

**State of Connecticut**



**Annual Progress and Services Report  
2016**

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

**By:  
Department of Children and Families**

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Commissioner**

**June 30, 2015**

Table of Contents

**A. Background ..... 5**  
**Introduction ..... 5**  
**Mission and Vision..... 5**  
**2015 PERFORMANCE EXPECTATIONS ..... 6**

**B. Connecticut CFSP Goals and Objectives, 2015-2019..... 10**  
**Strategic Plan and use of Results Based Accountability ..... 12**

**Section C. APSR Requirements..... 14**  
**STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM - FFY 2015 (TITLE IV-B (SUBPART 1)) ..... 14**  
**TITLE-IV-B, SUBPART II - PROMOTING SAFE AND STABLE FAMILIES - FFY 2015 ..... 19**  
**Monthly Caseworker Visitation Funds (See Section 7) ..... 27**

**Adoption and Legal Guardianship Incentive Payments (See Section 8)..... 27**  
**Child Welfare Waiver Demonstrations (See Section 9) ..... 27**  
**CHAFEE FOSTER CARE INDEPENDENCE PROGRAM - FFY 2015 ..... 27**  
**ETV ..... 29**  
**Child Welfare Demonstration Grants ..... 30**  
**Trainings in Support of CFSP Goals..... 30**

**GENERAL INFORMATION..... 31**

**State Interagency Coordination Council..... 48**  
**Systemic Factors ..... 72**  
**Information System ..... 72**  
**Case Review System..... 83**  
**Quality Assurance System..... Error! Bookmark not defined.**  
**Responsiveness to the Community ..... Error! Bookmark not defined.**

**3. Plan for Improvement and Progress Made to Improve Outcomes..... 103**

<b>Plan for Improvement</b> .....	<b>103</b>
<b>Implementation Supports</b> .....	<b>105</b>
<b>Progress Made to Improve Outcomes</b> .....	<b>106</b>
<b>Stephanie Tubbs Jones Child Welfare Services – Subpart I- FFY2016</b> .....	<b>151</b>
<b>Promoting Safe and Stable Families – Subpart II – FFY 2016</b> .....	<b>151</b>
<b>Chafee FFY 2016</b> .....	<b>152</b>
<b>Service Coordination</b> .....	<b>152</b>
<b>Populations at Greatest Risk of Maltreatment</b> .....	<b>155</b>
<b>Services for Children under the Age of Five</b> .....	<b>158</b>
<b>Services for Children Adopted from Other Countries</b> .....	<b>177</b>
<b>5. Program Support</b> .....	<b>178</b>
<b>Staff Training</b> .....	<b>178</b>
<b>Technical Assistance</b> .....	<b>188</b>
<b>Research and Evaluation</b> .....	Error! Bookmark not defined.
<b>6. Consultation and Coordination Between States and Tribes</b> .....	<b>190</b>
<b>7. Monthly Caseworker Visitation</b> .....	<b>193</b>
<b>8. Adoption and Legal Guardianship Incentive Payments</b> .....	<b>194</b>
<b>9. Child Welfare Waiver Demonstration Activities</b> .....	<b>194</b>
<b>10. Quality Assurance System</b> .....	<b>194</b>
<b>Section D: Child Abuse Prevention and Treatment Act (CAPTA)</b> .....	<b>194</b>
<b>CHILD ABUSE AND PREVENTION TREATMENT ACT (CAPTA) FFY 2015</b> .....	<b>194</b>
<b>CAPTA Spending Plan FFY 2016 (Proposed)</b> .....	<b>197</b>
<b>Citizen Review Annual Reports</b> .....	<b>201</b>
<b>Section E. Chafee Foster Care Independence Program</b> .....	<b>201</b>
<b>Education and Training Voucher Program</b> .....	<b>205</b>
<b>Section F. Updates to Targeted Plans</b> .....	<b>208</b>

<b>Adoption Recruitment/Retention/Support Activities .....</b>	<b>208</b>
<b>Health Care Oversight and Coordination Plan .....</b>	<b>219</b>
<b>Disaster Plan .....</b>	<b>230</b>
<b>Training Plan.....</b>	<b>231</b>
<b>Section G. Statistical and Supporting Information .....</b>	<b>231</b>
<b>1. CAPTA Annual State Data Report Items.....</b>	<b>231</b>
<b>Juvenile Justice Transfers .....</b>	<b>236</b>
<b>2. Sources of Data on Child Maltreatment Deaths: .....</b>	<b>236</b>
<b>3. Education and Training Vouchers: See Section E .....</b>	<b>242</b>
<b>4. Inter-Country Adoptions .....</b>	<b>242</b>

## A. Background

### Introduction

The Department of Children and Families is responsible for the legislative mandates of prevention, child protective services, children's behavioral health and juvenile justice. With an annual operating budget of approximately \$810 million, the Department provides contracted as well as direct services through a central office, fourteen (14) area offices, and two (2) facilities. The Department also operates a Wilderness School that provides experiential educational opportunities as well as Unified School District II, which is a legislatively created local education agency for children with no other educational nexus or who are residents in one of the Department's facilities.

### Mission and Vision

The Department's mission is to work together with families and communities for children who are healthy, safe, smart and strong. To ensure that all our activities contribute to that mission, the following seven cross-cutting themes have been established to guide the Department's work:

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

This mission is grounded in a core set of beliefs that encompass the Department's vision for how to provide services to Connecticut's children and families. We believe that children do best when living safely at home with their family of origin. When living at home with a parent is not reasonably safe, the best alternative is to live with another family member who can provide a safe and nurturing home. If no family member can provide a suitably

safe home that meets the child's needs, the child should receive care and services in an appropriate foster home until timely permanency can be achieved through reunification, transfer of guardianship or adoption. Foster care should only be used as a short-term intervention. While in foster care, regular and ongoing contact with parents and siblings is maintained. Finally, all youth are to exit the Department's care with legal and/or relational permanency.

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

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

## 2015 PERFORMANCE EXPECTATIONS

### **1. Exit from Juan E. Consent Decree**

- a. Sustain outcome measures that are pre-certified
  - i. Continue meeting measure as reported through the outcome measures
- b. Achieve outcome measures not yet pre-certified
  - i. Measure: Percent improvement as identified through internal case reviews
    1. OM 3: Case planning
    2. OM 10: Sibling placement
    3. OM 15: Needs met
  - ii. Measure: Percent improvement as identified through automated reports

1. OM 1: Commencement of investigation
2. OM 2: Completion of investigation
3. OM 7: Reunification
4. OM 9: Transfer of guardianship
5. OM 11: Re-entry
6. OM 13: Foster parent training
7. OM 17: in-home visitation
8. OM 18: caseload standards

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

- a. Increase the proportion of children who are served in their homes
  - i. Measure: Of all children served by CPS, the proportion of children in CPS cases served in-home versus out-of-home
  - ii. Measure: Of all children committed delinquent, the proportion of children being served in the community versus out of home placement
- b. Increase the use of preferred permanency goals
  - i. Measure: the percent of children in care with preferred permanency goal vs. APPLA
  - ii. Measure: Children exiting to permanency
  - iii. Measure: time to permanency
- c. Increase the proportion of children in care who are in kinship care
  - i. Measure: Percent of children in relative or special study placements
- d. Increase the proportion of children in care who are in family foster care settings
  - i. Measure: Percent of children in DCF core, kinship, or therapeutic foster care settings
- e. Assure the community-based service system is effective and meets the needs of the community
  - i. Measure: Number of clients served (by program)
  - ii. Measure: Rate of utilization of contracted slots (by program)
  - iii. Measure: For those clients who meet eligibility criteria, length of time from referral to admission
  - iv. Measure: The percent of consumers satisfied with services they have received
  - v. Measure: The percent of funded services with RBA performance measures
  - vi. Measure: For those clients completing community-based programming, the percent who have received the intended benefit (are better off) as defined by each program type

- f. Assure congregate care services are brief, family-engaged, connected to the community, and include discharge planning that begins at admission
  - i. Measure: Length of stay rates
  - ii. Measure: Rates of readmission to the same, or higher, level of care

### **3. Achieve Racial Justice Across the DCF system**

- a. Reduce disparities for children served by Child Welfare Services
  - i. Measure: The Disparity Index for alleged victims in Family Assessment Responses
  - ii. Measure: The Disparity Index for alleged victims in CPS Investigations
  - iii. Measure: The Disparity Index for substantiated victims
  - iv. Measure: The Disparity Index for children in cases opened for services
  - v. Measure: The Disparity Index for children entering care
  - vi. Measure: The Disparity Index for children in family care
  - vii. Measure: The Disparity Index for children in congregate care
- b. Reduce disparities for children served by the Juvenile Justice System
  - i. Measure: The Disparity Index for children placed in secure treatment on a pretrial basis
  - ii. Measure: The Disparity Index for children committed delinquent
  - iii. Measure: The Disparity Index for children committed delinquent and placed in secure treatment
  - iv. Measure: The Disparity Index for children committed delinquent and placed in congregate care
  - v. Measure: The Disparity Index for children committed delinquent and placed on parole
- c. Reduce disparities for children served by Behavioral Health Services
- d. Reduce disparities for children served by Education Services
  - i. Measure: The disparity index for DCF-involved children relative to performing at grade level
  - ii. Measure: The disparity index for DCF-involved children who are chronically absent
  - iii. Measure: The disparity index for DCF-involved children with in-and out-of-school suspensions, expulsions, and disciplinary actions
  - iv. Measure: The disparity index for DCF-involved children graduating on time from high school

### **4. Prepare children and adolescents in care for success**

- a. Ensure children and adolescents in care are safe and stable
  - i. Measure: Of all children who enter out-of-home-care in a 12-month period, the rate of placement moves per day of out-of-home-care.



- ii. Measure: Of all children in out-of-home-care during a 12 month period, the rate of maltreatment per day of out-of-home-care.
  - iii. Measure: the percent of 17 year-olds with documented lifelong family ties
- b. Provide quality education and support services that lead to educational success
  - i. Measure: The percent of children who are performing at "proficient or better" based on CM, CAPT or SBAC test results
  - ii. Measure: The on-time graduation rate
  - iii. Measure: The percent of adolescents aging out of care participating in Post-Secondary Education (including vocational) or employed full time
- c. Provide formal and informal life skills
  - i. Measure: The number and percent of committed adolescents, over 14 years old, who have been assessed using the approved DCF life skills program on an annual basis
  - ii. Measure: The percent of adolescents aging out of care who score "advanced" on all relevant domains of the approved DCF life skills program
- d. Ensure physical, mental, and dental health needs of children in care are met
  - i. Measure: Rates of obesity
  - ii. Measure: Of all children in care with asthma, percent of children receiving appropriate care
  - iii. Measure: Of all children in care with diabetes, the percent of children receiving appropriate care
  - iv. Measure: Rates of up-to-date dental care
  - v. Measure: Court Monitor case reviews

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

- a. Create stability in the workforce
  - i. Measure: Rate of staff turnover
  - ii. Measure: Rate of lateral transfers
  - iii. Measure: Consistent and effective supervision
  - iv. Measure: Percent of newly-hired social workers with MSWs or BSWs
  - v. Measure: Establishment and functioning of staff support teams in each facility, office, and central office
- b. Train managers and supervisors in supervisory and management skills
  - i. Measure: Percent of social work supervisors successfully completing the Leadership Academy for Supervisors
  - ii. Measure: Percent of program managers successfully completing the Leadership Academy for Middle Managers
  - iii. Measure: Improved performance management through the Organizational Intervention
  - iv. Measure: The percent of Program Development and Oversight Coordinator s trained in contracting and performance management

- c. Support regions, facilities and communities in their work on behalf of children and families
  - i. Measure: Length of time for Fiscal to approve spending requests
  - ii. Measure: Length of time for OFAS to approve adoptions
  - iii. Measure: Length of time for Human Resources to fill vacancies
  - iv. Measure: Data access provided by Information Systems and Office of Research and Evaluation
    1. Development of protocol for data reporting
    2. Full implementation of new SACWIS system
  - v. Measure: Length of time for policy to be developed
    1. Length of time for policy owners to finalize policy drafts
    2. Length of time for Legal to finalize policy and post to the web.

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

#### **B. Connecticut CFSP Goals and Objectives, 2015-2019**

The Department's plan for improvement is an extension of the implementation of our Strengthening Families Practice Model and Differential Response System. Connecticut's Practice Model is implemented through seven core strategies:

- Family Engagement
- Trauma-Informed Practice
- Family Centered Assessments
- Child and Family Teaming
- Purposeful Visitation
- Effective Case Planning
- Leadership, Management and Supervision

Over the past five years, we have made considerable progress implementing these strategies and positively impacting outcomes for the children and families we serve. In the

next four years, we will continue to focus on three goals aimed at continuing to achieve the Department's mission that all children will be healthy, safe, smart and strong.

**Goal 1:** Children will be served in their family of origin whenever possible and appropriate.

Objectives:

1. The number of children in foster care will be reduced by 25% through continued implementation of Considered-Removal Team Meetings (CRTM).
2. The in-home service array will be expanded and strengthened to support keeping children with their family of origin.
3. Forty percent of all initial placements and 30% of overall placements will be with relatives and kin.
4. An adequate array of foster home placements is available for children who cannot be placed with their own families.

**Goal 2:** Timely permanency will be achieved for all youth who enter care.

Objectives:

1. Children entering care will achieve their permanency goal in a timely manner as measured by entry-cohort reports for reunification, adoption and transfer of guardianship.
2. Permanency Teaming will be implemented to improve the likelihood of permanency for all children and to reduce the use of APPLA by 50%.
3. The number of youth aging out of care without legal or relational permanency will be reduced by 50%.

**GOAL 3:** Treatment in congregate care will only be used on a short-term basis, with extensive family involvement in the treatment process.

Objectives:

1. The number of children placed in congregate care settings will be no more than 10% of the population of children in placement.
2. All congregate care settings have extensive family involvement as part of the treatment process.

### Strategic Plan and use of Results Based Accountability

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

Result Statement: All Connecticut children grow up in stable environments, safe, healthy, and ready for success.

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

#### SAFE

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

#### HEALTHY

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

#### STABLE

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

#### FUTURE SUCCESS

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

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

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

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

In addition to these seven cross-cutting themes, nine overarching strategies have been developed and continue to be utilized.

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

## Section C. APSR Requirements

### STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM - FFY 2015 (TITLE IV-B (SUBPART 1))

The figures provided below reflect anticipated expenditures. The services/activities that are described in this section are funded at levels that exceed the award amount. These programs are being supported through multiple year awards, including FFY 2014 and FFY 2015. Individuals occupying the positions supported by grant funding were selected through an interview process. The providers for Triple P and KJMB were selected through a procurement process. JRA Consulting, the Connection, CCMC, and UCONN were selected based on their level of expertise.

Services/Activities	Total Funding	Family Support	Prot Svcs	Family Pres	Reun Svcs	Adopt	Group/In s Care	Indep Living	Admin Costs
Children Services Positions - Solnit South	\$955,667						\$955,667		
Office Assistant Positions	\$147,911		\$36,977	\$36,977	\$36,980	\$36,977			
JRA Consulting - Racism	\$90,000	\$22,500	\$22,500	\$22,500	\$22,500				
CCMC	\$220,500		\$110,250	\$110,250					
Central Office Staff	\$135,260								\$135,260
Personnel- Manager	\$84,620	\$21,155	\$21,155	\$21,155	\$21,155				
The Connection	\$200,000			\$100,000	\$100,000				
Triple P America	\$105,550	\$35,183	\$35,184	\$35,183					
Travel/Conferences	\$10,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000			
Domestic Violence/Substance Abuse	\$110,000		\$36,666	\$36,668	\$36,666				
Parents with Cognitive Limitations	\$4,000	\$2,000	\$2,000						
KJMB Solutions	\$335,430	\$67,086	\$67,086	\$67,086	\$67,086	\$67,086			
Total:	\$2,398,938	\$149,924	\$333,818	\$431,819	\$286,387	\$106,063	\$955,667	\$0	\$135,260

## DESCRIPTION-STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM- FFY2015

Staff Positions: The Albert J. Solnit Psychiatric Centers' North Campus is a facility run by the Connecticut Department of Children and Families. It provides brief treatment, residential care and educational instruction for abused and neglected children between the ages of 10 and 18 from all across the state. It offers complete multidisciplinary medical and mental health assessments for those children under its care. Individual services are designed to meet the children's unique needs and to facilitate and support community placements when clinically indicated. The grant helps support multiple positions including Children's Services Assistants, Lead Children Services Workers and a secretarial position for a facility administrator.

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

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

Connecticut Children's Medical Center (CCMC): Funding supports additional staffing for child sexual abuse, physical abuse and psychosocial evaluations of children for whom abuse or neglect is suspected. CCMC provides the following array of services: DCF case consultations, training, medical evaluations, psychosocial assessments, family and professional interviews, and ongoing participation in Multidisciplinary Team meetings. The contract is supported by both state and federal funding. The federal funding is used to increase capacity for case consultations when child abuse/neglect is suspected.

Personnel - Administrative Positions: The grant supports a full time administrative position within the Division of Grant and Contracts Management, an Accountant who provides fiscal management and oversight of the child welfare grants, and salary of a full-time Program Manager through 3/31/15 who had provided managerial oversight of multiple federal child welfare related grants and oversaw the development and implementation of key child welfare initiatives.

The Connection: The Supportive Housing for Families program provides permanent housing and intensive case management services to DCF families. The program began over 14 years ago, to help families recovering from substance use. In 2001, DCF received Federal Unification Program Vouchers and was able to expand eligibility to accept non-substance using clients into the program. The program was renamed Supportive Housing for Families (SHF).

DCF contracts with the Connections, Inc. to provide intensive case management services to assist families to develop and utilize a network of services in the following areas: economic (financial support, employment assistance), social (housing, transportation, family support, parenting education, child care) and health (medical/mental health care for adult and child, relapse prevention, and domestic/child/substance abuse issues). The Connections, Inc. has nine sub-contracted agencies to provide these services statewide. Permanent housing is established through DCF's partnership with the Department of Social Services (DSS). The DSS provides a Housing Choice Voucher (formally "Section 8" - federal program) or Rental



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

Triple P America: Federal funds were allocated to the Positive Parenting Program (Triple P) to offer two week-long Level 4 Standard and Standard Teen Triple P trainings in FFY 2014-2015. A total of 22 new Triple P staff members were trained and accredited. This allocation supports ongoing training opportunities for provider staff to ensure no interruption in the provision of services. Triple P, is an evidenced-based model that provides an in-home parent education curriculum along with support and guidance so that parents will become resourceful problem solvers and be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths.

Travel/Conferences: Federal funding was used to support travel and registration fees for Managers to attend various conferences, including but not limited to Differential Response. In order to access funds, managers must demonstrate how the conference aligns with the Department's Performance Expectations and how the Manager intends to share the content of the conference with their respective office, region or division.

Domestic Violence/Substance Abuse: Funding was used to support a variety of training opportunities for DCF and provider staff relative to domestic violence/substance abuse. A Program Director within the Clinical and Community Consultation and Support Division attended the 2015 Fatality Review Communities and Social Change Conference sponsored

by the National Domestic Violence Fatality Review Initiative. This two-day event brought together team members and stakeholders from across the country to learn about fatality reviews and advance their efforts. The conference explored the ways communities have changed their responses to domestic violence as a result of their fatality review work. The conference highlighted the importance of civic engagement, agency and stakeholder contributions, and democratic practice. The conference was held May 18 – May 19, 2015.

A Manager attended the 2015, Adolescent Community Reinforcement approach (A-CRA) with the Assertive Continuing Care (ACC) intervention training through the Chestnut Health systems. A four-day initial training workshop is designed for clinical staff who plan to implement A-CRA/ACC with adolescent treatment participants and/or provide clinical supervision of A-CRA/ACC cases, as well as those in support and administrative roles for programs implementing A-CRA/ACC. The training uses demonstrations to model how A-CRA and ACC are used with adolescents and their families, and participants have an opportunity to practice procedures.

Intimate Partner Violence – Family Assessment Intervention Response (IPV-FAIR) 5 day service training for newly awarded providers, as well as staff added to the initial provider group since the first training in June 2015. This provides the opportunity to provide a second training of the model to support statewide implementation.

IPV-FAIR booster sessions: 2 ½ day (each offered x2) booster sessions for IPV-FAIR providers on emerging clinical treatment issues that providers identify as they begin to deliver IPV-FAIR services and to provide additional training support where there are gaps (e.g. Motivational Interviewing to increase engagement, supervision).

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

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

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

- Incident data collection/event reporting
- Implementing and supporting additional programs/projects including web services support to enhance real time data collection to minimize delays and duplication in entering data, as well as improve data integrity and analysis.

