For example, 66 percent of the juveniles placed on probation or supervision in 2005 were re-arrested by the time their 24-month follow up period ended in 2007. The trend is beginning to decline showing a 63% re-arrest rate in 2012.
- Performance Measure 4 – Juveniles Committed to the Department of Children and Families: Juveniles committed to either long-term residential placement or for incarceration at the Connecticut Juvenile Training School have decreased by nearly 50 percent in the past 7 years, from 401 juveniles committed in 2004 to 214 in 2011 and a projection of 208 juveniles for 2012, despite the inclusion of 16 and 17 year olds in the juvenile system.

**Methods:** A core goal of the CSSD strategic plan is to engage in activities that provide a diverse, gender responsive and culturally competent environment for staff and clients that are sensitive to values and responsive to needs. CSSD established a Cultural Competency Advisory Committee which guides the implementation of this strategic goal. CSSD employees a diverse staff that is representative of the population served, including in key management positions within the agency. The Training Academy has embarked on an organization-wide cultural competency training initiative. CSSD provides culturally competent, research- and evidence-based programming, interventions and supervision services through the use of race- and gender-neutral screening and risk/need assessment tools, and a network of contracted providers. CSSD requires all contractors to meet cultural competence expectations in hiring and service delivery. CSSD routinely reviews operation and program performance measures for any disparities based on gender or race/ethnicity. In addition no

race/ethnicity disparity was found in case handling, adjudication rates, court outcomes and placement rates in an independent report, *A Reassessment of Disproportionate Minority Contact (DMC) in the Connecticut Juvenile Justice System* (May 2009), funded by the OPM Juvenile Justice Advisory study. Beginning in 2011, CSSD began work with the Hartford and Bridgeport communities on specific disproportionate minority contact reduction initiatives that have increased diversion from court rates and resulted in a revision to the Probate Graduated Sanctions Policy to include incentives to encourage compliance with court orders and decrease the use of detention for probation violations.

**Other:** CSSD has implemented several strategies to support the prevention or diversion of children and youth from court referral, including a focus on increasing family engagement, decreasing school arrests, and building local partnerships. Detention clinicians are meeting with families of newly detained juveniles to engage the family in the child's care while in detention and to help prepare the family for working with the Court and treatment providers to support the child's success and limit further court involvement. Probation staff is being trained in parent engagement to assist officers in working with families to support them in managing at home behaviors and providing parents with alternatives to calling police during domestic disagreements. Juvenile Probation also engages in outreach efforts to better coordinate with schools to manage the in-school behaviors of court involved juveniles. In addition, CSSD recently revised the Probation Intake policy to allow probation supervisors to return any referral that does not warrant court intervention, which resulted in the return of over 300 referrals in the first year. These efforts, in addition to the expansion of the School-based Diversion Initiative highlighted below, should reduce the number of court referrals for in-school arrests, which may be better managed by local schools and service providers. CSSD, in conjunction with DCF and through its partnership with other stakeholders of the Executive Implementation Team of the Joint Juvenile Justice Strategic Plan, has established a local interagency services team (LIST) for each juvenile court district to increase local awareness and support for the needs of children at risk for juvenile justice involvement. The LIST initiative is increasing community attention and local-state partnerships in addressing the contributing factors to juvenile delinquency.

A model intervention that holds great promise in diverting school-based arrests is the School-based

Diversion Initiative (SBDI), jointly developed and piloted by CSSD, DCF and CHDI, and funded by the MacArthur Foundation. SBDI seeks to bridge existing behavioral health services and supports to children and youth with mental health needs to prevent juvenile justice involvement. The creation of SBDI was based on three areas of concern in Connecticut, and nationally. First, although juvenile arrest rates have trended downward in the last 5 to 10 years, there remain high rates of *in-school* arrests, as well as expulsions and out of school suspensions, particularly among students with mental health needs. Exclusionary discipline results in more arrests, leading to academic failure and eventually to school drop-out. Youth with unmet behavioral health needs are disproportionality represented among students arrested in schools and approximately 65-70% of youth in detention have a diagnosable behavioral health condition. Second, students who are arrested or expelled are disproportionately to be students of color, particularly African-American and Hispanic males. Even when the behaviors are the same, too often school responses to behaviors are more severe for students of color. Third, to meet the needs of students at-risk of arrest or expulsion, schools report a need for better linkage to community-based mental health resources, particularly crisis response.

The SBDI model was designed to address these concerns and attends to the underlying needs of school professionals, which in turn allows schools to more effectively meet the needs of at-risk students. SBDI incorporates a Graduated Response model for disciplinary intervention, which seeks to ensure that school policies and procedures are fair and equitable, do not rely excessively on juvenile justice system interventions, and effectively meet students' needs.