#### TITLE-IV-B, SUBPART II - PROMOTING SAFE AND STABLE FAMILIES - FFY 2015

The figures provided in the table below reflect anticipated expenditures. The programs are funded at levels that exceed the award amount. These programs are being supported through multiple year awards, including FFY 2014 and FFY 2015. The Community Collaboratives, the Family Advocate through FAVOR, The University of Connecticut's Adoption Assistance Program, Adopt a Social Work Program, CT Association for Infant Mental Health, Visit Coaching, KIPS, the National Family Preservation Network, and Easter

Seals Adoption Support Group were selected by the Department based on their expertise, the nature and scope of the work directly aligned with key areas of focus for the Department and their ability to provide the service as described below. The providers for Reunification Services and Homebuilders were selected through a procurement process.

Service Description	Total Funding	Family Preservation	Family Support	Family Reunification	Adoption	Planning
Reunification Services	\$1,165,653	388,511	388,511	388,511		
Community Collaboratives	\$284,700				\$284,700	
FAVOR	\$50,000	25,000	25,000			
UCONN -Adoption enhancements	\$300,000		50,000		250,000	
Easter Seals Support Group	\$20,000		10,000		10,000	
Homebuilders Pilot	\$57,297	19,099	19,099	19,099		
UCONN PIC Expansion	\$129,420	43,140	43,140	43,140		
Adopt a SW program	\$95,275	31,758	31,758	31,758		
Visit Coaching	\$18,992	9,496		9,496		
CT Association for Infant MH	\$37,667	18,834		18,833		
KIPS Training	\$32,515			32,515		
National Family Preservation Network	\$15,000	7,500		7,500		
National Kinship Conference	\$2,468					2,468
<b>Total</b>	<b>\$2,208,987</b>	<b>\$543,338</b>	<b>\$567,508</b>	<b>\$550,852</b>	<b>\$544,700</b>	<b>\$2,468</b>
		25%	26%	25%	25%	0%

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

Reconnecting Families Program: Last year the Reconnecting Families Program was redesigned and a new service type was created containing three core services as described below:

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

- Review/explore safety concerns and risk factors that may impact child safety with the family and DCF;
- Assess family functioning, skills, parental capabilities, and parent's motivation to change;
- Identify family strengths and needs;
- Implement the Visit Coaching Model
- Provide Family Time/Therapeutic Family Time services
- In collaboration with the family Identify family resources and informal/formal supports and how they may be used in safety planning;
- Observe family interactions;
- Provide a minimum of weekly visits with the parent and child.
- Identify problems and barriers that may be impacting reunification; and
- Complete initial (North Carolina Family Assessment Scale for General Services and Reunification (NCFAS- G+R) within 14 days of referral.

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

- Utilizes the North Carolina Family Assessment Scale for General Services (NCFAS - G+R) to inform service delivery
- Delivers a Staged Model to support families throughout the reunification process

- Adopts a Wrap Model philosophy to engage the family and build their network of supports
- Employs Permanency Child and Family Teaming model to engage the family and their supports in case planning and decision-making
- Active engagement and involvement of father's (including non-custodial parent) in the reunification process
- Therapeutic Family Time interventions/treatment approaches including the Visit Coaching Model
- Flexibility in staff assignments based on presenting needs of the family
- Step-Down option if families require additional supports

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

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

An RFP was released in June 2014 and contracts were awarded. The service began statewide in January 2015. As of 4/17/15, 332 families have been served by the three service types; 58 families have been discharged from the program since implementation; 20 families have experienced successful reunifications.

Community Collaboratives: The Department continues to support Community Collaboratives designed to recruit, strengthen and support neighborhood-based culturally competent foster/adoptive resources for children. Collaboratives have been established to

serve all the Area Offices and are responsible for engaging new partners to broaden community ownership for planning and implementing activities that recruit and support foster and adoptive families. Funds are distributed through a fiduciary (Advanced Behavioral Health) and used to support meeting costs, planning efforts and activities implemented by the collaborative for the purpose of recruiting and retaining foster and adoptive families.

FAVOR: The DCF Office for Community Mental Health has contracted with FAVOR, Inc., a statewide family advocacy organization. Family System Managers (FSM) are embedded statewide in DCF regional offices. Each Family System Manager works in partnership with the DCF Regional Systems Development Manager, DCF staff and the CT Behavioral Health Partnership (BHP), with formal reporting and supervision provided through the Contractor. They are required to promote family driven and youth guided practices throughout the local and regional service system and to support the identification, recruitment, and participation of families in behavioral health system analysis, planning and service provision. They provide leadership in the local and regional behavioral health system development from the family perspective while providing technical assistance and support to local systems of care including their governance. They assist the geographic local regional areas in identifying, developing, and supporting informal supports and service networks (e.g. faith community, service organizations, recreational agencies, etc.). This is accomplished by working in partnership with DCF Systems Managers, Hub Service Agencies, and other system leaders and stakeholders to advance the health and well-being of children and families. They work in conjunction with DCF Systems Managers to analyze system needs, monitor system functioning, and promote and sustain system improvements across the regional service network. The FSMs assist in the organization and implementation of the Citizen's Review Panels. They assist and promote improved communication and linkages among similar, cross child-serving community meetings/groups/collaboratives (Area Advisory Councils, Regional Advisory Councils, Local Interagency Service Teams, Early Childhood Collaboratives, Community Collaboratives, and others); are broadly focused and work on all DCF mandates for full system integration.

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

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

These positions are funded predominately by state funding. In 2015, 28 families were served.

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



total of 132 hours of support services from 17 Connecticut Child Placing Agencies both pre and post legal permanency. This program is funded by both state and federal funds.

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

Homebuilders Pilot: Last year, the Department allocated federal and state funding to implement a pilot Homebuilders Program in Region 5. The federal funding is being used to support staffing and access to wrap funding to help meet/support the basic needs of families that are being served by the program.

UConn PIC Expansion: UConn School of Social Work has been functioning as the Performance Improvement Center for the Community Support for Families Program, a contracted service designed to provide support to families who received a Family Assessment Response from the Department. This past year, the Memorandum of Agreement between the Department and UConn was amended to expand their analysis to include all our Family Assessment Response dispositions to allow a more robust and comprehensive evaluation of our Family Assessment Response.

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

Visit Coaching: The Therapeutic Family Time component uses the **Visit Coaching** best practice model developed by Dr. Marty Beyer and involves the child, parents, foster parents and social worker. Visit coaching is based on parental strengths and child needs, and has clear indicators for progress. Visit coaching provides the opportunity for the parents to become more confident in parenting by increasingly recognizing and responding to their child's needs. Federal funding was used to provide training to contracted Reunification and

Therapeutic Family Time Providers. A total of 97 provider staff participated in the Visit Coaching training. These staff also participated in follow up training sessions and will participate in follow up consults in the near future.

CT Association for Infant Mental Health: The Connecticut Association of Infant Mental Health was contracted to provide 8 full days of training focused on unresolved trauma, ***“Understanding Infant/Toddlers and Their Families and the Challenges of Unresolved Loss and Trauma: working towards deeper integration between DCF and Head Start.*** Presenters known nationally for their work in child welfare and Early Head Start offered their expertise on observations of young children and their families in child welfare, on integrating a trauma lens into work with very young children and their families, on making child welfare visitations a relationship-focused experience for parents and young children. Local presenters added their competencies in reflective practice, cultural sensitivity, and assessment/referral. The training was offered in other regions throughout the state and is currently being offered in Region 3 (Willimantic, Middletown and Norwich). Region 2 will begin training in August 2015. In addition, 12 months (2 hours/month) of reflective consultation facilitated by an endorsed clinician was offered to Department staff and community partners. This is delivered through a cross training approach to support workforce development both within DCF and with the provider network.

KIPS: (Keys to Interactive Parenting Scale). An evidence-based tool for assessing parenting strengths and needs in diverse families was incorporated into the Reunification and Therapeutic Family Time program. The purpose of the tool is to provide information to guide staff observation, tailor services to individual families, track family progress, offer opportunities for reflective supervision, and to evaluate program goals. Funding was used to purchase the tool and provide on-line training to contracted staff. Training is currently underway and a total of 93 provider staff have registered for the training. In addition to the training, funds were used to purchase the scales in English and Spanish.

National Family Preservation Network: The Department purchased the NCFAS-G and NCFAS-G+R for use in several key child welfare programs including the Community

Support for Families Program, the Reunification and Therapeutic Family Time Program and the new service, Intimate Partner Violence – (FAIR). In addition, funding was used to purchase newly validated domains related to trauma and well-being.

National Kinship Conference: Funding supported a Manager’s attendance at this conference in Louisiana.

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

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

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

CHAFEE FOSTER CARE INDEPENDENCE PROGRAM - FFY 2015

The figures provided in the table below reflect anticipated expenditures. Personnel positions were supported through grant funding were identified through an interview process. The providers who deliver Community Based Life Skills were selected through a procurement process. Our Work to Learn programs were selected through a procurement process. Many of the providers delivering One on One Mentoring have done so for over 12 years through a sole source contract. The most recent Contractors were selected through a procurement process.

Service Description	Funding
Personnel Expenses	\$ 45,846
One on One Mentoring	\$322,013
Community Based Life Skills	\$398,430
Work to Learn	\$726,908
Youth Advisory Board Stipends	\$50,000
Center’s for Children Advocacy	\$11,470
Total	\$1,554,667

## SERVICE DESCRIPTIONS - CHAFEE FOSTER CARE INDEPENDENCE PROGRAM

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

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

Community-Based Life Skills: The Department currently contracts with 10 community agencies to provide community based life skills in 15 Area Offices, to DCF committed youth placed in community settings. Currently the Department is using the LIST (Assessment Tool and Curricula) for the provision of life skills. It provides youth age 14 and older who are in foster care with the life skills necessary to successfully transition to adulthood.

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

- *Our Piece of the Pie* (OPP): A comprehensive work/learn model located in Hartford that helps youth access and attain a combination of educational, employment and

personal development opportunities that promote success. OPP is also operating a second Work/Learn site in Norwich.

- *Lifebridge Community Services*. (Formerly FSW): This Bridgeport program partners youth with technical experts and role models in a youth-centered small business. They develop transferable skills, identify goals and reinforce the personal skills needed for successful employment.
- *Marrakech Inc*: Located in New Haven and Waterbury, these sites offer a comprehensive work/learn model that helps youth access and attain a combination of educational, employment and personal development opportunities that promote success.

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

Centers for Children Advocacy (Speak Up Project): Federal funding was used to assist with the Training and youth advocacy program for youth in foster and congregate care. The project utilizes electronic and printed publication to educate and inform youth in the system as to how to advocate for themselves. Youth are given information about Child Protective Services and the Court System. There are video vignettes to further assist the youth with a variety of relevant topics.

#### ETV

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

### Child Welfare Demonstration Grants

Connecticut has not been awarded a Child Welfare Demonstration Grant.

### Trainings in Support of CFSP Goals

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

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

This past year, the CR-CFTM Facilitators conducted training to Area Office staff around the CR-CFTM process focusing on model fidelity, importance of parental, youth and relative participation in meetings, and the positive outcomes of family and youth involvement in planning and decision making activities. The Training Academy has delivered statewide training on permanency teaming to direct service staff, managers, office directors, and provider staff. Additionally, the Department has provided permanency preparation training by the national developer to congregate care providers, therapeutic foster care providers and PPSP providers to further support the Department's efforts to achieve timely permanency for children. Data around our CR-CFTM process demonstrates our success in maintaining children safely in the home and engaging relatives and kin in safety planning.

## Collaboration

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

The Department receives community input from a number of statewide and local advisory councils. At the statewide level, the State Advisory Council (SAC) is a 17-member council appointed by the Governor to advise the Commissioner on all matters pertaining to services for children and families. The Department also receives significant input from a statewide Children's Behavioral Health Advisory Council (CBHAC), local Regional Advisory Councils (RACs) affiliated with each of our six regions, advisory councils at each of our facilities and Youth Advisory Boards (YAB).

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

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

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

### [Community Collaboratives](#)

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

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

### [DCF Interface with DMHAS and DDS](#)

DCF collaborates closely with both the Department of Mental Health and Addiction Services (DMHAS) and the Department of Developmental Services (DDS). DCF, in conjunction with DMHAS and DDS, has developed a significant number of protocols and processes to support



transition planning and collaboration. These apply to youth aging out of foster care as well as those involved in other parts of the DCF system (Voluntary Services, Juvenile Justice, In-home services, etc.).

DMHAS offers a specialized Young Adult Services program (YAS) for 18-25 year olds aging out of the DCF system who have significant psychiatric disabilities and who will need services and supports when they leave the children's system. DMHAS also has an array of adult mental health services but most of the youth who meet the program criteria and are identified with needs go directly to the specialized YAS program. DCF refers between 200 and 300 youth to DMHAS each year. These referrals are made at age 16 unless the youth enters care later. DMHAS cannot start services until age 18. DCF transitions an average of 110 youth to DMHAS each year between the ages of 18 and 21.

DDS works with individuals who have developmental disabilities and are likely to need support and services throughout their lifetime. DDS has an array of services and has been able to target resources, which are not available to the general public, specifically to youth aging out of DCF. As of May 2015, DCF has identified 201 children/adolescents who have been referred to and made eligible for DDS and who will eventually transition to adult services, typically at age 21. DCF and DDS maintain a "shared client list" which is updated regularly to assure that DCF involved youth are identified, referred and transitioned. DCF has been tracking transitions to DDS since SFY 2011, and an average of 73 youth per year have transitioned to DDS.

DDS also has a program for children and adults on the autism spectrum (ASD) but who do not have intellectual disabilities (ID). The program has a limited number of slots and only 50 for children. In FY 13 and 14, DCF transitioned 36 youth to this program. In addition, DCF maintains a list of eligible youth for transition when space is available. The waiting list for these services is anticipated to be reduced over time with the implementation of the state's Medicaid coverage for children with ASD up to age 21 which give some families another option for services.

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

1. Agency specific Memorandum of Agreements which formally define coordination and collaboration;
2. Statewide screening process utilizing standardized criteria to identify youth starting at age 15 who need referral to DMHAS or DDS (DCF screens an average of 849 youth annually);
3. Centralized process to track and monitor referral timeliness and completion and provide regular feedback to Regional and Central Office administrators and staff;
4. Centralized referral processing for DMHAS and centralized monitoring of referrals sent to DDS;
5. Identification of a liaison to DMHAS and DDS in each DCF Region and an Office of Interagency Client Planning located in DCF Central Office which specifically manages DMHAS and DDS related activities and supports local collaboration; and
6. Formal mechanisms which focus on the coordination of referral, eligibility and transition:
  - At the local level, DCF Area Offices have monthly, bimonthly or quarterly meetings with DMHAS and DDS staff:
    - DMHAS Young Adult Services staff plus representatives from their local YAS Programs meet with DCF Area Office staff to discuss individuals who have been referred to DMHAS and are in need of or already in the process of transitioning; they address any issues that impact transition and identify problems or resource needs that impede smooth and timely transitions.
    - DDS Regional Office staff meet with DCF local Area Office and Central Office staff to review and track youth transitioning from DCF to DDS utilizing a DDS/DCF shared client list; the purpose of the meeting is to identify who is transitioning, what is the transition plan and the timing, who is involved and if there are barriers that need to be addressed.

- DMHAS holds monthly meetings with the Albert J. Solnit Children's Center and the Connecticut Juvenile Training School to assure coordination when youth are in DCF operated inpatient or psychiatric residential treatment facilities; staff from the Office of Interagency Client Planning in DCF Central Office also participate in these meetings.
- Case-specific transition planning is done between the Social Worker at the DCF Area Office and the DMHAS or DDS Case Manager.
- At the administrative level, bi-monthly meetings are convened to assure that systems issues and barriers that cannot be resolved at the local level have a forum in which to be discussed and addressed:
  - One meeting is held between DCF and DMHAS Central Office administrators.
  - A separate meeting is held between DCF and DDS Central Office administrators.
  - There is a combined inter-departmental meeting with DCF, DMHAS, DDS, along with the Office of Policy and Management (the Governor's budget office), Court Support Services Division (Juvenile and Adult Probation) and the Department of Social Services.

7) Informal mechanisms are also available to assure case-specific issues are addressed when they arise including:

- If individual clinical, resource or system issues are identified as impeding a transition, an individual case conference may be convened. This brings a larger group of stakeholders together to discuss a particular situation and come up with solutions.
- Staff of the DCF Office of Interagency Client Planning is available to provide training, technical assistance and consultation on client specific, administrative and/or systems issues related to screening, referral, eligibility, transition and interagency coordination. This consultation is available to both staff in the DCF system and to DMHAS and DDS. General in-service training on DCF/DMHAS/DDS interface is also available for other agencies and community groups.

- Office of Interagency Client Planning also provide training as part of the Department's Adolescent Services and Voluntary Services Certification program.

8) Provision of data and reports regarding DDS and DMHAS processes is another element that supports collaboration and helps to ensure better compliance with MOA requirements and DCF Outcome Measures. This includes but is not limited to:

- Number of individuals screened;
- Timeliness of referrals;
- Number of referrals;
- Number of youth transitioned;
- Tracking the completion of SSI applications (which is required for transition to both DMHAS and DDS) and
- Tracking the completion of Transition Action Plans which are a DMHAS document used to guide the transition process.

9) Participation in a number of interagency committees/workgroups by the DCF Office of Interagency Client Planning including:

- Statewide TBI Advisory Committee;
- DDS Autism Spectrum Division Advisory Council;
- DDS Children's Services Committee; and
- The Connecticut Family Support Council.

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

11) Special transition initiatives between DCF and DDS for transfer of:

- a) DCF Voluntary cases to the DDS Voluntary Program;
- b) Children on the autism spectrum to the DDS Autism Division Medicaid Waiver program; and
- c) Early age outs to DDS prior to age 21 in certain circumstances.

#### Special Collaboration Project – Life Skills preparation

DCF and DMHAS have been working together for a number of years to identify ways to

better prepare youth for adult roles and responsibilities. DMHAS provided feedback that many of the youth, coming from both foster care and congregate care settings, had few, if any practical skills to prepare them for community living.

DCF and DMHAS began a pilot project in one Area Office (New Britain) around both better transition planning and improving life skills. The collaboration brought together DCF, DMHAS, community provider staff as well as youth who had already transitioned to DMHAS and could provide feedback on what did/did not work. To look at the area of life skills, DMHAS also included Occupational Therapists with special training in assessing and teaching skills to young adults with psychiatric disabilities. A specific assessment tool (Learning Inventory of Skills Training – LIST) was developed and piloted and is now being expanded statewide for use with all adolescents - both DMHAS and non-DMHAS bound.

#### Moving Forward – Collaboration in the Next 5 Years

With the mechanisms described previously, interagency collaboration between DCF and DMHAS/DDS has been built into the core of the work and will continue to be a priority. In addition to maintaining the existing coordination protocols and processes, it is critical to move the work forward to improve, enhance and expand what can be and is accomplished. Progress toward goals established for the next 5 years are reported below. Each of these, unless otherwise identified, will continue to be priorities for the Office of Interagency Client Planning in DCF Central Office:

1. Expand the Life Skills pilot to additional Regions (beyond the New Britain Office) so that all youth leaving DCF care for DMHAS (and elsewhere) are prepared – *the first step in this process is to add an annual LIST reassessment in the New Britain Office for each client having had a baseline LIST completed; this will allow a comparison of the baseline LIST scores against a new assessment to see if progress has been made; resources for staff training are being identified for expansion to other offices and this is also part of the large DCF LIST initiative.*

2. Enhance coordination and communication between DCF and DMHAS throughout the transition process by formally tracking and reporting on the use of the DMHAS Transition Action Plan and providing feedback to DCF and DMHAS staff – *this is in the early stages of implementation and DCF and DMHAS are meeting regularly and sharing information to begin this tracking process; data is being collected and reviewed to assure accuracy.*
3. Update the Memorandum of Agreements to assure they reflect current practice – *DMHAS MOA draft revision has been prepared and reviewed at both DMHAS and DCF; this is going through a final review before submission to the Commissioners.*
4. Enhance transition from DCF to DDS through coordination of benefits transfer, particularly around Medicaid and SSI related issues; this has been identified as a barrier to timely and smooth transitions – *SSI completion is being tracked for both DMHAS and DDS and there is ongoing coordination with the DCF Revenue Enhancement around IV-E issues which may impact the timing of SSI applications.*
5. Develop practice guides for DCF staff around screening, eligibility, referral and transition to DMHAS and DDS – *this is still in early stages of development with a plan to discuss at the Clinical and Systems Community of Practice for input and guidance.*
6. Development of a more formal transition protocol between DCF and DDS which accounts for the various ways in which a child/youth might transfer from DCF to DDS – *this will be reviewed as part of the revision of the MOA between DCF and DDS.*
7. Identify 1-3 interagency pilot projects addressing special needs populations for youth who “fall between the cracks” and/or don’t meet eligibility criteria of current agencies. This involves working with DDS, DMHAS, CSSD, DSS and the Office of Policy and Management to develop a cross- or multi-agency funding mechanism to assure service availability for these youth – *the Inter-Departmental working group has shifted its focus and determined that the most effective way to address this issue and these challenging populations is through the implementation of an Interagency Case Review team which will recommend case specific service and support plans for*

*individuals who do not meet existing agency eligibility criteria and for whom specific funding resources may need to be identified.*

8. Develop a specific plan for transition of youth to DMHAS and DDS in foster care settings; for DDS this includes a collaboration between the staff working with DDS licensed Community Care Homes and the DCF Foster Care staff to review licensing, rates, provider and family expectations and services offered in each model, develop a system to educate current foster care parents on DDS CCH options and cross-train staff – *for DDS, this process has begun with a review on a case-by-case basis as DCF and DDS identify, as early as possible, those cases for whom DDS CCH may be appropriate; DDS CCH staff has been meeting with foster families (and DCF staff) to identify if this is the desired direction in which to go. For DMHAS-bound youth, foster families who may be willing to continue as a resource are being identified at the local level; DMHAS is identifying ways to support these youth if they choose to remain with the foster family. This is still in early stages but DMHAS has been very receptive to finding a way to both support youth in family settings and incorporate permanency into their service plans for young adults. Towards this end, DMHAS has had several staff participate in the Permanency Teaming training and DCF staff has presented around permanency issues to the Young Adult Services provider leadership team. In addition, language has been added around permanency to the DCF/DMHAS MOA.*

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

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

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

- Provide access to a more complete, coordinated and effective system of community-based behavioral health services and supports
- Support recovery and access to community services, ensuring the delivery of quality services to prevent unnecessary care in the most restrictive settings
- Enhance communication and collaboration within the behavioral health delivery system and with the medical community, thereby improving coordination of care
- Improve network access and quality
- Recruit and retain traditional and non-traditional providers

In Calendar Year 2014, over 53,000 Medicaid enrolled children and youth (under age 18) utilized a behavioral health service and approximately 5000 of these individual children were involved with DCF through child welfare, juvenile justice or voluntary services. 2014 program targets for youth focused on identifying youth with frequent and unnecessary behavioral health visits to the ED in order to propose crisis planning and diversionary interventions, and monitoring youth with repeat inpatient admissions. The Partnership also continues to focus on strengthening the provider network for IICAPS, an intensive home-based intervention designed to help youth with psychiatric challenges who have had previous inpatient stays to succeed at home and in the community.

#### [CAFAP](#)

Since 1995 DCF and The Connecticut Association of Foster and Adoptive Parents have engaged in a partnership benefiting thousands of children and families. The Connecticut Association of Foster and Adoptive Parents makes a difference in the lives of foster, adoptive and relative caregivers by providing support, training, and advocacy. They receive an average of 150 inquiries to the KidHero line a month. There are currently 2078 DCF licensed families; CAFAP provides support to all DCF licensed families.



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

CAFAP has been very responsive to the increasing focus on placing children with kinship families and in maintaining those placements through the services of the CAFAP liaisons. Each DCF Office has a CAFAP liaison working with the local Foster Care units to help maintain the placement, provide services to the foster family and child(ren) and to collaborate with DCF on achieving permanency. In 2015-2016 we expect to see the partnership with CAFAP continue to grow. One new area of focus is on CAFAP developing a new online training system for post-licensing trainings. This system will enable foster parents to complete post-licensing modules from any computer with Internet access and not have to travel to a training. Hopefully this will increase the completion rate of post-licensing trainings for foster parents. CAFAP is also exploring purchasing an online LMS system that will aggregate these module results and report to CAFAP and DCF what modules are being completed and where improvements in the system are needed.

### [Juvenile Court](#)

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

For example;

1. As a member of the Court Improvement Project (CIP), DCF continues to collaborate with the Judicial Branch, Office of the Chief Public Defender, Department of Education, Office of the Child Advocate and others to develop strategies and

processes for encouraging the Juvenile Court to play a more active role in the educational outcomes of committed children. DCF participated in a statewide video training that was broadcast live to all the Juvenile Courts where judges, lawyers, court personnel and DCF educational specialists were able to interact with the presenters and the audience in other courts. The focus of the training was an overview of how courts, lawyers and DCF can advocate for the educational needs of children.

2. DCF completed a project with DDS, DAS and DPH to streamline the licensing process for community based non-profits who provide congregate care services to children and adults. The collaboration has resulted in a uniform license application, online filing of applications to each agency, and reduction of duplication for providers seeking licenses from more than one state agency.
3. The RSVP program, a collaboration between DCF, DMHAS and the Judicial Branch that provides recovery case managers to parents who have lost custody of children through an OTC due to substance use has expanded to the Manchester office and Rockville court and the Norwich office and Waterford court. In addition, the RSVP core team has coordinated training in substance use related areas for court personnel and lawyers who practice in Juvenile Court.
4. As a result of new federal and state legislation, DCF, the Office of the Attorney General and the Juvenile Court collaborated to create new forms and a new procedure for continuing court review of cases involving youth who reach the age of 18 and voluntarily remain in DCF care. The collaboration resulted in a process that permits the state to continue to claim Title IV-E reimbursement for these youth.
5. DCF, the Juvenile Court are working on initiatives to track and reduce recidivism among youth in the juvenile justice system.

### [DCF Headstart Partnership](#)

For over 15 years the CT Headstart State Collaborative Office (HSSCO) has staffed, funded and co-convened this valuable collaboration to work better together in support of families. DCF and Head Start staff from the 14 local DCF Area teams from across the state come together quarterly with their key partners, ECCP and Supportive Housing for Families, and more recently Part C/Birth to Three and Child First, to strengthen their understanding of the various programs and foster working relationships to better support families. An Early Childhood Child Welfare federal grant infused Strengthening Families and Infant Mental Health into practice with families.

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

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

This population needs to be recognized as distinctive and in need of specific services tailored to its needs. Currently, there are few community supports tailored to meet the ongoing needs of these families who often require longer term services than most of our systems currently fund. In addition, many of our systems fund services for an individual (e.g. child or substance abusing parent) but not for the family.

To address these issues, The Workgroup developed a training on "Identifying and Working with Parents with Cognitive Limitations" which has been offered in many communities throughout the State and additional trainings will continue to be offered each year. To date, the Workgroup has trained close to 3,000 service providers through the work of an interdisciplinary, interagency training team. In addition to offering a conference for administrators and supervisors, and an international conference, the Workgroup also created an Interview Assessment Guide to assist workers in identifying these families. The Workgroup has drafted recommendations regarding the use of plain language in communicating with all parents and developed a training on plain language.

The Department established an internal Workgroup to make recommendations regarding our practice with these families. Those recommendations are currently being reviewed through our Change Management system.

### [Early Childhood Cabinet](#)

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

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

- Department of Developmental Services,
- Department of Public Health
- Department of Social Services
- Department of Children and Families
- State Department of Education
- Office of Policy and Management
- Commission on Children

- Family Resource Center
- Local Education Agency
- CT State Employees Association
- Early Childhood Community Educator
- Early Education and Child Care Provider
- Grossman Family Foundation
- Headstart State Collaboration Office

The Cabinet has articulated four priority areas:

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

As of June 2012, three additional work groups have been formed:

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

In April 2015, the Cabinet is pursuing collective impact in early childhood policy in two key focus areas: 1) pregnant women and families with young children who are experiencing homelessness or unstable housing and 2) vulnerable families with infants and toddlers. The Cabinet intends to operate within a collective impact framework and use a two generation approach when tackling this important work. For each focus area, the cabinet will work to develop and implement a common policy and legislative agenda.

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

During the 2013 legislative session, the General Assembly passed Public Act 13-178, which directed the Department of Children and Families to produce a children's behavioral health plan for the state of Connecticut by October 2014. The Act required development of a

comprehensive and integrated plan that meets the behavioral health needs of all children in the state and that prevents or reduces the long-term negative impact for children of mental, emotional, and behavioral health issues.

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a “system of care” for youth and families facing mental health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system. A system of care is defined as:

*A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.<sup>i</sup>*

The Institute of Medicine (IOM) framework aligns services and resources along a continuum that includes universal services for all children to promote optimal social and emotional development; selective services (e.g., early identification, early intervention) for children at high risk for developing a behavioral health condition; and indicated services for treating those with serious and complex disorders. The continuum of care is used to organize the planning and implementation of a system that will meet the needs of all youth and their families.

The theory of change driving this plan is that a children’s behavioral health system based on the system of care core values and principles will result in improved health outcomes.

Three core values drive the development of a system:

- **Family-driven and youth guided**, with the strengths and needs of the child and family determining the types and mix of services and supports provided;

- **Community-based**, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- **Culturally and linguistically appropriate**, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.
- **Trauma informed**, with the recognition that unmitigated exposure to adverse childhood experiences including violence, physical or sexual abuse, and other traumatic events can cause serious and chronic health and behavioral health problems and is associated with increased involvement with the criminal justice and child welfare systems.

In addition, the Plan reflects the understanding that an effective system must be reorganized to include data-informed implementation, pooled funding across all payers (public and private), and mechanisms for care coordination, with families and youth as full participants in the governance of that system.

DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate an extensive input gathering process that served as the cornerstone for the preparation of the Plan. Family members, youth, Family System Managers from FAVOR, Inc., family advocates from the African Caribbean American Parents of Children with Disabilities, Inc. (AFCAMP), and consultants from Yale University took lead roles in input gathering activities, in partnership with CHDI staff. A Steering Team and an Advisory Committee oversaw the process. The core elements of the input gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth
- Open Forums held in six locations and attended by 232 individuals
- Facilitated Discussions on 12 specific topic areas, attended by 220 individuals
- Website input forms submitted by over 60 individuals and groups
- A review of background documents and data pertaining to the children's mental health system in Connecticut

The process yielded the identification of seven areas that will result in significant

improvements to the children's mental health service system in Connecticut:

- a. System Organization, Financing and Accountability
- b. Health Promotion, Prevention, Early Identification, and Early Intervention
- c. Access to a Comprehensive Continuum of Care
- d. Pediatric Primary Care and Mental Health Care Integration
- e. Disparities in Access to Culturally Appropriate Care
- f. Family and Youth Engagement
- g. Workforce Development

The Plan presents a set of goals and key strategies for each of these seven areas. This will continue to be an area of focus this upcoming year. Since the plans submission of the report on October 1, 2014, an Implementation Advisory Board has been developed. This group is comprised of other state agency representatives, parents, advocates, trade associations and private providers.

#### [State Interagency Coordination Council](#)

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

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



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

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

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

2. Advise and assist the Commissioner of the Department of Developmental Services on issues concerning:

- The development of standards and procedures
- The transition of children from Birth to Three into Dept. of Ed services
- Identifying barriers that impede timely and effective services delivery
- The adoption of rules and regulations

In May 2015, a strategic planning meeting was held to develop and renew working relationships in order to increase collaboration, establish priorities, and identify committee structures to assist in the development and implementation of the strategic plan.

The following represents a summary of the Strategic Planning process focusing on three key areas:

*Quality/Systems:*

- Assist in the development, implementation, and evaluation of the State Systemic Improvement Plan (SSIP)
- Fully implement evidence-based practices/agreed upon practices in early intervention

- Support expansion of Reflective Supervision to all programs as part of workforce development
- Revise self-assessment/focused monitoring tool to align with CT Part C

*Legislative/Fiscal:*

- Ensure fiscal stability for B-3 providers and system
- Enhance collaboration and communication between SICC and Ct's Legislative body

*Communication and Education:*

- Increase ICC membership by recruiting parents
- Develop OEC/ICC relationship during and after the move to OEC (Birth to 3 will be moving to the Office of Early Childhood).
- Broaden B-3 Imaging – public relationships, health care

Subcommittees are being created in the above categories to develop specific strategies to achieve the goals and objectives. This will be an area of focus the Council this upcoming year.

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

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

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

aims to:

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

DCF continues to collaborate with state partners, community agencies, and service providers to implement the new program. However, DCF's two primary partners are The Connection Inc. (TCI), who will provide intensive housing and case management services, and The University of Connecticut (UConn) researchers, who will evaluate the program.

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

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

- b. Complete UConn and DCF Internal Review Board Applications
  - c. Final program study consent form
5. Sustainability
- a. Conduct regular management meetings
  - b. Establishing ISHF Program Advisory Board

In year two of the project (Oct. 1 2013 –Sept. 30 2014) we continued working in all above areas including the following:

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

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

The Project Advisory Board called the *CT Collaborative on Housing and Child Welfare* is a subcommittee of the “Three Branch Institute” focused on improving the social and emotional well-being of child welfare involved children in participating states by facilitating more effective coordination between the work of states’ executive, legislative and judicial branches of government in participating states. On Monday September 29, 2014 the advisory board held its first kick off meeting, with keynote speaker Dr. Kenneth Hardy. The meeting was well attended by state officials, community providers and Supreme Court judges. The second meeting was held in the Spring of 2015 and included an

overview from Connecticut's housing advocates on state policy, initiatives, and proposed legislation regarding homeless families, an update on the grant and utilization of the new assessment tool, and workgroup assignments that are focused on system change within areas (education, employment, and housing) that impact families and their vulnerability to becoming homeless.

The *Quick Risk Assessment Family Triage (QRAFT)*, the abbreviated version of the Risk Assessment Family Triage tool, was developed by the evaluation team and implemented by DCF Intake Workers to assess all new families reported to the child welfare. The goal of this additional screen was to evaluate families housing needs at the beginning of child welfare involvement and prompt immediate referral of families who appear to have severe housing problems to the supportive housing project. Implementation of this process began in early November 2014. The evaluation team conducted an analysis on all the QRAFT data collected and produced the first technical report on the QRAFT titled "*Implications for Client Targeting and Enrollment in CT's Housing and Child Welfare Demonstration*" on February 23<sup>rd</sup> 2015. Feedback received indicated the process was useful, not burdensome, and provided significant housing data on families that would not have normally been collected at Intake in Connecticut's child welfare system. DCF officials agreed to maintain this process in the project's initial region and will utilize the same process during the expansion into the Hartford area and eventually statewide.

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

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

1. Continue to evaluate the referral process and the target population to ensure quality, compliance and that the highest need families are served.
2. Continue building community resource manual

3. Enhance collaboration with all service providers through interdisciplinary teaming and include housing authorities.
4. Enhancement of program curriculum, core skill sets and training
5. Analyze and report out on client data
6. Conduct focus groups with Case Managers and clients
7. Establish and utilize data-sharing agreements between state agencies
8. Continued work on Engagement and Cost studies.

## 2. Assessment of Performance

The below are Connecticut data pertaining to each of the CFSR Items. These data, which come from the Round 3 Data Indicators, reveal that the state is below the national standard as it pertains to a number of the items.

<b>CFSR ITEM</b>	<b>Cohort</b>	<b>Demon</b>	<b>Number</b>	<b>Observed Performance</b>	<b>National Standard</b>
Perm in 12 Months	Ch. Entering Care in 12 month period	1996	419	21.3%	40.40%
Perm in 12 Months	Ch. In care 12-23 months as of 1st day of 12 month period	864	264	28.9%	43.70%
Perm in 12 Months	Ch in Care 24 or > as of the 1st day of a 12 month period	1243	236	19.0%	30.30%
Re-Entry in 12 Months	Ch. Enter care in a 12 month period + exiting within 12 months	403	41	10.2%	8.30%
Recurrence of Maltreatment	Victims of a substantiated maltreatment report in a 12 month period	7931	546	6.9%	9.00%

<b>CFSR ITEM</b>	<b>Cohort</b>	<b>Entries</b>	<b>Demon</b>	<b>Number</b>	<b>Observed Performance</b>	<b>National Standard</b>
Placement Stability	Ch. Entering foster care in a 12 month period	1861	315865	877	2.78	4.12

<b>CFSR ITEM</b>	<b>Cohort</b>	<b>Served</b>	<b>Demon.</b>	<b>Number</b>	<b>Observed Performance</b>	<b>National Standard</b>
Maltreatment in FC	Ch. In FC during a 12 month period	5321	1401753	105	7.49	8.04

The Department's latest AFCARS submission was not accepted. Therefore, the previously provided file is the most current upon which Connecticut can report. The Department is working on identified issues to support the receipt and acceptance of that file.

We have, however, run these data from our statewide information system trying to closely replicate the AFCARS specifications to get a sense of our current attainment levels. Some of the data points are as follows:

1. Entry Rates: There were 1833 (rate 2.3/1k in child pop) children who entered DCF care during CY '14 who met the AFCARS definitions.

2. Kinship Care: Of the 1833 entries, 748 (40.8%) were initially placed into a Kinship Foster home.

3. Congregate Care: There were a total of 5100 children who spent any amount of time in DCF care during CY '14 who met the AFCARS definitions. Of those, 904 (17.7%) spent any amount of time in a Congregate Care setting, which includes Safe Homes, Shelters, Group Homes, Residential Treatment Centers, DCF Facilities or Hospitals (for medical and/or psychiatric reasons). The number of days spent in a Congregate Care setting, however, accounted for only 13.3% of all the days that these 5100 children spent in DCF care during CY14.

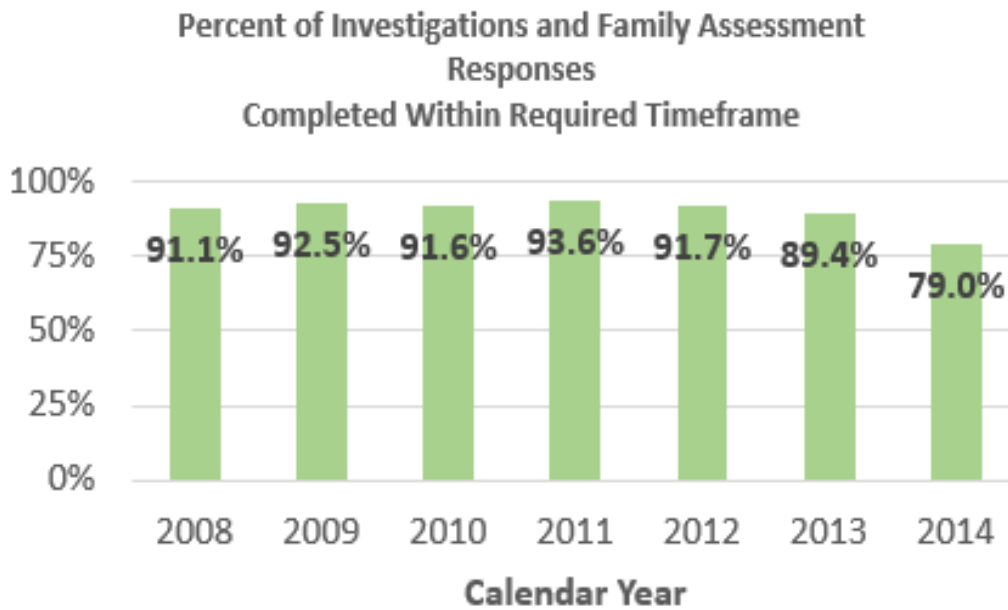
4. Timely Reunification CFSR Measure C1.3: Of the 949 children who entered DCF care for the first time between 7/1/2013 and 12/31/2013, and whose episode lasted at least 8 days, 208 (21.9%) were discharged to Reunification in less than 12 months.

5. Re-Entry CFSR Measure C1.4: Of the 694 children who were discharged from DCF care to Reunification between 1/1/2013 and 12/31/2013, 105 (15.1%) re-entered DCF care in less than 12 months from the date of their discharge.

6. Achieving Permanency for Longer Stayers CFSR Measure: Of the 1792 children in placement on 1/1/2014 that had been in care for 24 months or longer, 432 (24.1%) were discharged to a permanent home by the end of the year.

7. Absent of maltreatment recurrence CFSR Measure: Of the 3308 unique children with at least one maltreatment allegation substantiated between 1/1/14 and 6/30/14, 3180 (96.1%) were not victims of another substantiated maltreatment allegation within the next six months.

**Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect**

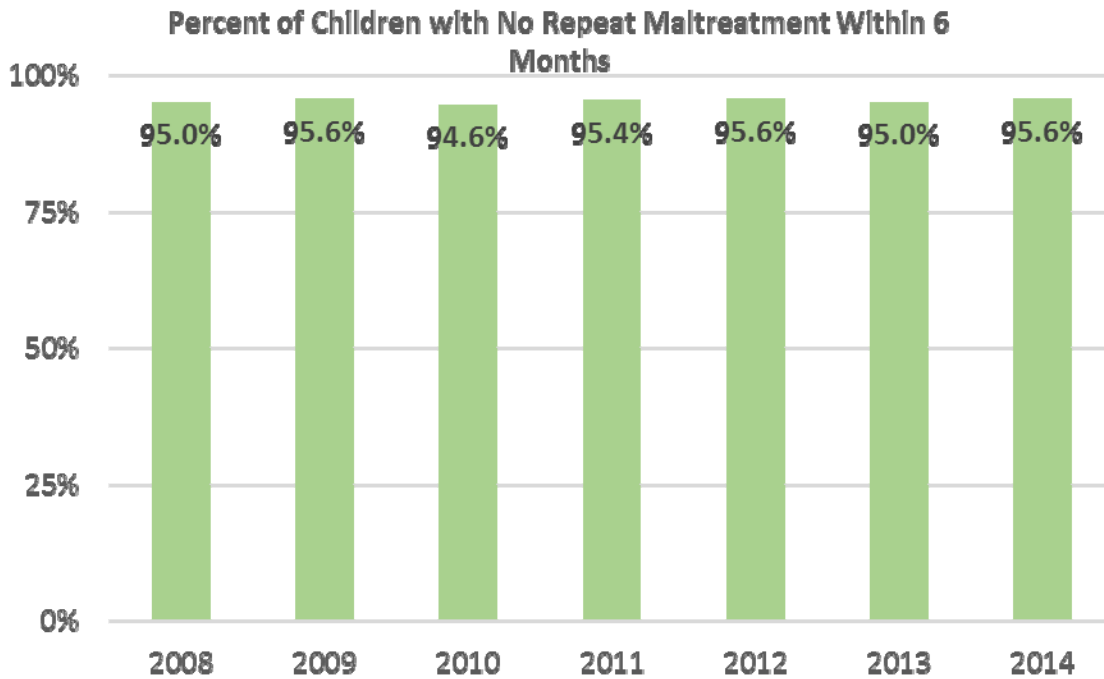
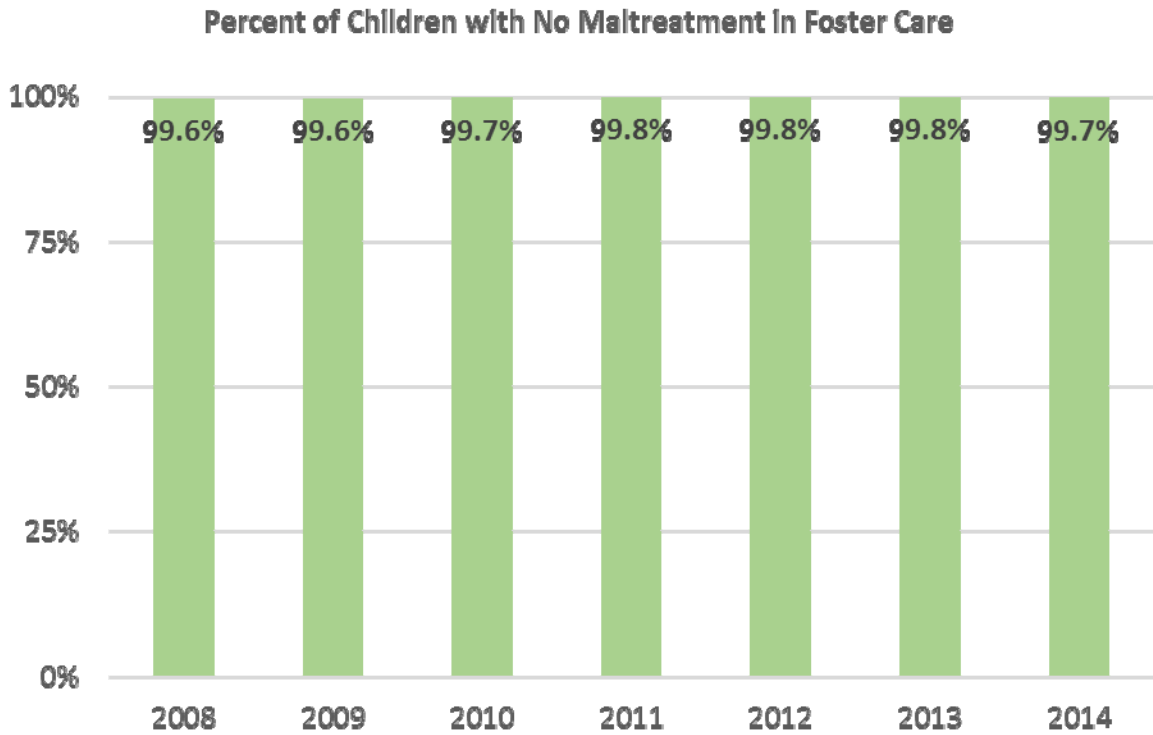






The above table indicates that during 2013 and 2014, the completion attainment levels dropped. This was due to staffing issues. The Department, however, has been able to hire 89 additional social workers and it is expected that the completion rates will return to previous high levels.

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.



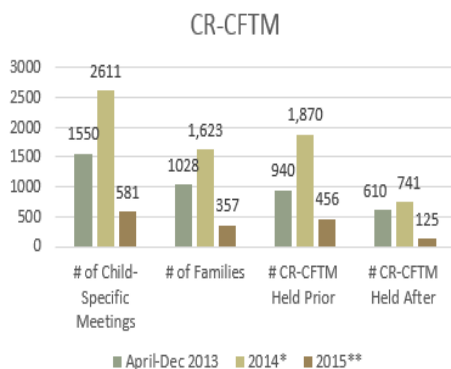
The Department initiated Considered Removal Child and Family Team Meetings (CR-CFTM) about two years ago. This approach is designed to engage parents and family in safety planning and placement-related decision-making. Its goals are to safely preserve the family unit and, when children must be placed, minimize the disruption and trauma associated with the removal, placement and separation of the child from his or her family. The consistent and effective use of the CR-CFTM process promotes family engagement and can restore safety, social and emotional well-being and secure family permanence for the child. Data regarding the effectiveness and success of CR-CFTM are below:



PE 2: CW, Early and Middle Childhood: Considered Removal Child and Family Teaming (CR-CFTM)

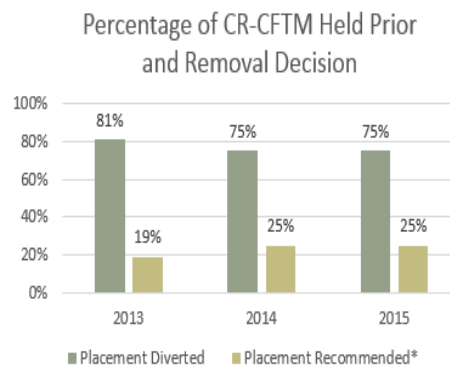
Considered Removal Child and Family Teaming (CR-CFTM) was implemented in February 2013. The purpose of a CR-CFTM is to mitigate safety factors in order to prevent removal from the home by identifying and utilizing the family's natural or formal supports in safety planning. The meeting results in a live decision about safety/removal and recommendations regarding placement.

**How Much Did We Do?**

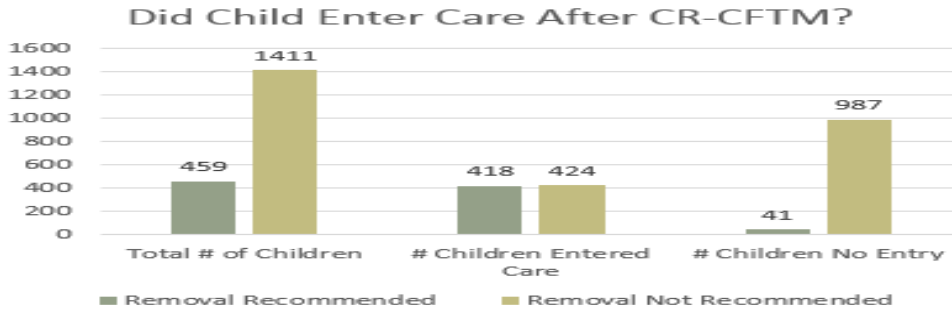


- o Represents CR-CFTM documented in LINK at time of release in April 2013. 2014 Data: Full Calendar Year.
- o Represents first quarter of 2015 (January-March 2015).
- o Includes children who have had more than 1 meeting.
- o 2013: 61% of meetings occurred prior; 39% occurred after child's removal
- o 2014: 72% of meetings held prior; 28% occurred after child's removal
- o 2015: Trend continues: 78.5% occurred prior; 21.5% occurred after child's removal.

**How Well Did We Do?**



- o Represents CR-CFTM documented in LINK, beginning April 2013.
- o 2014 Data: Full Calendar Year.
- o Represents first quarter of 2015 (January-March 2015).
- o Percentage determined based on meetings held prior to the child's removal.
- o 2013: Prior: N= 940. Removal was not recommended for 764 children.
- o 2014: Prior: N= 1870. Removal was not recommended for 1411 children.
- o 2015: Prior: N= 456. Removal was not recommended for 342 children.



Represents 2014 Data.  
 Includes CR-CFTM held prior. N= 1,870.  
 Removal was recommended for 459 children. 418 of those children entered care; 41 did not.  
 For children in which removal was not recommended (1411), 424 children entered care and 987 children did not enter care.

As these data reveal, the Department has been able to avoid entry into care for about 70% of the children for whom there was not a recommendation for entry. While there were still 842 children out of the 1870 total children who were the subject of a CR-CFTM, the Department’s foster and kinship numbers evidence the Department’s focus on relative placements when out of home care is needed. The chart immediately below shows the Department’s May 1, 2015 achievement with respect to kin placements (i.e., relative and special study) (35.6%). The second chart shows where the Department was in January 2011 (21%). The Department has made considerable strides in its kinship placements over the past four years.

CIP DASHBOARD			% of Total Children-i		
Observation Date	Total Caseload Points	Total CIP	Family Foster Care		
			Foster Care	Relative Care	Special Study
06/01/2014	15,023	4,123	43.7 %	27.4 %	6.2 %
07/01/2014	14,730	4,091	43.6 %	28.5 %	6.1 %
08/01/2014	14,117	4,099	44.4 %	28.8 %	5.8 %
09/01/2014	13,800	4,024	45.4 %	29.3 %	5.8 %
10/01/2014	14,279	4,002	45.5 %	29.6 %	5.9 %
11/01/2014	14,436	4,015	45.4 %	29.7 %	6.2 %
12/01/2014	14,286	3,946	45.4 %	29.3 %	6.4 %
01/01/2015	14,106	3,966	44.5 %	29.4 %	6.4 %
02/01/2015	13,714	4,000	44.6 %	29.5 %	6.4 %
03/01/2015	13,827	4,023	44.5 %	28.6 %	6.6 %
04/01/2015	13,879	4,032	44.6 %	28.7 %	6.4 %
05/01/2015	13,737	4,018	44.4 %	29.4 %	6.2 %

CIP DASHBOARD			% of Total Children		
Observation Date	Total Caseload Points	Total CIP	Family Foster Care		
			Foster Care	Relative Care	Special Study
1/1/2011	16214	4780	46.5%	17.3%	3.7%
2/1/2011	15794	4842	46.6%	17.6%	3.6%

**Permanency Outcome 1: Children have permanency and stability in their living situations.**

The following trend data on Permanency Outcomes comes from our Results Oriented Management (ROM) system. These data are pulled from LINK.

**TIMELY REUNIFICATION (USED IN CFSP - NOT EP MEASURE)**

	2008	2009	2010	2011	2012	2013	2014
Report Period	2008	2009	2010	2011	2012	2013	2014
Met	<a href="#">819</a>	<a href="#">836</a>	<a href="#">842</a>	<a href="#">825</a>	<a href="#">615</a>	<a href="#">467</a>	<a href="#">419</a>
Not Met	<a href="#">1356</a>	<a href="#">1355</a>	<a href="#">1201</a>	<a href="#">1279</a>	<a href="#">1203</a>	<a href="#">983</a>	<a href="#">1209</a>
Total	<a href="#">2175</a>	<a href="#">2191</a>	<a href="#">2043</a>	<a href="#">2104</a>	<a href="#">1818</a>	<a href="#">1450</a>	<a href="#">1628</a>
Met	37.7%	38.2%	41.2%	39.2%	33.8%	32.2%	25.7%
Not Met	62.3%	61.8%	58.8%	60.8%	66.2%	67.8%	74.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cohort	2007	2008	2009	2010	2011	2012	2013

## REUNIFICATION (EP MEASURE)

	2008	2009	2010	2011	2012	2013	2014
Report Period	2008	2009	2010	2011	2012	2013	2014
Met	<a href="#">697</a>	<a href="#">836</a>	<a href="#">745</a>	<a href="#">600</a>	<a href="#">432</a>	<a href="#">414</a>	<a href="#">379</a>
Not Met	<a href="#">442</a>	<a href="#">428</a>	<a href="#">396</a>	<a href="#">299</a>	<a href="#">323</a>	<a href="#">254</a>	<a href="#">181</a>
Total	<a href="#">1139</a>	<a href="#">1264</a>	<a href="#">1141</a>	<a href="#">899</a>	<a href="#">755</a>	<a href="#">668</a>	<a href="#">560</a>
Met	61.2%	66.1%	65.3%	66.7%	57.2%	62.0%	67.7%
Not Met	38.8%	33.9%	34.7%	33.3%	42.8%	38.0%	32.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

While reunification and timely reunification has decreased since 2011, it should be noted that the Department implemented a Differential Response System (DRS) approach in March 2012. Therefore, from 2012 forward the Department's caseload is representative of much more complex families. In preceding years, there was a mix of families with less complex needs, whereby timely reunification might be more tenable. Even though we think we are currently serving a larger proportion of families with more complex needs, we are focused on trying to ensure permanency for the children we serve. The Department is implementing Permanency Teaming. We think that that approach and the work that we do through Considered Removal- Child and Family Team Meetings at the onset will support our increasing the levels and timeliness of reunification.

**TIMELY ADOPTION (USED IN CFSP - NOT EP MEASURE)**

	2008	2009	2010	2011	2012	2013	2014
Report Period	2008	2009	2010	2011	2012	2013	2014
Met	<a href="#">249</a>	<a href="#">211</a>	<a href="#">217</a>	<a href="#">182</a>	<a href="#">149</a>	<a href="#">167</a>	<a href="#">145</a>
Not Met	<a href="#">719</a>	<a href="#">600</a>	<a href="#">587</a>	<a href="#">567</a>	<a href="#">666</a>	<a href="#">626</a>	<a href="#">596</a>
Total	<a href="#">968</a>	<a href="#">811</a>	<a href="#">804</a>	<a href="#">749</a>	<a href="#">815</a>	<a href="#">793</a>	<a href="#">741</a>
Met	25.7%	26.0%	27.0%	24.3%	18.3%	21.1%	19.6%
Not Met	74.3%	74.0%	73.0%	75.7%	81.7%	78.9%	80.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cohort	2006	2007	2008	2009	2010	2011	2012

Timely adoption has dipped since 2011. This may be attributed to the focus on kinship placements. Since 2011, the number of out of home placements that were with relatives increased from 21% to the June 1, 2015 level of 36%. The Department offers very robust services and supports for families caring for children who are placed out of home. For some kin, adoption may not be viewed by as a viable option if they think that there are supports that they need and fear they might lose by adopting. The Department must do a better job to communicate and educate families as to the support, services and benefits that are provided and can be provided through adoption.

## GUARDIANSHIP (EP MEASURE)

	2008	2009	2010	2011	2012	2013	2014
Report Period	2008	2009	2010	2011	2012	2013	2014
Met	<u>257</u>	<u>240</u>	<u>239</u>	<u>234</u>	<u>210</u>	<u>189</u>	<u>165</u>
Not Met	<u>111</u>	<u>73</u>	<u>61</u>	<u>47</u>	<u>50</u>	<u>74</u>	<u>65</u>
Total	<u>368</u>	<u>313</u>	<u>300</u>	<u>281</u>	<u>260</u>	<u>263</u>	<u>230</u>
Met	69.8%	76.7%	79.7%	83.3%	80.8%	71.9%	71.7%
Not Met	30.2%	23.3%	20.3%	16.7%	19.2%	28.1%	28.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

While the guardianship achievement levels have decreased over the past couple of years, the Department believes recent legislation may aid in reversing the trend. As noted, the Department has substantially increased the levels of kin placement. Newly minted legislation will expand guardianship opportunities. In particular, the legislation now defines “fictive kin caregivers,” allows child placement with one of these individuals, makes such caregivers eligible for guardianship subsidies, and allows for the transfer of such subsidies from one caregiver to a successor caregiver.



**MAINTAIN PERMANENCY 12 MONTHS (NOT EP MEASURE - OF ALL EXITS, THOSE WITH NO SUBSEQUENT EPISODE IN NEXT 12 MONTHS)**

	2008	2009	2010	2011	2012	2013	2014
Report Period	2008	2009	2010	2011	2012	2013	2014
Met	<a href="#"><u>2627</u></a>	<a href="#"><u>2454</u></a>	<a href="#"><u>2592</u></a>	<a href="#"><u>2355</u></a>	<a href="#"><u>1973</u></a>	<a href="#"><u>1843</u></a>	<a href="#"><u>1591</u></a>
Not Met	<a href="#"><u>247</u></a>	<a href="#"><u>229</u></a>	<a href="#"><u>260</u></a>	<a href="#"><u>176</u></a>	<a href="#"><u>187</u></a>	<a href="#"><u>155</u></a>	<a href="#"><u>162</u></a>
Total	<a href="#"><u>2874</u></a>	<a href="#"><u>2683</u></a>	<a href="#"><u>2852</u></a>	<a href="#"><u>2531</u></a>	<a href="#"><u>2160</u></a>	<a href="#"><u>1998</u></a>	<a href="#"><u>1753</u></a>
Met	91.4%	91.5%	90.9%	93.0%	91.3%	92.2%	90.8%
Not Met	8.6%	8.5%	9.1%	7.0%	8.7%	7.8%	9.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cohort	2007	2008	2009	2010	2011	2012	2013

**MAINTAIN PERMANENCY 12 MONTHS (USED IN CFSP - EP MEASURE - OF ALL ENTRIES, THOSE WITH NO PRIOR EPISODE IN LAST 12 MONTHS)**

	2008	2009	2010	2011	2012	2013	2014
Report Period	2008	2009	2010	2011	2012	2013	2014
Met	<a href="#">2263</a>	<a href="#">2080</a>	<a href="#">2246</a>	<a href="#">1936</a>	<a href="#">1553</a>	<a href="#">1707</a>	<a href="#">1686</a>
Not Met	<a href="#">188</a>	<a href="#">202</a>	<a href="#">179</a>	<a href="#">133</a>	<a href="#">123</a>	<a href="#">122</a>	<a href="#">108</a>
Total	<a href="#">2451</a>	<a href="#">2282</a>	<a href="#">2425</a>	<a href="#">2069</a>	<a href="#">1676</a>	<a href="#">1829</a>	<a href="#">1794</a>
Met	92.3%	91.1%	92.6%	93.6%	92.7%	93.3%	94.0%
Not Met	7.7%	8.9%	7.4%	6.4%	7.3%	6.7%	6.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The above tables indicate that these measures have held relatively steady over the past couple of years. Activities such as Considered Removal-Child and Family Team Meeting and Permanency Teaming are approaches that should maintain, if not increase these levels.

**Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.**

As noted, the Department has increased kin placement from 21% to 36% over the last four years. Data from our Administrative Case Review (ACR) process sets forth the Department’s efforts to ensure the continuity of relations of children with their families.

Measure	Statewide	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	2014	2014	2014	2014	2014	2014	2014
	Strength	Strength	Strength	Strength	Strength	Strength	Strength
	%	%	%	%	%	%	%
Continuity of Relationship - Child w/ Parents	93%	83%	96%	98%	89%	92%	99%
Continuity of Relationship - Child w/ Fathers	91%	78%	93%	97%	85%	90%	98%
Continuity of Relationship - Child w/ Mothers	95%	86%	98%	99%	92%	93%	99%
Permanency Delays	19%	22%	25%	18%	18%	21%	13%
Clinical reasons exist preventing placement w/ siblings	91%	74%	92%	98%	87%	93%	99%
Planning for Permanency	95%	95%	96%	98%	92%	96%	97%

The below is the Department’s achievement on Sibling Placement under our Federal Consent Decree measure. While the Department has not achieved the specified Juan F measure, a review by the Department’s Office for Research and Evaluation (ORE) reveals that when the assessment is based upon placing sibling groups of less than three children, the Department readily meets the measure. We found that excluding the sibling sets of three increase the "Met" percentages about three to four percent each quarter, resulting in the measure being met at an average of 97.4%. Our Court Monitor agrees that the standard should be based on a smaller sibling grouping and will be looking to “pre-certify” this measure, attesting to our Plaintiffs that the Department has achieved this item pursuant to the Consent Decree.