The primary goals and objectives of SBDI include:

Goal 1: Enhance knowledge and capacity of school professionals for early identification of mental health needs, diversion from arrest and expulsion, and referral to community-based services

Objective 1: Coordinate delivery of expert training to school professionals in key content areas

Objective 2: Facilitate staff skill development and attitude change regarding key competencies

Goal 2: Reduce number of in-school arrests and expulsions and associated racial/ethnic disparities

Objective 3: Develop individualized school policies and procedures to build capacity for reducing arrests and expulsions

Objective 4: Enhance awareness of racial/ethnic disparities in arrests and expulsions

Goal 3: Increase utilization of community-based resources as alternatives to arrest or expulsion for youth with mental health needs

Objective 5: Enhance collaboration between participating schools, local law enforcement, and service providers to improve service referrals

Objective 6: Improve early identification and referral of youth with mental health needs to effective diversionary services such as Emergency Mobile Psychiatric Services (EMPS)

Students in SBDI-participating schools are diverted from arrest whenever possible, and instead linked to appropriate community-based resources. SBDI emphasizes use of each community's local EMPS team. EMPS is a statewide mobile crisis response program that deploys teams of specially trained mental health professionals to respond immediately to requests for crisis stabilization, provide brief treatment, and ensure appropriate linkage to ongoing care. EMPS providers respond directly to homes, schools, and emergency departments and services are intended to reduce inappropriate service referrals to correctional and inpatient settings. EMPS is available to every school in the state; however, existing data suggests that schools have historically underutilized this resource due to a lack of awareness and in some cases, a history of poor collaboration with the broader mental health provider community. SBDI seeks to strengthen relationships between schools and EMPS as a key community resource.

**Outcomes:** SBDI was piloted in four school districts (2 in SY 09-10, 2 in SY 10-11), expanded to three districts (SY 11-12). Results of school and student-level data collected from participating SBDI schools indicate:

- In-school arrests of students decreased 50-69% per school, particularly among youth with behavioral health needs
- On average, suspensions dropped 9% in-school and 8% out-of-school
- EMPS utilization tripled, while ambulance calls decreased up to 22%

A 2011 evaluation by Yale University compared EMPS utilization rates and arrest data for communities with SBDI compared to similar communities without SBDI using survival analyses with the following results:

- Youth first served by EMPS had less subsequent juvenile justice involvement compared to those initially referred to CSSD (47% re-arrest rate for EMPS vs. 66% for CSSD).
- Among youth with previous CSSD involvement, rates of subsequent juvenile justice referrals were significantly lower in SBDI communities (31%), even after controlling for race, age, gender, and previous delinquency, compared to non-SBDI communities (43%)
- Youth with previous CSSD involvement in SBDI communities experienced lower risk and delayed onset of recidivism (398 days to re-arrest), compared to non-SBDI communities (258 days).

**Educational Support Services:** Approximately 50% of the children referred to the juvenile justice system have learning difficulties and/or academic performance concerns. High school graduation is closely linked to future success as related to income earning levels, court involvement and recidivism. The goal of Education Support Services is to support families in ensuring that their children’s educational needs are properly identified and that children have access to a free and appropriate education as required by law. Education Support Services include legal case consultation, advocacy, and training by contracted special education attorneys serving families and probation officers of children referred to juvenile court due to status offending or delinquent behaviors, and who exhibit school difficulties and/or performance challenges. Services were available at all twelve (12) juvenile courts.

**Number Served:** 317 cases opened, 288 cases closed in 2011-2012

**Program Cost: FY 2011-2012** \$646,800

**Performance-Based Standards:**

- Percentage of clients that obtained/modified/preserved special education services
- Percentage of clients that overcame proposed suspension or expulsion
- Percentage of clients that obtained education-related benefits
- Percentage of clients that obtained procedural protections

**Performance-Based Outcomes:**

- 63% of clients obtained/modified/preserved special education services
- 16% of clients overcame proposed suspension or expulsion
- 49% of clients obtained education-related benefits
- 21% of clients obtained procedural protections

**Performance-Based Vendor Accountability:** CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD “contractor data collection system” (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

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**Family Support Centers:**

Since 2005, legislative change impacting the treatment and handling of status offenders (Families with Service Needs, FWSN) resulted in the development of distinct services for FWSN children and their families. Beginning with the prohibition on a court’s placing an adjudicated child in detention for a violation of a court order, changes in the law also called for statewide process modification for the handling of FWSN referrals. Public Act 05-250 established that “no child that is found to be in violation of any such FWSN order may be punished for such violation by commitment to any juvenile detention center”. In 2006, the legislature authorized an amendment to this legislation, Public Act 06-188, which established the Families with Service Needs Advisory Board to oversee the implementation of services in response to 05-250. The most recent legislative change came in an amendment of 46b-149 which changed the FWSN statute substantially, resulting in the development and funding of Family Support Centers.

A Family Support Center (FSC) is a multi-service “one-stop” service center for children and families referred to juvenile court due to status offenses (e.g., truancy, beyond control, runaway) and serves as a diversion to formal court processing. There were four (4) FSCs servicing the Bridgeport, Hartford, New Haven, and Waterbury juvenile courts. FSCs services were made available to the eight (8) remaining juvenile courts in FY 10-11. The purpose of the FSC is to quickly assess service and/or treatment needs for the children and families and then provide and/or access the needed services in a timely fashion. Services offered include assessment, crisis intervention, family mediation,

educational advocacy, case planning and management, psycho-educational groups, and flexible funds for prosocial supports.

**Number Served:** 1,097 participants

**Program Cost: FY 2011-2012** \$3,305,232

**Performance-Based Standards:**

- Program completion rate: completion of the FSC program means that the client satisfied 80 percent of the goals identified on the collaborative plan. The goal through December 2011 is for 85% of clients under age 16, and 78% of 16 and 17 year olds to successfully complete the program.
- Arrest rate for completers: percentage of program completers arrested within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.
- Re-referral rate for completers: percentage of program completers who have a new status offending court referral within 12 months of program discharge. The goal is improved program performance by at least one percentage point each year.

**Performance-Based Outcomes:**

- Program completion rate: 87% for clients under age 16, and 78% for clients ages 16 and 17.
- Arrest rate for completers: 32% for clients under age 16, and 29% for clients ages 16 and 17.
- FWSN referral rate for completers: 21% for clients under age 16, and 12% for clients ages 16 and 17.

**Performance-Based Vendor Accountability:** CSSD has established a continuous quality improvement team for each contracted service. Each team includes best practices staff, who develop program models based on the best practice literature and oversee program implementation; contract compliance specialists, who ensure that providers are adhering to the program model and the contract requirements; data collection support staff, who ensure that providers are inputting data into the CSSD “contractor data collection system” (CDCS) and the data meets quality standards; and program analysis staff, who analyze the data to ensure that programs are meeting benchmarks. Provider performance is reviewed by CSSD management staff on a quarterly basis, and the CQI team works with the provider to ensure quality service.

- **Title V Delinquency Prevention Program**

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**TITLE V DELINQUENCY PREVENTION PROGRAM:** The Title V Delinquency Prevention Program provides grants to cities and towns (units of local government) in Connecticut for delinquency prevention and early intervention projects based upon a risk and protective factor approach. This approach calls on communities to identify and reduce risk factors to which their children are exposed and to identify and increase/enhance protective factors which mitigate risk. Risk-focused delinquency prevention provides communities with a conceptual framework for prioritizing the risk and protective factors in their own community, assessing how their current resources are being used, identifying resources which are needed, and choosing specific programs and strategies that directly address those factors.

**Program Cost: FY: 2011-2012**      **\$33,486**

**Performance-Based Standards:** Program communities must develop and implement a local delinquency prevention plan that:

- Assess the prevalence in the community of specific, identified risk and protective factors, including the establishment of baseline data for the factors and a list of priority factors to be addressed;
- Identify all available resources in the community;
- Assess gaps in the needed resources and how to address them;
- Establish goals and objectives along with an implementation timeline; and
- Insure the collection of data for the measurement of performance and outcome of planned program activities.

**Performance-Based Outcomes:** Program grantees are required to collect the following data elements:

**Outputs**

- Number of full time equivalent employees funded with grant funds;
- Number of planning activities conducted; and
- Number of program youth served.

**Outcomes**

- Number and percent of program youth exhibiting an increase in school attendance;
- Number and percent of program youth completing program requirements;
- Number and percent of program youth satisfied with the program; and
- Number and percent of program staff with increased knowledge of program area.

**Performance-Based Vendor Accountability:** Program grantees prepare quarterly progress reports and collect evaluation data for the measurement of performance and outcome of planned program activities.

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**Enforcing Underage Drinking Laws:** The Office of Policy and Management and the Juvenile Justice Advisory Committee support comprehensive programs designed to combat underage drinking. Grantees receive training and technical assistance from the Governor's Prevention Partnership, Mothers Against Drunk Driving-CT (MADD-CT) and the Liquor Control Division of the Department of Consumer Protection.

**C.G.S. Section 4-67x (g)**

(g) (1) On or before November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

(3) Each agency report shall also include (A) long-term agency goals, strategies and outcomes to promote the health and well-being of children and families, (B) overall findings on the effectiveness of prevention within such agency, (C) a statement of whether there are methods used by such agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods, if any, and (D) other information the agency head deems relevant to demonstrate the preventive value of services provided by the agency. Long-term agency goals, strategies and outcomes reported under this subdivision may include, but need not be limited to, the following:

(i) With respect to health goals, increasing (I) the number of healthy pregnant women and newborns, (II) the number of youths who adopt healthy behaviors, and (III) access to health care for children and families;

(ii) With respect to education goals, increasing the number of children who (I) are ready for school at an appropriate age, (II) learn to read by third grade, (III) succeed in school, (IV) graduate from high school, and (V) successfully obtain and maintain employment as adults;

(iii) With respect to safety goals, decreasing (I) the rate of child neglect and abuse, (II) the number of children who are unsupervised after school, (III) the incidence of child and youth suicide, and (IV) the incidence of juvenile crime; and

(iv) With respect to housing goals, increasing access to stable and adequate housing.