Statewide	Positive Outcomes For Children						
Measure	Measure	Baseline	Q1 2015	Q4 2014	Q3 2014	Q2 2014	Q1 2014
10: Sibling Placement	>=95%	57%	91%	91%	89%	89%	91%

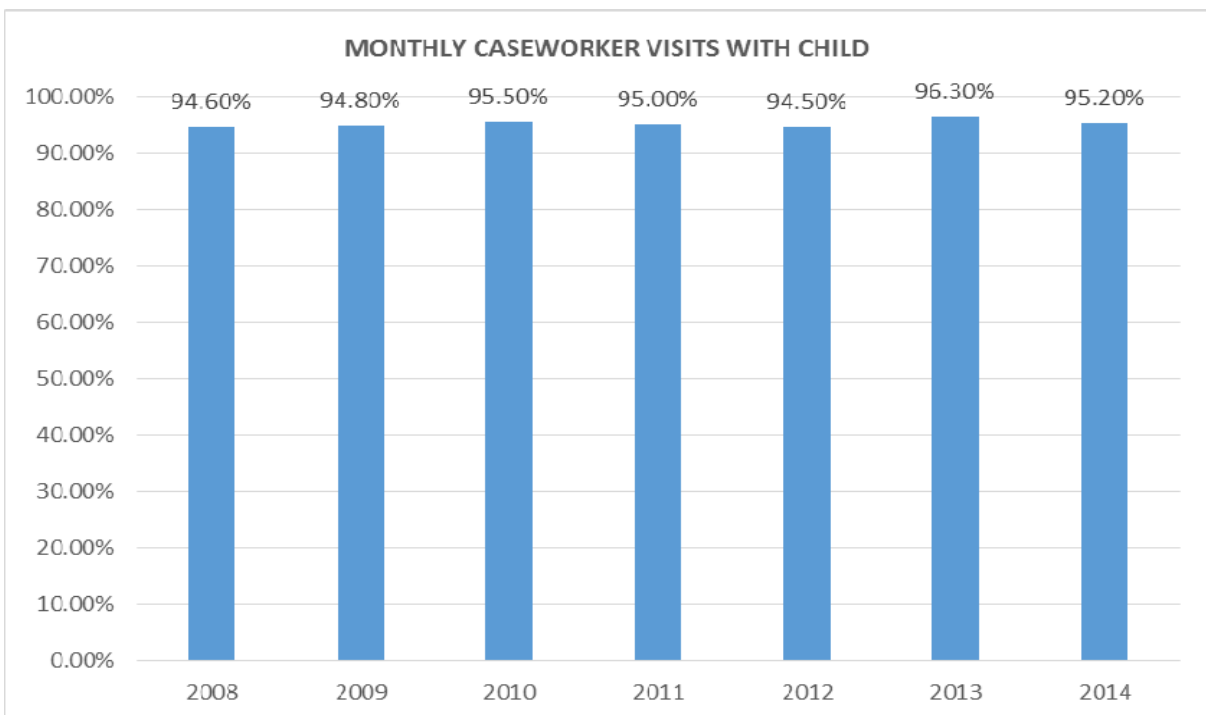
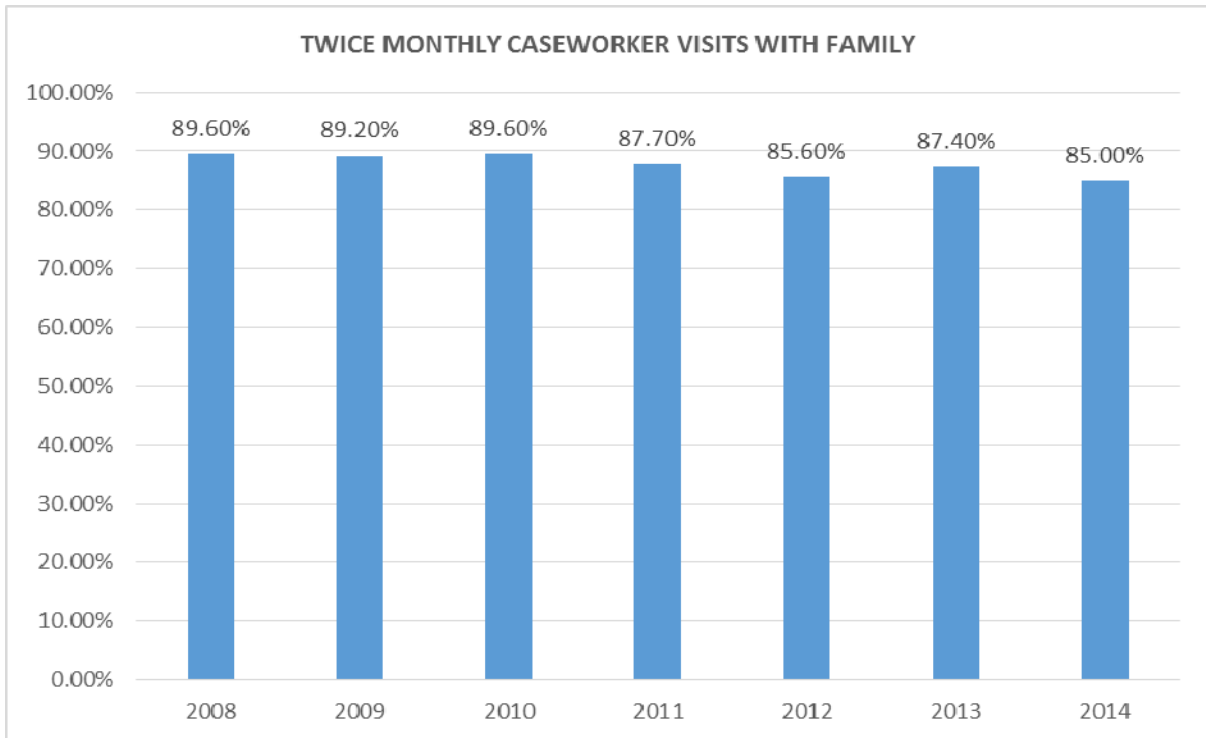
**Well-Being Outcome 1: Families have enhanced capacity to provide for their children’s needs.**

These data from the qualitative ACR process set forth the 2014 assessment of needs, frequency and quality of visits between child and the caseworker, and the same between caseworker and mothers and father.

Measure	Statewide	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	2014	2014	2014	2014	2014	2014	2014
	Strength	Strength	Strength	Strength	Strength	Strength	Strength
	%	%	%	%	%	%	%
Parent Needs	79%	65%	90%	93%	61%	81%	94%
Needs Assessed - Fathers	75%	57%	85%	92%	60%	78%	95%
Needs Assessed - Mothers	85%	74%	93%	96%	73%	89%	95%
Children Needs	78%	67%	91%	91%	67%	84%	91%

Measure	Statewide	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
	2014	2014	2014	2014	2014	2014	2014
	Strength	Strength	Strength	Strength	Strength	Strength	Strength
	%	%	%	%	%	%	%
Visitation with Child and Parents	73%	67%	70%	88%	57%	73%	84%
Frequency of visits - Parents	70%	64%	73%	88%	51%	76%	86%
Frequency of visits - Father	64%	55%	65%	86%	44%	71%	84%
Frequency of visits - Mother	74%	71%	79%	90%	56%	80%	87%
Quality of visits - Parents	71%	65%	69%	89%	55%	76%	84%
Quality of visits - Father	65%	55%	61%	87%	49%	71%	83%
Quality of visits - Mother	75%	72%	74%	91%	61%	80%	86%
Frequency of visits - Child	79%	77%	86%	91%	63%	82%	86%
Quality of visits - Child	79%	77%	78%	94%	67%	82%	88%

Below is quantitative data from LINK regarding achievement of the Department's policy identified monthly visits with the family and the child. Some of the presented decrease in visitation attainment may be attributed to higher caseloads the last couple of years due to staffing. During 2014, additional social worker positions were hired. It is expected as caseloads decrease, the levels of visitation will increase.



The below show the participation rates of mother and fathers at ACRs. As the data reveal, the Department has some work to continue to do to better support parents' participation in the ACRs, especially fathers. The Department does make conference lines available for parents and providers so that they can call into ACRs. In addition, ACR reviewers will try to call parents at the time of the meeting if a contact number is available. The ACR is developing materials that it hopes will better explicate the ACR process and encourage greater parent participation.

Mother/Father ACR Participation May 2014 - May 2015		State	
Attendee	Total # Invited	% Total Participation	# Total Participation
Mother	9,817	53%	5220
Father	8,738	31%	2690

May 2014 - May 2015		Region 1		Region 2		Region 3		Region 4		Region 5		Region 6	
Attendee	Total # Invited	% Total Participation	# Total Participation	% Total Participation	# Total Participation	% Total Participation	# Total Participation	% Total Participation	# Total Participation	% Total Participation	# Total Participation	% Total Participation	# Total Participation
Mother	9,817	53%	579	52%	699	55%	1109	53%	1185	51%	970	55%	673
Father	8,738	25%	228	29%	313	33%	630	29%	587	32%	541	36%	387

**Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.**

See graphic below.

**Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.**

The below ACR *Needs Assessment* report, pulled from the ACR Instrument (ACRi) SharePoint data portal, shows the percentages of persons for whom specific identified needs were not met. The first table presents the data for mothers and fathers. The second table is the percentages for children. These data set forth the levels of attainment with respect to assessing and addressing the needs of the mothers, fathers and children whose case plans and file were reviewed during an ACR in CY 2014.

The data reveal some challenges with respect to addressing the needs of fathers, especially,

and children in some regions. The Exceptional Case Plan process whereby regional managerial staff will be reviewing the completed ACR Instrument in order to identify the areas of strength and challenge, is expected to result in increased attainment in the areas noted.

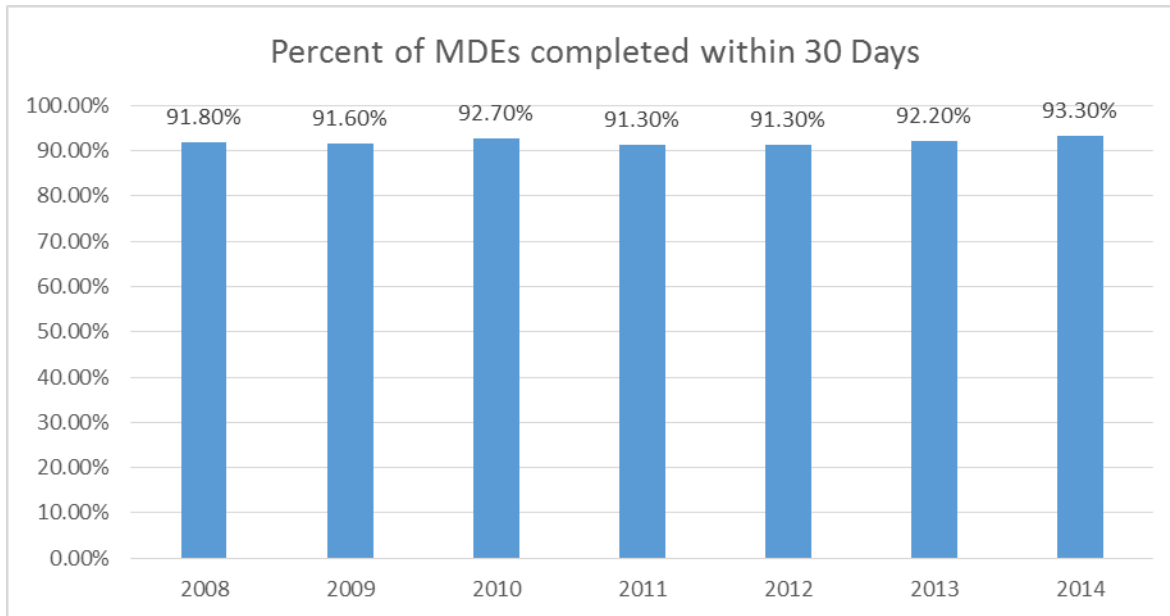
In addition, the Department has a standardized Multi-disciplinary Exam (MDE) documentation and referral process. MDEs are required within 30 days for every child who enters DCF care. DCF continues to achieve this at over a 90% level.

Needs Assessment - Percentages For State Date Range 1/1/2014 To 12/31/2014

	State		Region 1	Region 2	Region 3	Region 4	Region 6	Region 8
	Total # people	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services
Substance Abuse	8220	23%	29%	14%	15%	30%	20%	17%
Physical Health	8218	10%	12%	6%	5%	18%	10%	1%
Social Support System	8220	12%	13%	6%	7%	20%	12%	1%
Household Relationship Skills	8220	18%	29%	11%	12%	29%	14%	5%
Parenting Skills	8220	24%	38%	16%	17%	30%	22%	16%
Emotional Health/Coping skills	8220	26%	38%	16%	21%	33%	25%	17%
Resource Management/Basic needs	8220	15%	20%	12%	10%	20%	15%	6%

Needs Assessment - Percentages For State Date Range 1/1/2014 To 12/31/2014

	State		Region 1	Region 2	Region 3	Region 4	Region 6	Region 8
	Total # people	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services	% Not Receiving Services
Educational/Development	3317	17%	23%	10%	6%	25%	13%	4%
Substance Abuse	3317	7%	8%	5%	4%	10%	7%	2%
Behavioral Health/Coping skills	3317	16%	26%	8%	8%	21%	12%	7%
Physical Health	3317	19%	25%	6%	7%	29%	14%	6%
Social Support System	3317	8%	10%	5%	4%	10%	7%	2%



## Systemic Factors

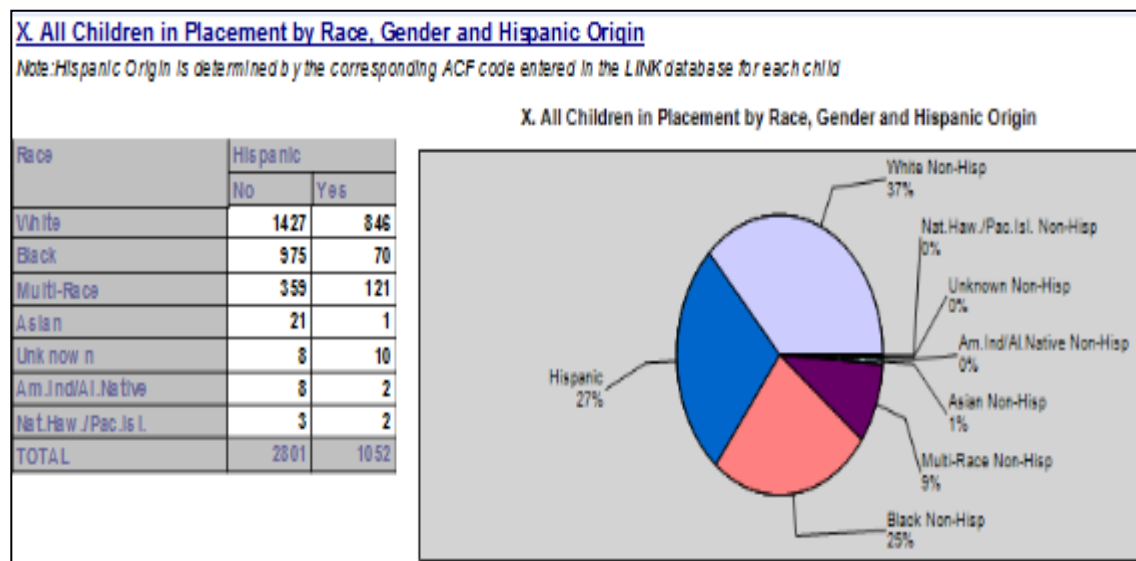
### SYSTEMIC FACTORS

#### Information System

The Department has invested in the development of a variety of data dashboards that allow agency staff to readily glean information about the numbers of children in care and their placement settings. These dashboards pull data from DCF's statewide information system, LINK. Many of the dashboards can be filtered to review the data by age, race/ethnicity, gender and Region/Area Office. A screenshot of the LINK Reporting switchboard is as follows:



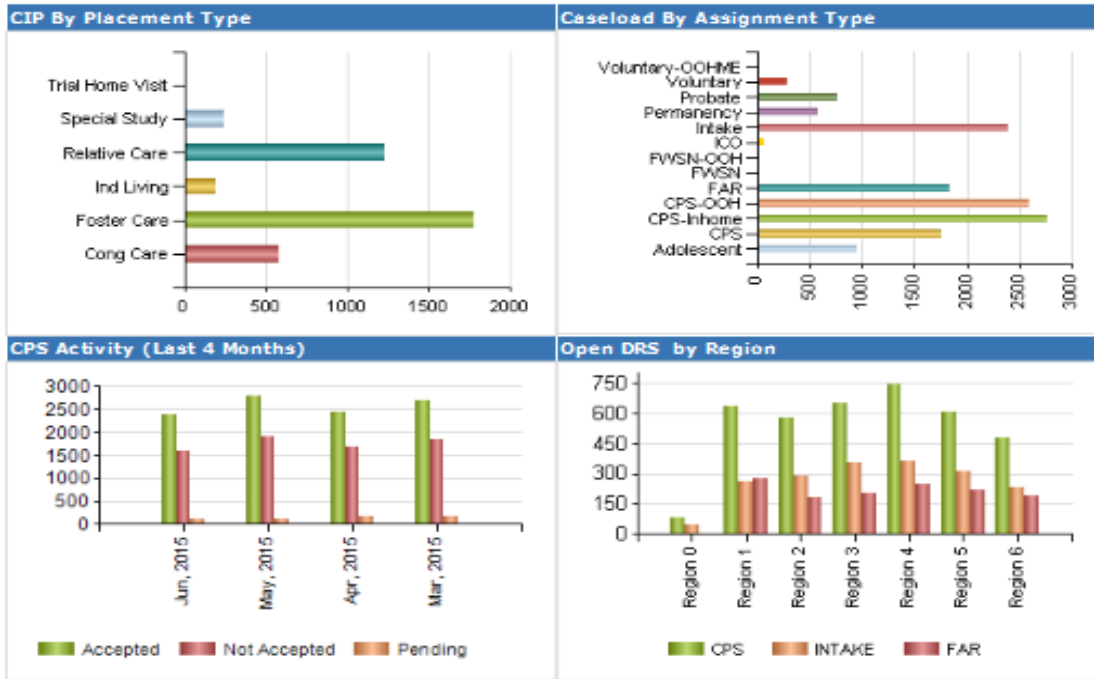
Next, the below report displays the children in placement (CIP) data by age, gender, race and ethnicity who are part of the *Juan F* class. This data is produced for the Court Monitor and Plaintiffs of the *Juan F* consent decree from our LINK system. These data are housed on the DCF Office for Research and Evaluation (ORE) SharePoint site and are accessible to all DCF staff. The screenshots below reflect data from June 27, 2015. These data are also available by age and gender cross-tabulation.





The below displays another dashboard that present caseload by assignment, including distinguishing CPS-Out of Home (foster care) versus CPS-In Home. These data are also from LINK reflecting placements as of June 29, 2015:

Total Caseload Points and Children-in-Placement (CIP) Distributions July, 2014 to June, 2015



This other dashboard, from June 1, 2015, shows the Statewide Child in Placement data. It shows the distribution of children in foster, relative and special study care. The percentage of children in congregate care settings. It also shows the percentage of initial placements into relative care. These data are available by Region and Area Office. Other versions of this dashboard allow for filtering by age cohorts, race/ethnicity, and gender.

Total Caseload Points and Children-in-Placement (CIP) Distributions July, 2014 to June, 2015

Statewide

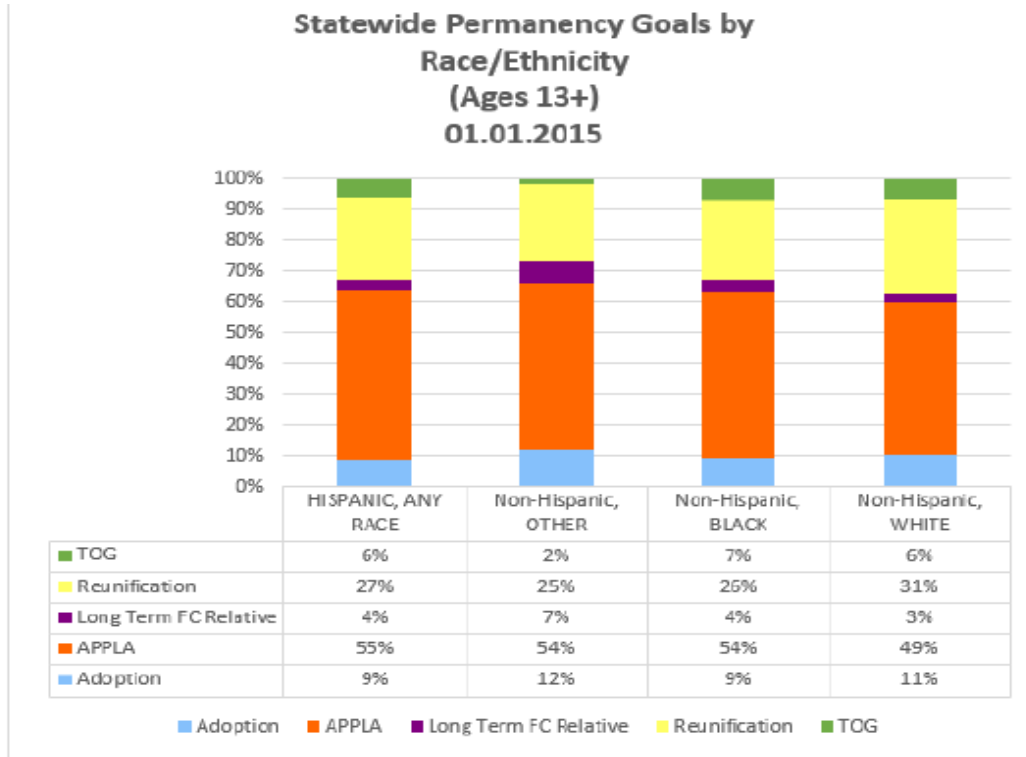
State	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6												
<b>CIP DASHBOARD</b>																		
Observation Date	Total Caseload Points	Total CIP	% of Total Children-in-Placement (CIP)					# In Congregate Care Subgroups				# and % of Children Entering Placement During Month						
			Family Foster Care			Independent Living	Congregate Care	Out of State	Age Group			Entries During Month	Kinship Care			Foster Care	Congregate Care	Independent Living
			Foster Care	Relative Care	Special Study				>=18	7-12	<8		Relative Care	Special Study	Foster Care			
07/01/2014	14,730	4,091	43.6%	28.5%	6.1%	3.1%	18.8%	21	718	44	6	189	32.3%	3.7%	45.5%	18.0%	0.5%	
08/01/2014	14,117	4,099	44.4%	28.8%	5.8%	2.8%	18.1%	19	698	41	4	172	25.0%	6.1%	50.0%	16.9%	0.0%	
09/01/2014	13,800	4,024	45.4%	29.3%	5.9%	2.8%	16.7%	17	631	36	4	171	34.5%	9.4%	44.4%	11.7%	0.0%	
10/01/2014	14,279	4,002	45.5%	29.6%	5.9%	2.7%	16.3%	15	613	33	5	167	35.9%	12.6%	37.1%	13.2%	1.2%	
11/01/2014	14,436	4,015	45.4%	29.7%	6.2%	2.8%	15.9%	14	603	30	4	129	29.5%	7.0%	42.6%	20.9%	0.0%	
12/01/2014	14,286	3,945	45.4%	29.3%	6.4%	2.9%	15.9%	12	586	37	5	157	42.7%	3.8%	30.6%	15.3%	7.6%	
01/01/2015	14,106	3,965	44.5%	29.4%	6.4%	3.7%	16.1%	13	600	35	4	145	32.4%	4.8%	38.6%	19.3%	4.8%	
02/01/2015	13,714	3,999	44.6%	29.5%	6.4%	4.2%	15.4%	12	572	36	6	139	28.1%	5.0%	40.3%	21.6%	5.0%	
03/01/2015	13,827	4,021	44.5%	28.6%	6.6%	4.9%	15.4%	12	581	33	5	168	36.9%	6.5%	36.3%	17.3%	3.0%	
04/01/2015	13,879	4,021	44.5%	28.7%	6.4%	5.0%	15.3%	13	576	35	5	151	39.7%	5.3%	39.7%	13.2%	2.0%	
05/01/2015	13,737	4,014	44.5%	29.4%	6.2%	5.0%	14.9%	11	556	35	8	176	30.1%	7.4%	43.2%	17.0%	2.3%	
06/01/2015	14,193	4,035	44.4%	29.4%	6.6%	5.0%	14.6%	11	552	32	6	135	45.2%	6.7%	34.8%	13.3%	0.0%	
% Change from 7/1/2014 to Latest	-3.8%	-1.4%	0.4%	1.7%	7.2%	60.8%	-29.2%	-47.8%	-23.1%	-27.3%	0.0%	-28.8%	0.0%	28.8%	-45.3%	-47.1%	-100.0%	

The Department is prioritizing permanency for all children and youth who come into DCF care. As noted in this document, Permanency Teaming is an approach that the Department is using to support permanency planning for children/youth in foster care or at risk of entering the foster care system. The desired outcomes of permanency teaming are to identify a legal parent; achieve legal permanence or establishment of a nature network of supportive relationships. Implementation of Permanency Teaming is underway. Thus, the Department has created an OPPLA dashboard to monitor this designation. A screenshot is below.

As of June 1, 2015, there were 382 youth between the ages of 7-12 (N=10) and 13-17 (N=364) who have an OPPLA goal. 512 young adults 18+ have an OPPLA goal. Point in time data from October 2014 indicates that 491 youth between the ages of ages 7-12 (N=14) and 13-17 (N=477) had an OPPLA goal. As these data demonstrate, the Department has made progress in the last 9 months to reduce the number of youth with OPPLA goals. It is expected that the full implementation of Permanency Teaming will have an even greater reductive impact on the number of youth with OPPLA goals.

Region	Summary							
	CC CIP		CC CIP INOOSP		CC CIP With OPPLA Count		All CIP With OPPLA Goal	
	#	%	#	%	#	%	#	%
Region 0	10	66.7%	1	10.0%	0	0.0%	0	0.0%
Hotline	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Region 1	71	15.6%	3	4.2%	19	26.8%	108	23.7%
Bridgeport	57	18.0%	2	3.5%	14	24.6%	85	26.9%
Norwalk/Stamford	14	10.1%	1	7.1%	5	35.7%	23	16.5%
Region 2	108	18.2%	0	0.0%	38	35.2%	183	30.9%
Milford	43	17.8%	0	0.0%	16	37.2%	66	27.4%
New Haven	65	18.5%	0	0.0%	22	33.8%	117	33.2%
Region 3	102	12.6%	3	2.9%	36	35.3%	135	16.7%
Middletown	15	12.8%	0	0.0%	4	26.7%	33	28.2%
Norwich	63	15.0%	2	3.2%	19	30.2%	56	13.3%
Williamantic	24	8.9%	1	4.2%	13	54.2%	46	17.0%
Region 4	139	16.0%	2	1.4%	50	36.0%	174	20.1%
Hartford	102	17.3%	0	0.0%	41	40.2%	129	21.8%
Manchester	37	13.4%	2	5.4%	9	24.3%	45	16.3%
Region 5	69	9.3%	0	0.0%	31	44.9%	130	17.6%
Danbury	7	4.4%	0	0.0%	2	28.6%	20	12.5%
Torrington	23	16.1%	0	0.0%	15	65.2%	34	23.8%
Veterbury	39	8.9%	0	0.0%	14	35.9%	76	17.4%
Region 6	91	16.3%	2	2.2%	52	57.1%	156	28.0%
Meriden	24	13.9%	0	0.0%	11	45.8%	47	27.2%
New Britain	67	17.4%	2	3.0%	41	61.2%	109	28.3%
Grand Total	590	14.6%	11	1.9%	226	38.3%	886	22.0%

In addition, the Department has created Permanency Goal datasheets for each of the Regions to support recent permanency forums with judges and community providers. An example is as follows:



Race/Ethnicity	Adoption	APPLA	Long Term FC Relative	No Goal <sup>2</sup>	Reunification	TOG	Grand Total
HISPANIC, ANY RACE	46	292	19	52	142	31	582
Non-Hispanic, OTHER	14	62	8	14	29	2	129
Non-Hispanic, BLACK	45	264	21	86	126	33	575
Non-Hispanic, WHITE	57	259	15	26	165	33	555

## Case Review System

The Department is able to capture whether a child has a written case plan and whether that case plan is approved by the supervisor (see screenshot below). This is an area upon which the Department is assessed by the Court Monitor. In addition, the case plan is used to support the ACR records review. As noted above, the Department also collects data on parent's participation in the ACR process. There is still work to be done to increase mother's and father's participation. The Department is developing a new SACWIS. We are discussing how technology might be utilized to better notify families of their ACR and to allow them to electronically comment on their case plan.

Case Plans With Pending Approvals			
case plans with pending approvals by plan type - summary			
Summary		Detail	
Area Office	Plan Type		
	CIP	Family	Total
Danbury		1	1
Hartford	1		1
Manchester	1	1	2
Meriden	2	2	4
New Britain	3	1	4
New Haven	1	1	2
Norwalk	3	1	4
Torrington	1	1	2
Willimantic	1	2	3
<b>Total</b>	<b>13</b>	<b>10</b>	<b>23</b>

The Department has a strong Administrative Case Review process. There were over 12,000 ACRs held during Calendar Year 2014. The ACR process occurs every 6 months for children in placement. An initial ACR is to occur for all In Home cases, as well.

There are currently 51 full and part-time Social Work Supervisor positions dedicated to ACR. The Office of ACR (OACR) is helmed by a Program Director (PD). There are four Program Managers assigned to oversee the daily regional operations of the ACR process. The OACR PD reports to the DCF Chief of Quality and Planning. The DCF Chief of Quality reports directly to the

Commissioner. The OACR continues to partner with the Department's Office of Research and Evaluation to engage in activities to ensure that ACR process is consistent and reliable across reviewers (See Quality Assurance System for additional information).

The below data shows that the Department does fairly well to ensure that the first Permanency Hearing occurs within 12 months of the child entering care (i.e., over 90%). In contrast, the Department must develop stronger mechanisms to ensure that Permanency Hearings are occurring as required after the initial hearing.

Did the first Permanency Hearing occur within 12 months of child entering out of home care?			
YES	NO	N/A	Youth 18+
4048	288	3113	1109

Did Permanency Hearing occur within the last 12 months, thereafter the initial hearing?		
YES	NO	N/A
87	174	8295

Finally, the Department does not have an automatic reporting mechanism that allows it to readily respond to Items 23 and 24. The Department is embarking upon the development of a new SACWIS. That system is scheduled to go-live October 1, 2017. We will look to enhance our reporting capacity through the new SACWIS to allow us to better demonstrate our functioning in those areas.

### Quality Assurance System

The Department convenes a Quality Improvement Council (QIC) that meets twice a month. The QIC is comprised of the Quality Assurance Managers from the DCF Regional Offices, the Director of the Office for Research and Evaluation, the Director of the Office of Administrative Case Reviews (OACR) and four OACR Managers. Managers from one of the DCF operated facilities, a Manager from the DCF Office of Adolescents and Juvenile Services, a Manager from the Quality Assurance Unit and two representative from the IS SACWIS team also participate.

This body helps to vet qualitative projects in the Department and support uniformity with respect to performance expectations and qualitative review processes. During this Calendar Year, the QIC will be focusing on developing a data governance structure and related policies. They will also be identifying key reports and dashboards for the new SACWIS.

Further, the Department's Office for Research and Evaluation (ORE) is advancing DCF's approach and access to comprehensive data and information to improve outcomes. ORE is increasing partnerships within and external to the Department to support assessment of core DCF functions and services. In particular, ORE has lead three qualitative reviews of congregate care exits. They have been done with participation by DCF Area Office Quality Improvement Managers and staff from the Federal Court Monitor's Office. ORE is currently working on the 4<sup>th</sup> such report.

ORE is also conducting a cross-sectional study aimed to assess levels of quality and satisfaction of foster home placements and to identify associated factors among children in DCF and privately licensed foster care homes and their caregivers. This involves face-to-face interviews among a random sample of foster children aged 8 years and older and their foster parents. Foster children aged 13 years and above will be asked to complete a self-administered questionnaire, in addition to the face-to-face interview. As a means to support candor and confidentiality, survey data will be identified only by a participant ID and the final report of the survey will be based on the aggregated data. The preliminary results from this survey are due later this summer.

The Department Office of Administrative Case Review (OACR) continues to partner ORE to develop and implement its CQI activities. OACR and ORE outreached to other partners, including but not limited to the Quality Improvement Council (QIC), the Court Monitor's Office, Training Academy, and the OACR Advisory Group to participate in Monthly Interrater Reliability Reviews (MRR). These entities were engaged in the development of the MRR protocol, participated in reviews, and were provided with copies of subsequent reports and recommendations that were generated.

The purpose of MRR is to support the consistency, integrity, efficacy and ongoing quality of the ACR process. They are intended to support continuous monitoring of inter-rater reliability improvements, efficacy of training; and training needs. They will also allow OACR to continuously track and monitor its improvements since the January 2014 Inter-Rater Reliability (IRR) study and its progress towards achieving and eventually sustaining its ultimate IRR goal of 95% percent of agreement.

Next, the Department’s ACR process contributes greatly to our quality assurance system. There are a variety of OACR reports available to track and monitor agency performance with respect to various case plan elements. A screenshot of the ACR reports’ portal is below:

ACR Management Reports	
Case Practice by Reviewer	The Case Practice by Reviewer identifies areas of strength and areas needing improvement for 21 key case practice indicators for each ACRI Worker.
ACRIs Not Completed in 15 Days	The ACRIs Not Completed in 15 Days report identifies when an ACRI form has not been completed 15 days after the scheduled date of the last session.
Completion Report by Region	The Completion Report by Region tracks the number of days to completion from the date of the last session.
Completion Report by ACR Supervisor	The Completion Report by ACR Supervisor report tracks number of days to completion from the last session.
48 Hour Notification and CTM Notification	48 Hour Notification and CTM Notification
ACR Reports	
Case Practice Report	The Case Practice Report identifies areas of strength and areas needing improvement for 10 key case practice indicators.
90 Day CTM Report	The 90 Day CTM Report identifies when a 90 Day CTM is required and the meeting status. The user can filter by Region, Area Office, ACR Meeting Scheduled Date and Meeting Status (Meeting Held or Cancelled).
CIP Well Being	The CIP Well Being report identifies barriers to meeting the mental health, substance abuse and social support needs of all children in placement. The report shows percentages for the state and regions and offers a drill down feature.
Needs Assessment	The Needs Assessment report is a report of in home children and all adults for whom a needs assessment was completed in the ACRI.
Permanency Barriers	The Permanency Barriers report identifies all barriers to permanency for all CIP ACRI's where there are delays in progress or achievement of permanency.
OM3 Elements Report	This report has been inherited from CTM Percentages report. This data is gathered pre ACR feedback.
ACR Attendance Report	The ACR Attendance Report is a report of all participants listed by role in the ACRI. It is further broken down by method of participation (in person, teleconference and written reports).
Rescheduled Meetings	The Rescheduled Meetings report is a report of all meetings whose first session was rescheduled and the reasons for that reschedule.
No Manager Response 15 days after proposed 90 day CTM	The No Manager Response 15 days after Proposed 90 day CTM is a report of all ACRI forms where a 90 Day CTM is required and 15 days after the 90 day CTM proposed date, the Manager Response section has not been completed.
Historical CTM Reports	
Historical 90 day CTM Report	Historical 90 day CTM Report
Historical Percentages	Historical CTM Percentages Report.
Historical ACR Worker Percentages	Historical CTM ACR Worker Percentages Report
Historical Summary Reports	Historical CTM Summary Reports

Data from the ACR Case Practice Report is below. The chart shows the top ten case practice data elements. This data comes from the ACR Instrument SharePoint portal. There are 30 additional elements that can be included in the report using filters. Regional views of these data are also available.

SLNo	Measure	Statewide		
		January, 2015	February, 2015	March, 2015
		strength %	strength %	strength %
1	Visitation with Child and Parents	70%	67%	64%
10	Risk & Safety - Child in Placement	94%	93%	92%
12	Continuity of Relationship - Child w/ Parents	92%	92%	88%
15	Collateral Contact - Parents	77%	77%	74%
19	Parent Needs	76%	77%	75%
24	Physical health care - Child	88%	87%	83%
25	SA/Social Support/MH - Child	92%	93%	88%
38	Transition Plan	97%	97%	95%
39	Permanency	94%	93%	93%
45	Case Plan Assessment	82%	82%	81%

As the data reveal, there are a number of measures in which the Department is doing well. Others, such as Visitation, Collateral Contact and Parent Needs are ones in which improvement could occur. The Department has just begun to implement an Exceptional Case Planning (ECP) practice.

The ECP approach requires Area Office Program Managers to regularly review the findings in the ACRI for their staff to assess case practice strengths and systemic areas needing improvement. Individual Service Plans are developed for staff whose performance on the ACR and individual elements is not satisfactory, particularly as it relates to areas of case planning and client’s needs being met.

Next, the Department has required all Regions, Division and the Facilities to develop Operational

Strategies to identify the means by which they will achieve the agencies 2015 Performance Expectations. The first Performance Expectation relates to our federal *Juan F.* Outcome Measures (OM). Three OM’s of focus are:

- **Outcome Measure 3: Treatment Plans:** In at least 90% of the cases, except probate, interstate, voluntary and subsidy only cases, clinically appropriate individualized family and child specific treatment plans shall be developed in conjunction with parents, children, providers and others involved with the case and approved by a DCF supervisor within 60 days of case opening in a treatment unit, or a child’s placement out-of-home, whichever comes sooner, and for each six (6) month period thereafter.
- **Outcome Measure 15: Children's Needs Met:** At least 80% of all families and children shall have all their medical, dental, mental health and other service needs provided as specified in their most recently approved clinically appropriate treatment plan.
- **Outcome Measure 17: Worker-Child Visitation (In-Home):** DCF shall visit at least 85% of all in-home family cases at least twice a month, except for probate, interstate or voluntary cases.

Data on these Outcome Measures for 4<sup>th</sup> Quarter 2014 reveal the need for improvement in the areas of treatment planning, needs met and visitation:

Positive Outcomes For Children- Statewide		
Measure	Measure	Q4 2014
3: Treatment Plans	>=90%	42%
15: Children’s Needs Met	>=80%	53%
17: Worker-Child Visitation (In-Home)	>=85%	83%



The introduction of Exceptional Case Planning and the implementation of Regional Operational Strategies are thought to be solid mechanisms to aid with producing better results with respect to case planning, needs being met and sufficient, quality visitation occurring.

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

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

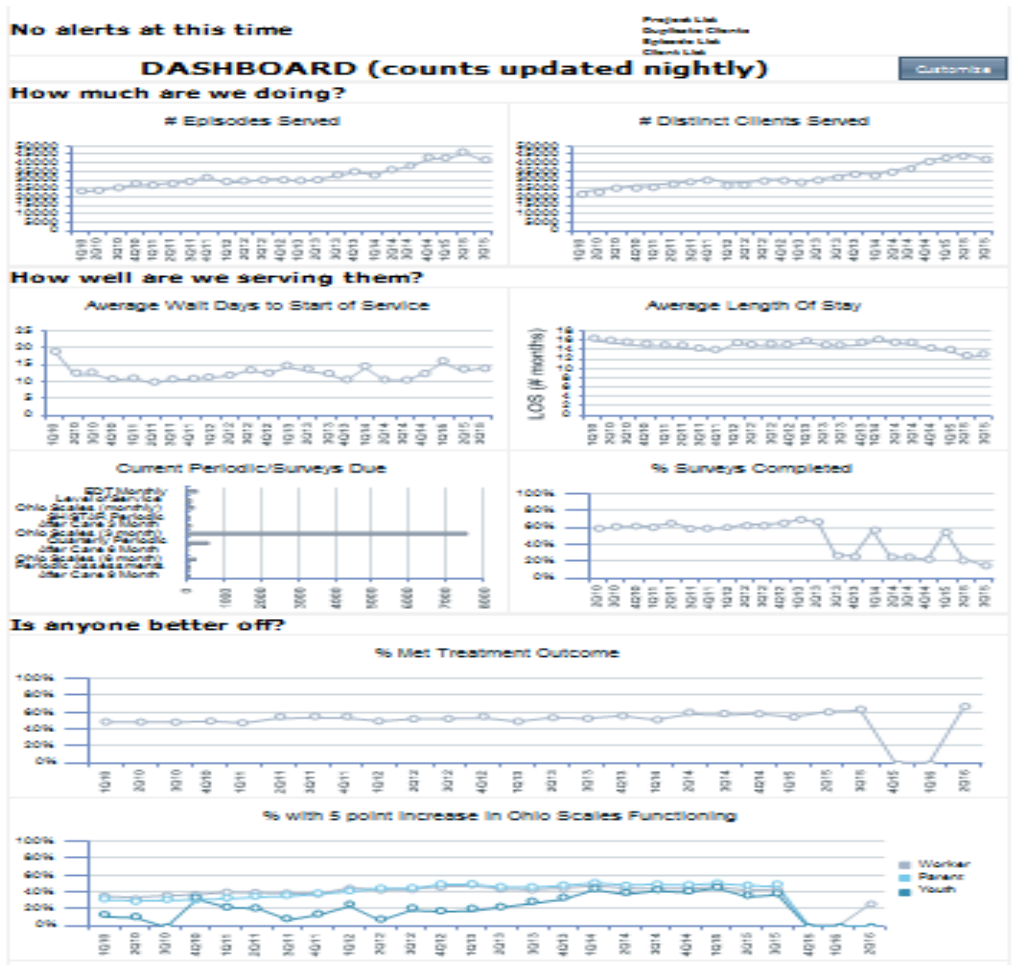
The below screen shot shows the reports layout within PSDCRS.

The screenshot displays the PSDCRS interface with the following sections:

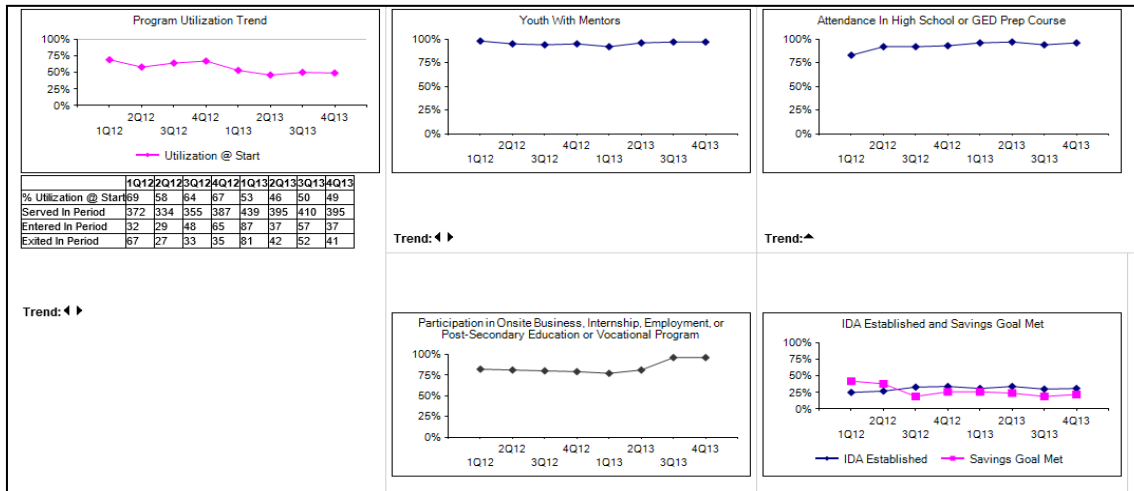
- VERSION 6.3 Updated: 11/17/2014**
- WHAT'S NEW**
  - ASSIGN EXTRACTS
  - DASHBOARD
  - QUERIES
  - WHAT'S NEW SETUP
  - CHANGE LOG
  - REPORTS
  - RBA REPORT CARD**
- Logged in to: DCF Oversight**
  - CHANGE ACCESS
  - READ ONLY ACCESS
- Logged in as: susan**
  - REQUEST NEW ACCESS
  - CHANGE PASSWORD
  - ACCOUNT INFO
  - LOGOUT
  - NEW SUPPORT REQUEST
  - SUPPORT REQUESTS
  - TRAINING INFO
  - HELP DOCS & FORMS
  - REQUEST NEW ACCOUNT
  - REQUEST SPECIAL ACCESS
- TECHNICAL ASSISTANCE Provided By**
  - kjmb solutions**
- How can I review and/or improve my data?**
  - Data Element Master List
  - Data Quality Monitoring
  - Unanswered Data Elements
  - Response Percentages
  - Surveys Completed or Due
  - Audit Log
  - Data Extraction
    - Data Extraction (Choose Data Elements)
    - Data Extraction (Periodic Data)
    - Data Extraction (Activity Data)
  - Duplicate Clients
    - RCF--Activity Detail
    - CSF--Activity Detail
    - Walkthrough Detail
- How much did we do?**
  - Episode List
  - Dyad Client Count Report
  - Relationship List
  - Client List
  - Average Level of Service Report
  - W2L Episode Count Report
  - Episode Count and Length of Stay
  - Episode Count and Length of Stay by Gender
  - Episode Count and Length of Stay by Race
  - Episode Count and Length of Stay by Age
  - Episode Count and Length of Stay by Provider
  - Episode Count and Length of Stay by Project
  - Episode Count by Gender by Provider
  - Episode Count by Race by Provider
  - Episode Count by Age by Provider
  - Episode Count by Gender by Project
  - Episode Count by Race by Project
  - Episode Count by Age by Project
  - Protective Factors Survey Report
  - 211 Calls Report
  - 211 Call Summary Report
  - Referral Detail Report
- How well did we serve them?**
  - Client Wait Days before Start of Service by Provider
  - Client Wait Days before Start of Service by Project
  - EDT--Report 1 (Multi-Family Group Attendance)
  - EDT--Report 2 (Initial Assessment Attendance)
  - EDT--Report 3 (Initial Treatment Plan Attendance)
  - EDT--Report 4 (Treatment Plan Review Participation)
  - EDT--Report 5 (Family Therapy Session Attendance)
  - EDT--Report 7 (Ohio Scale Completion)
  - Walkthrough Aggregate
    - Respite: All Episode Months
    - Respite: PUR Episode Months
  - YSSF Outcomes
  - Referral Trend
- Is anyone better off?**
  - Reasons for Discharge
  - Reasons for Discharge by Gender
  - Reasons for Discharge by Race
  - Reasons for Discharge by Age
  - Reasons for Discharge by Project
  - Ohio Scales Report (Functioning/Problem Severity)
  - Ohio Scales: Parent and Worker Ratings
- Summary Reports**
  - URS Table Generator for Fiscal Year 2014-2015
- What helps me understand my Projects**
  - Project Status
  - Cross-Provider Episode List
  - Project List
  - Batch Status
  - User List
- How well is KJMB serving us?**

Some programs in PSDCRS also collect periodic data (e.g., client data updates ever quarter or six months). Activities or event level data is also collected for select service types in PSDCRS. This level of data allows for the Department to assess information about key service provision (e.g., face to face contact with a client, duration of visits, location of services, participants, etc.). PSDCRS collects post-discharge/aftercare data for some services. An example of aftercare data would be evidence of supporting transition and monitoring stability of a step down from Therapeutic Foster Care to core foster, relative placement or reunification.

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



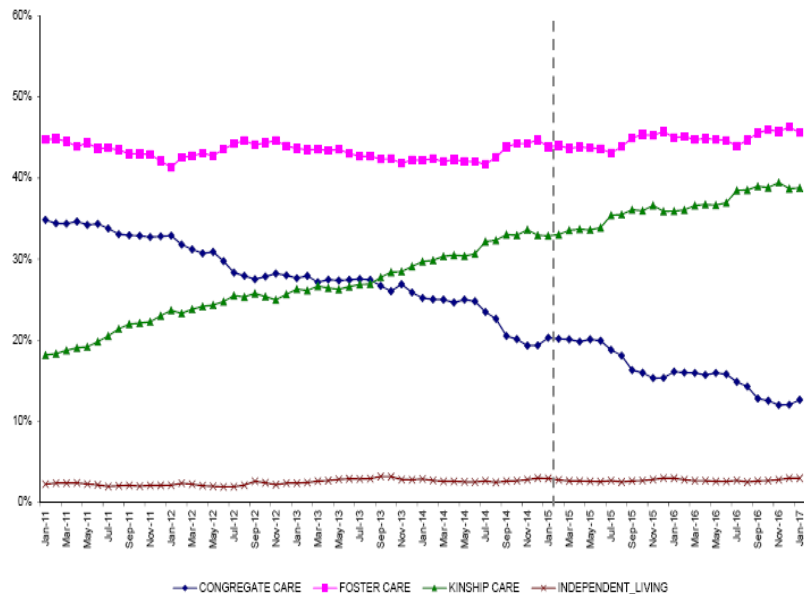
The Department will be expanding the array of reports available to DCF Staff and providers. In particular, a fully automated Reports Based Accountability (RBA) Report Card is in development. A beta test version of that Report Card currently exists. It automatically populates the Report Card with *How Much*, *How Well* and *Better Off* data and trends that information to display improvement, a decline, or no change. DCF contract leads will have the ability to put in the accompanying RBA Report Card narrative. A Screenshot of that tool is below



In addition, the types and sophistication of data and analysis by the Department is also different than in years past. For example, the Department began constructing forecasts/population projections three years ago. These data aid in determining the likely placement landscape months and often years in advance. This assists the Department in making decisions about the category of services in which it will need to more greatly invest (e.g., congregate versus community-based).

Most recently, the Department has begun to disaggregate these projections by key demographics such as race/ethnicity, gender and age cohorts. This enhanced view of the forecasts allow us to more adroitly develop a service array that will better meet the needs of the children and youth who we expect to serve. We will be working with our statistician to construct multivariate forecasts to allow for even more complex trend projections.

Trend in the Percentage of MALE Children in DCF Placement by Placement Type:  
Observed Data Thru January 2015, Forecasted Data From February 2015



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

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

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

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

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

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

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

- Developing documents, identifying screening and assessment measures, and measuring treatment fidelity across sites.
- Identifying training needs, developing a standardized training curriculum, identifying expert trainers, ensuring delivery of required trainings, and ensuring the quality and effectiveness of the training curriculum.
- Analyzing data to ensure services are accessible and capacity is sufficient and ensure that services are of the highest quality.
- Identifying important goals and associated outcomes and measuring achievement of those goals.

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

PIC Type	Contracted Entity
Emergency Mobile Psychiatric Services (EMPS)	Child Health and Development Institute (CHDI)
Differential Response Services (DRS)	UConn School of Social Work
Therapeutic Group Homes (TGH)	Value Options, Inc.

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

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

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

Exit Plan Indicators	Other Indicators	Informational Reports
<a href="#">Commencement of Investigation - EP#1</a>	<a href="#">Timely Permanency (24 months)</a>	<a href="#">Pending Investigations</a>
<a href="#">Completion of Investigation - EP#2</a>	<a href="#">Timely Reunification (12 months)</a>	<a href="#">Missing Removal/Discharge Data</a>
<a href="#">Placement Resource Search - EP#4</a>	<a href="#">Timely Adoption (24 months)</a>	<a href="#">Children in DCF Placement by Length of Stay</a>
<a href="#">Child Safety Maintained 6 months (no recurrence) - EP#5</a>	<a href="#">Timely Guardianship (24 months)</a>	<a href="#">Subsidized Guardianship</a>
<a href="#">Child Safe in Out-of-Home Care (no abuse/neglect) - EP#6</a>	<a href="#">Maintain Permanency 12 months (no re-entry)</a>	<a href="#">Subsidized Adoptions</a>
<a href="#">Reunification - EP#7</a>		
<a href="#">Adoption - EP#8</a>	<b>SDM Reports</b>	<b>Other LINK Reports</b>
<a href="#">Transfer of Guardianship - EP#9</a>	<a href="#">SDM Initial Safety Assessments</a>	<a href="#">LINK Reports Home</a>
<a href="#">Maintain Permanency (no re-entry) - EP#11</a>	<a href="#">SDM Initial Risk Assessments</a>	
<a href="#">Monthly Worker-Child Visitation Out-of-Home - EP#16</a>	<a href="#">SDM Initial In Home Family Strengths &amp; Needs Assessments</a>	
<a href="#">Twice Monthly Worker-Case Visitation In-Home - EP#17</a>	<a href="#">SDM Initial Out of Home Family Strengths &amp; Needs Assessments</a>	
<a href="#">Multidisciplinary Exams - EP#22</a>	<a href="#">SDM In-Home FSNA &amp; Risk Re-assessments</a>	
	<a href="#">SDM Out-Of-Home FSNA &amp; Reunification Re-assessments</a>	
	<b>OFCS Reports</b>	
	<a href="#">OFCS Reports Home</a>	

The Department is also finalizing a Research Agenda. ORE has met with the Department's various Divisions and Teams, including CJTS, to identify key evaluative questions. Some of the areas include:

**Safety:**

- What are protective and risk factors for child abuse and neglect among Connecticut children age 0-3 years?
- What are the predictors of critical incidents among DCF-involved children age three years and younger?
- What are indicators of sex trafficking of minors?
- What is the geospatial relationship between neighborhood characteristics and child abuse and neglect?
- **Permanency and self-sufficiency**
- What is the long term effect on self-sufficiency for the choice of traditional college vs. vocational education?
- What factors contribute to self-sufficiency since aging out of the foster care system?

**Well-being**

- What are the levels of academic performance and risk behaviors among Connecticut school-age children served by DCF?
- To what extent are fathers engaged in child care among DCF-involved families? Are more engagements associated with better outcomes?
- What are the factors (e.g., type and degree of family involvement) associated with recidivism to the Connecticut Juvenile Training School (CJTS)? Do the factors differ between boys and girls?
- What is the health wellness among children in care? Do children in care receive adequate health (including physical and mental health) services?
- Does training in Wilderness School increase participant's self-esteem, resilience, and internal locus of control, and build good relationships with peers and adults?
- What is the effect of early screening for the developmental and social-emotional delays among children under age three years with substantiated cases of abuse or neglect?
- Are educational needs of youth involved in the juvenile justice systems met? What are the main barriers to improving education performance?

It is the Department's intention to use its Institutional Review Board (IRB) process to solicit university partners who will work with our ORE to research and study these various questions.

Finally, the below articulates how the Department would approach a self-driven CFSR process, including developing our Universe and Sampling Frame for the Child and Family Services Review (CFSR) for Foster Care aka Child-in-Placement (CIP) cases. A similar process will be developed for reviews of the In-Home services population. It is our intention to utilize our ongoing State Case Review process (i.e., ACRs) to accomplish the CFSR reviews, and we intend to conform to all federal requirements for selecting cases to include in those reviews. The process for doing so will be as follows:

- 1) Starting the month prior to the first month of the Review Period, the Office for Research and Evaluation will pull a monthly universe of children that had been in placement during the month the year prior, and that do not fit any of the CFSR elimination criteria. Children will not be included in the universe if:
  - The child is in foster care for fewer than 24 hours during the Sampling Period
  - The child was on a Trial Home Visit during the entire Sampling Period
  - The child is in foster care but reached the age of 18 prior to the Sampling Period
  - The child had been in foster care, but was discharged (including finalization of adoption or guardianship) prior to the Sampling Period
  - A child whose caregiver is receiving only subsidized adoption or guardianship payments during the Sampling Period
  - A child who is in the care and responsibility of another state, but has been placed in CT for supervision through an Interstate Compact on the Placement of Children (ICPC) agreement
  - A child who was placed for the entire Sampling Period in a locked juvenile facility or other placement that does not meet the federal definition of foster care
  
- 2) DCF is currently in the process of ensuring that the instrument utilized in our ongoing Administrative Case Review (ACR) process conforms to CFSR requirements, and half of the cases pulled for the CFSR review will come from those already scheduled for ACRs. The other half will be for children whose cases are not scheduled for ACRs during that month, but had also been in placement during the Sampling Period.



- 3) Cases identified for inclusion in the sample will be assigned to a two-person team for review. The team will schedule the interviews to occur during the review month. If the case is scheduled for an ACR, then interviews will be scheduled to occur prior to the ACR meeting to avoid any misunderstandings of the role of the reviewers.
  
- 4) Review documentation and all QA reviews will be completed within 15 days of the latest interview/meeting held. The precise method of data entry into OMS has yet to be determined. Ideally, DCF would like to have its own system for storing such documentation, out of which the data collected on cases identified for the official CFSR Review Period would be imported into OMS.

For demonstration purposes, a dataset conforming to the above criteria was pulled from CT SACWIS (LINK) for all children that had been in placement during the FFY13b time period (4/1/13 - 9/30/13). Additional information was pulled concerning scheduled ACR dates during the same calendar months the following year (4/1/14 - 9/30/14). Separate random samples were pulled from the two groups that comprise the universe, those with a scheduled ACR during the Review month, and those without a scheduled ACR during that month. In that manner, all cases in the universe have an opportunity to be included in the sample.

It is our intention to pull a single foster care aka CIP (and In-Home, though that data is not modeled in the current analysis) case from each of our offices for review on a monthly basis. DCF currently has 14 separate offices, so this will result in a total of 84 foster care aka CIP cases reviewed across the required 6-month Review Period. This figure is more than twice the required minimum of 40 foster care aka CIP cases to be included in the CFSR sample. As indicated above, half of the cases are drawn from those with scheduled ACRs, and the other half from those with no scheduled ACRs. Please see the sample distribution in the table below to illustrate this methodology.

		# of ACR Meetings Scheduled During 6 Month Period		
Data	Sample Type	0	>=1	Grand Total
#	APRIL_NO_ACR	5	2	7
	APRIL_STILL_IN_CARE		7	7
	MAY_NO_ACR	3	4	7
	MAY_STILL_IN_CARE		7	7
	JUNE_NO_ACR	2	5	7
	JUNE_STILL_IN_CARE		7	7
	JULY_NO_ACR	3	4	7
	JULY_STILL_IN_CARE		7	7
	AUG_NO_ACR	5	2	7
	AUG_STILL_IN_CARE		7	7
	SEPT_NO_ACR	1	6	7
	SEPT_STILL_IN_CARE		7	7
	UNIVERSE	2460	2300	4760
	%	APRIL_NO_ACR	0.1%	0.0%
APRIL_STILL_IN_CARE		0.0%	0.1%	0.1%
MAY_NO_ACR		0.1%	0.1%	0.1%
MAY_STILL_IN_CARE		0.0%	0.1%	0.1%
JUNE_NO_ACR		0.0%	0.1%	0.1%
JUNE_STILL_IN_CARE		0.0%	0.1%	0.1%
JULY_NO_ACR		0.1%	0.1%	0.1%
JULY_STILL_IN_CARE		0.0%	0.1%	0.1%
AUG_NO_ACR		0.1%	0.0%	0.1%
AUG_STILL_IN_CARE		0.0%	0.1%	0.1%
SEPT_NO_ACR		0.0%	0.1%	0.1%
SEPT_STILL_IN_CARE		0.0%	0.1%	0.1%

	UNIVERSE	50.8%	47.5%	98.3%
Total#		2479	2365	4844
Total%		51.2%	48.8%	100.0%

The following shows the percentage of cases in the Sample alone.

% Sample Type	# of ACR Meetings Scheduled		
	0	>=1	Grand Total
APRIL_NO_ACR	6.0%	2.4%	8.3%
APRIL_STILL_IN_CARE	0.0%	8.3%	8.3%
MAY_NO_ACR	3.6%	4.8%	8.3%
MAY_STILL_IN_CARE	0.0%	8.3%	8.3%
JUNE_NO_ACR	2.4%	6.0%	8.3%
JUNE_STILL_IN_CARE	0.0%	8.3%	8.3%
JULY_NO_ACR	3.6%	4.8%	8.3%
JULY_STILL_IN_CARE	0.0%	8.3%	8.3%
AUG_NO_ACR	6.0%	2.4%	8.3%
AUG_STILL_IN_CARE	0.0%	8.3%	8.3%
SEPT_NO_ACR	1.2%	7.1%	8.3%
SEPT_STILL_IN_CARE	0.0%	8.3%	8.3%
Grand Total	22.6%	77.4%	100.0%

### Summary of Major Activities

1. May 11 – June 30<sup>th</sup>: Pilot Phase 1 (pilot of OSRI and instructions, including reviewer data on time required and rolling QA)
2. June 1 – Nov 30<sup>th</sup>: Data collection for specified Statewide Self-Assessment metrics
3. Sept 7 – Oct 30<sup>th</sup>: Pilot Phase 2 (pilot of complete ongoing monthly process for October universe/sample)
4. Dec 14 – March 31<sup>st</sup>: Initial Implementation Phase (full implementation of ongoing process, but reviews will not be included in official CFSR submission)
5. Feb 1 – Statewide Self-Assessment Final Draft due for submission to the Children’s Bureau

6. March 14– Sept 30<sup>th</sup>: Official CFSR Review Phase (all reviews will be included in official CFSR submission, and Children’s Bureau staff will routinely come onsite to provide secondary QA and conduct required stakeholder interviews and/or focus groups)
7. Oct 1 – tbd: Program Improvement Plan (PIP) Phase (review process to continue indefinitely as a key component of our CQI system, and will also serve as the basis for whatever ongoing reviews end up being required as part of our PIP)

## Draft Monthly Detail

### April 2015

April 14<sup>th</sup> – Finalize volunteer reviewers and QA team for Pilots of Combined On-Site Review Instrument

April 15<sup>th</sup> – Select and Assign cases for Pilot (Phase 1)

- Tentatively will have 12 teams of 2 reviewers each reviewing total of 20 cases; 10 CIP and 10 IH
- 4 teams will do 1 case and then spend remainder of time on QA; total 4 cases, 2 CIP and 2 IH
- 8 teams will do 2 cases each, 1 CIP and 1 IH each for total 16 cases
- Combined OSRI will be completed manually

April 20<sup>th</sup> – Combined OSRI tool finalized and sent to the FEDS

April 30<sup>th</sup> – Meeting at DCF CO with CB staff to select Statewide Self-Assessment (SSA) metrics and integration of SSA with Child and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR) process

April 30<sup>th</sup> – Complete SharePoint form to collect Overall Summary Ratings

### May 2015

- May 8<sup>th</sup> – Monthly TC with CT/CB staff
- May 10<sup>th</sup> – Combined CT/CB OSRI completed, including QA Guide and SharePoint form to capture Overall Summary Ratings
- May 11<sup>th</sup> – All reviewers to have completed the on-line CFSR module
- May 11 – 13<sup>th</sup> – Conduct Training for Pilot (Phase 1)
- May 14 – June 30<sup>th</sup> – Conduct Pilot ([Phase 1](#)) – pilot of OSRI and instructions, including reviewer data on time required and rolling QA
- May 29<sup>th</sup> – All reviews completed

### June 2015

- June 1 – Nov 30<sup>th</sup> - Data Collection for Statewide Self-Assessment metrics
- June 5<sup>th</sup> – Complete all QA on Pilot cases
- June 5<sup>th</sup> - Monthly TC with CT/CB staff

- June 30<sup>th</sup> – All Pilot Phase 1 reviews and QA should be completed
- June 30<sup>th</sup> – APSR due to CB – content should be in line with SSA requirements

#### July 2015

- July 1<sup>st</sup> – Conduct Data Analysis on Pilot Phase 1 Results
- July 15<sup>th</sup> – CT Letter of Intent Due to CB
- July TBD - Monthly TC with CT/CB staff
- July TBD – Pilot Phase 1 Debriefing with CT/CB staff
- July TBD – Final edits/corrections/additions to Combined CT/CB OSRI
- July TBD – Select upcoming meetings to Pilot Stakeholder Interview questions

#### August 2015

- Aug TBD - Monthly TC with CT/CB staff
- Aug TBD – Provide final Combined CT/CB OSRI to IS for ACRI re-design
- Aug TBD – Finalize draft manual for CT Ongoing CFSR-level Review Process and provide to CB for comment/approval
- August 3 – Identify 3 cases (1 In-Home, 2 OOH) for MRR
  - Trio and ACR managers (ORE if available)
- Week of August 17th, debrief MRR cases
- Week of August 24th, make any necessary changes to OSRIC

#### September 2015

- Sept TBD - Monthly TC with CT/CB staff
- Sept 7 - Oct 16<sup>th</sup> – Pilot (Phase 2) – pilot of complete ongoing monthly process for October universe/sample
- Sept 7<sup>th</sup> – Pull Universe and Sample (including assigning reviews to teams)
  - 1 per office; 14 total cases with 7 CIP and 7 In-Home
- Sept 7<sup>th</sup> Inform SWs of the cases in the sample with an ACR scheduled in order to get permission from family for team member B to attend ACR
- Sept 10 – 11<sup>th</sup> – Pilot (Phase 2) Training
- Sept 14 – Oct 16<sup>th</sup> – Reviewers read cases, set up interviews, conduct interviews, attend ACRs (when applicable) and complete OSRI
- Sept 14<sup>th</sup> – Reviewers and stakeholder interviewers to begin Time Study in SharePoint

#### October 2015

- Oct 1 – CB Final Decision on Approving CT CQI System for 2016 CFSR
- Oct 1 – CB should provide Statewide Assessment Instrument with updated Data Profile to CT
- Oct TBD - Monthly TC with CT/CB staff
- Oct 16<sup>th</sup> – Complete Pilot (Phase 2) Reviews

- Oct 17 – 30<sup>th</sup> TBD – Debrief Pilot (Phase 2) and make any necessary edits to overall process/workflows

#### November 2015

- Nov TBD - Monthly TC with CT/CB staff
- Nov TBD – Finalize any edits to manual of CT Ongoing CFSR-level Review Process based on pilot and provide to CB for comment/approval
- Nov TBD – Begin/Complete UAT of re-designed ACRI (now OSRI) data collection site
- Nov 30<sup>th</sup> – Complete data collection on Statewide Self-Assessment metrics, for reporting purposes at least

#### December 2015

- Dec TBD - Monthly TC with CT/CB staff
- Dec TBD – OSRI development complete
- Dec TBD – Final Training for all Reviewers
- Dec TBD – Final Training for all QA Team members
- Dec 14<sup>th</sup> – Pull January 2016 Universe and Samples, and Assign to Review Teams
- Dec 14<sup>th</sup> Contact SW of the cases chosen with ACRs to obtain permission for Team Member B to attend ACR. Will have to oversample incase families say “No.”
- Dec 15 – 31<sup>st</sup> – Reviewers read January cases, identify case participants, schedule interviews and begin to conduct interviews
- Dec 18<sup>th</sup>? – Draft SSA due to CB for comments

#### January 2016

- Jan TBD - Monthly TC with CT/CB staff
- Jan 4<sup>th</sup> – Jan 29<sup>th</sup> – Reviewers finish January interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- Jan 8<sup>th</sup> – Comments from CB on Draft SSA due to CT to inform revision/finalization of SSA
- Jan 11<sup>th</sup> – Pull February 2016 Universe and Samples, and Assign to Review Teams
- Jan 12<sup>th</sup> – 29<sup>th</sup> - Reviewers read February cases, identify case participants, schedule interviews and begin to conduct interviews
- Jan 15<sup>th</sup> – CT must show CB that our ongoing CFSR assessment process is operational – Site Visit by CB required??
- Jan 29<sup>th</sup> – Final SSA due to CB

#### February 2016

- Feb 1<sup>st</sup> – Statewide Self-Assessment Final Draft due from CT to CB
- Feb 1<sup>st</sup> – Initial Debriefing of Reviewers on January cases – Should probably plan to include CB staff in this meeting instead of monthly TC

- Feb 1 – 29<sup>th</sup> - Reviewers finish February interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- Feb 8<sup>th</sup> - Pull March 2016 Universe and Samples, and Assign to Review Teams
- Feb 9 – 29<sup>th</sup> – Reviewers read March cases, identify case participants, schedule interviews and begin to conduct interviews

#### March 2016

- Mar 1 – CB to provide information on required stakeholder interviews
- Mar TBD – Monthly TC with CT/CB staff
- Mar 1 – 31<sup>st</sup> - Reviewers finish March interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- Mar 14<sup>th</sup> - Pull April 2016 Universe and Samples (begins official CFSR Review Period), and Assign to Review Teams
- Mar 15 – 31<sup>st</sup> – Reviewers read April cases, identify case participants, schedule interviews and begin to conduct interviews

#### April 2016 – BEGINNING OF OFFICIAL CFSR REVIEW PERIOD!

- Apr 1 – CB/CT finalize schedule and begin to conduct required stakeholder interviews
- Apr 1 - Debriefing of Reviewers on 1<sup>st</sup> Quarter cases – Should probably plan to include CB staff in this meeting instead of monthly TC
- Apr 1 – 30<sup>th</sup> - Reviewers finish April interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- Apr 11<sup>th</sup> - Pull May 2016 Universe and Samples (begins official CFSR Review Period), and Assign to Review Teams
- Apr 12 – 30<sup>th</sup> – Reviewers read May cases, identify case participants, schedule interviews and begin to conduct interviews

#### May 2016

- May TBD - Monthly TC with CT/CB staff
- May 2 – 30<sup>th</sup> - Reviewers finish May interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- May 9<sup>th</sup> - Pull June 2016 Universe and Samples (begins official CFSR Review Period), and Assign to Review Teams
- May 10 – 31<sup>st</sup> – Reviewers read June cases, identify case participants, schedule interviews and begin to conduct interviews

#### June 2016

- June TBD - Monthly TC with CT/CB staff
- June 1 – 30<sup>th</sup> - Reviewers finish June interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- June 13<sup>th</sup> - Pull July 2016 Universe and Samples (begins official CFSR Review Period), and Assign to Review Teams
- June 13 – 30<sup>th</sup> – Reviewers read July cases, identify case participants, schedule interviews and begin to conduct interviews

#### July 2016

- July TBD - Monthly TC with CT/CB staff
- July 1 –31<sup>st</sup> - Reviewers finish July interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- July 11<sup>th</sup> - Pull August 2016 Universe and Samples (begins official CFSR Review Period), and Assign to Review Teams
- July 11<sup>th</sup> - Debriefing of Reviewers on 2<sup>nd</sup> Quarter cases – Should probably plan to include CB staff in this meeting instead of monthly TC
- July 12 – 31<sup>st</sup> – Reviewers read August cases, identify case participants, schedule interviews and begin to conduct interviews

#### August 2016

- Aug TBD - Monthly TC with CT/CB staff
- Aug 1 –31<sup>st</sup> - Reviewers finish August interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- Aug 8<sup>th</sup> - Pull September 2016 Universe and Samples (begins official CFSR Review Period), and Assign to Review Teams
- Aug 9 – 31<sup>st</sup> – Reviewers read September cases, identify case participants, schedule interviews and begin to conduct interviews

#### September 2016 – END OF OFFICIAL 2016 CFSR REVIEW PERIOD

- Sept TBD - Monthly TC with CT/CB staff
- Sept 1 –30<sup>th</sup> - Reviewers finish September interviews, attend ACRs (as applicable) and complete documentation of results in OSRI
- Sept 12<sup>th</sup> - Pull October 2016 Universe and Samples (begins official CFSR Review Period), and Assign to Review Teams
- Sept 13 – 30<sup>th</sup> – Reviewers read October cases, identify case participants, schedule interviews and begin to conduct interviews

#### **Staff and Provider Training**

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

With respect to Quality Assurance, staff training is another means by which the Department will be improving outcomes. Program Development and Oversight Coordinators (PDOCs) are assigned to all of DCF’s POS contracted services. These individuals expected to partner with contracted providers, Regional/Area Office Staff, Systems Program Directors (SPDs), and Central Office Divisions to ensure the provision of effective quality services. Ensuring that the PDOCs and SPDs have the necessary skills and direction to successful fulfill their responsibilities is crucial. The Department has begun meeting with the PDOCs, SPDs, and Grants and Contracts Specialist as a joint group to share the Department’s priorities and to disseminate data and other resources. More advanced metrics training has been



provided (i.e., Pivot Tables and Advanced Analytics conducted by Chapin Hall out of the University of Chicago) to support them in conducting more depth analyses of provider program data.

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

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

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

There have been two TIPS-MAPP trainings to date. 26 participants at each for a total of 52. These first two have included staff from DCF and from the TFC agencies. There is another training in June that will be all TFC staff - again 26. A 4th training will take place in September - another 26 of both DCF and TFC. We are in the process of trying to secure funds for some additional training. There are two staff from DCF - one from Region 4 FASU and one from the Training Academy who are in the process of becoming certified in TIPS-MAPP so they can train.

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

### **Service Array and Resource Development**

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

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

Region/AO	# USE Plans	% of Total
<b>Region 1</b>	<b>5</b>	<b>3.76%</b>
Bridgeport	3	2.26%
Stamford	2	1.50%
<b>Region 2</b>	<b>33</b>	<b>24.81%</b>
Milford	19	14.29%
New Haven	14	10.53%
<b>Region 3</b>	<b>12</b>	<b>9.02%</b>
Middletown	5	3.76%
Norwich	7	5.26%
<b>Region 4</b>	<b>37</b>	<b>27.82%</b>
Hartford	19	14.29%
Manchester	18	13.53%
<b>Region 5</b>	<b>14</b>	<b>10.53%</b>
Danbury	2	1.50%
Torrington	7	5.26%
Waterbury	5	3.76%
<b>Region 6</b>	<b>32</b>	<b>24.06%</b>
Meriden	15	11.28%
New Britain	17	12.78%
<b>Grand Total</b>	<b>133</b>	<b>100.00%</b>

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

Row Labels	\$ Estimated Costs	\$ Average of Estimated Costs
<b>Region 1</b>	<b>245,286.40</b>	<b>49,057.28</b>
Bridgeport	107,172.00	35,724.00
Stamford	138,114.40	69,057.20
<b>Region 2</b>	<b>651,806.20</b>	<b>19,751.70</b>
Milford	460,510.60	24,237.40
New Haven	191,295.60	13,663.97
<b>Region 3</b>	<b>300,236.35</b>	<b>25,019.70</b>
Middletown	197,837.20	39,567.44
Norwich	102,399.15	14,628.45
<b>Region 4</b>	<b>1,210,457.40</b>	<b>32,715.06</b>
Hartford	649,641.90	34,191.68
Manchester	560,815.50	31,156.42
<b>Region 5</b>	<b>170,089.58</b>	<b>12,149.26</b>
Danbury	22,861.20	11,430.60
Torrington	80,445.78	11,492.25
Waterbury	66,782.60	13,356.52
<b>Region 6</b>	<b>278,623.80</b>	<b>8,706.99</b>
Meriden	101,644.60	6,776.31
New Britain	176,979.20	10,410.54
<b>Grand Total</b>	<b>2,856,499.73</b>	<b>21,477.44</b>

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

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

## Agency Responsiveness to the Community

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

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

During CY 2014, the SAC met 8 times. DCF’s Chief of Quality and Planning, a member of the Commissioner’s Executive Team, is staff to the SAC and attends every meeting. She has worked with the SAC to share information about Department initiatives, including those that specifically sought stakeholder feedback regarding service needs (e.g., Children’s Behavioral Health Plan Forums). They have been provided a copy of the latest Child and Family Services Plan. The Department posts its plan on its website so that the SAC and other stakeholders can easily access it. The link is as follows:

[http://www.ct.gov/dcf/lib/dcf/agency/pdf/connecticut\\_2015-2019\\_cfsp\\_revised\\_oct\\_2014\\_.pdf](http://www.ct.gov/dcf/lib/dcf/agency/pdf/connecticut_2015-2019_cfsp_revised_oct_2014_.pdf)

The SAC also developed a “Presentation Agenda” for 2014. They identified specific priority areas in which they wanted presentation from various DCF divisions (e.g., Legislation, Education, Behavioral Health, Substance Abuse Services, Family Violence). The Chief of Quality and Planning has coordinated receipt of those requested presentations. In addition, a DCF update is a standing agenda item for every SAC meeting.

In addition, during the SAC’s meeting year, the Commissioner’s Executive team presents to them about the Department’s goals, new initiative, and outcomes. Below is a listing of the Department’s 2015 Performance Expectations. The Chief of Quality and Planning went over these with the SAC. The Department’s Office of Research and Evaluation is developing a Performance Expectations Report Card. That will be regularly shared with the SAC when it is finalized.

Next, in September 2014, the SAC convened a day-long conference to identify systems issues and possible solutions. Regional breakout sessions also occurred. The areas of challenge and next steps from that day are attached has guided a variety of discussions at subsequent SAC meetings.

In addition, each RAC has a representative on the SAC. The intention is that the SAC and RAC will connect to disseminate information locally and to bring ideas and issues up to a statewide level. All RACs are provided with funds through the SAC to allow them to enhance stakeholder participation (especially parents/consumers) and to focus on areas of local priority. RACs are expected to submit an application to the SAC for these funds, outlining how they will be used. A report is also required by the

SAC from each RAC to discuss how the funds were used and how the intended goals were achieved. RAC updates are a standing agenda item at every SAC meeting.

Finally, twice a year the Department convenes a statewide meeting for all its provider agencies. An invitation is extended to the SAC. The Department shares information about its service array, upcoming initiatives and relevant data. The attendees are given an opportunity to ask questions of the Commissioner and her leadership team. These meetings are televised on the public Connecticut Television



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

### Foster and Adoptive Parent Licensing, Recruitment, and Retention

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

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

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

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

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

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

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

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

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

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

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

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

**3. Plan for Improvement and Progress Made to Improve Outcomes**

**Plan for Improvement**

The Department's plan for improvement is an extension of the implementation of our Strengthening Families Practice Model and Differential Response System. Connecticut's Practice Model is implemented through seven core strategies:

- Family Engagement
- Trauma-Informed Practice
- Family Centered Assessments
- Child and Family Teaming
- Purposeful Visitation
- Effective Case Planning
- Leadership, Management and Supervision

Over the past five years, we have made considerable progress implementing these strategies and positively impacting outcomes for the children and families we serve. In the next five year period, we will focus on three goals aimed at continuing to achieve the Department's mission that all children will be healthy, safe, smart and strong.

**Goal 1:** Children will be served in their family of origin whenever possible and appropriate.

<b>Objectives</b>	<b>Measures of Progress</b>
1. The number of children in foster care will be reduced by 25% through continued	<ul style="list-style-type: none"> <li>• Number of children in placement</li> <li>• Number of CRTM held</li> </ul>

implementation of Considered-Removal Team Meetings (CRTM).	<ul style="list-style-type: none"> <li>• Number of children diverted from placement</li> <li>• Number of children returned within 6 months of entering care</li> </ul>
2. The in-home service array will be expanded and strengthened to support keeping children with their family of origin.	<ul style="list-style-type: none"> <li>• Development of a trauma-informed continuum of services designed to ensure children remain with their family of origin.</li> </ul>
3. Forty percent of all initial placements and 30% of overall placements will be with relatives and kin.	<ul style="list-style-type: none"> <li>• Percent of children initially placed with relatives/kin</li> <li>• Percent of all children in placement with relatives/kin</li> </ul>
4. An adequate array of foster home placements is available for children who cannot be placed with their own families.	<ul style="list-style-type: none"> <li>• Number of available foster home beds per child who needs a non-relative home</li> </ul>

**GOAL 2:** Timely permanency will be achieved for all youth who enter care.

<b>Objectives</b>	<b>Measures of Progress</b>
1. Children entering care will achieve their permanency goal in a timely manner as measured by entry-cohort reports for reunification, adoption and transfer of guardianship.	<ul style="list-style-type: none"> <li>• Percent of children reunified within 12 months of entering care</li> <li>• Percent of children adopted within 24 months of entering care</li> <li>• Percent of children whose guardianship is transferred within 24 months of entering care</li> </ul>
2. Permanency Teaming will be implemented to improve the likelihood of permanency for all children and to reduce the use of APPLA by 50%.	<ul style="list-style-type: none"> <li>• The number and percentage of children in placement with an APPLA goal</li> </ul>
3. The number of youth aging out of care without legal or relational permanency will be reduced by 50%.	<ul style="list-style-type: none"> <li>• The number and percentage of youth aging out of care</li> </ul>

**GOAL 3:** Treatment in congregate care will only be used on a short-term basis, with extensive family involvement in the treatment process.

<b>Objectives</b>	<b>Measures of Progress</b>
1. The number of children placed in congregate care settings will be no more than 10% of the population of children in	<ul style="list-style-type: none"> <li>• The percentage of children and youth in placement who are in a congregate setting</li> </ul>



placement.	<ul style="list-style-type: none"> <li>• Length of stay</li> <li>• Treatment goals &amp; objectives achieved in a timely manner</li> </ul>
2. All congregate care settings have extensive family involvement as part of the treatment process.	<ul style="list-style-type: none"> <li>• The number and percentage of children whose family is actively involved in treatment</li> </ul>

### Implementation Supports

Connecticut DCF has several implementation supports that will be used to implement the goals and objectives of the CFSP. These include ongoing technical assistance from several external organizations and strong partnerships with local universities. For example, Connecticut will continue to partner with Casey Family Programs to make improvements to child welfare practice in the state. Casey supports practice innovation through direct grants to Connecticut and through ongoing technical assistance. We have also adopted a supervision model developed jointly with Yale University's Program on Supervision. We provided training and coaching on the supervision model, including the use of group supervision, to all managers and supervisors and promulgated policy to ensure it is implemented across the state. Finally, in 2014 Connecticut was awarded a university partnership grant with the University of Connecticut School of Social Work. This partnership will provide traineeships at the school of social work and will result in a child welfare concentration being added to the school's curriculum.

## Progress Made to Improve Outcomes

### Change Management

In 2012, The Department of Children and Families (DCF) established the Change Management Committee, charged with coordinating statewide change initiatives to ensure effective and consistent implementation in all regions, facilities and the central office. Embedded in this design are multiple communities of practice composed of representatives who come together either based on their function within the organization or their role relative to a specific initiative. There are currently ten (10) communities of practice (COP).

The 10 overarching committees include:

- Office Directors: charged with leading area office, special investigations unit, and Careline statewide change initiatives to ensure effective and consistent case practice.
- Systems and Clinical Program Directors: charged with assisting in shaping and implementing major system-wide policy and practice initiatives while also providing a mutual learning environment among colleagues to support effective and consistent practice. This COP is in the process of transitioning into two separate COPs. One will focus on system development and the other on the implementation of Connecticut's Behavioral Health Plan.
- Intake Program Managers with a subcommittee specific to the agency's Family Assessment Response. The Managers group is charged with planning statewide change initiatives to ensure effective and consistent intake practice in all regions.
- Adolescent Program Managers: charged with providing guidance, input, feedback, recommendations and expertise to senior leadership by ensuring ongoing planning and development of comprehensive, individualized, and coordinated programs to meet the needs of youth in every facet of out of home care.

- Juvenile Justice: charged with providing guidance, input, feedback, recommendations and expertise to senior leadership by ensuring ongoing planning and development of comprehensive, individualized, and coordinated programs to meet the needs of youth with juvenile justice involvement. This group was a subcommittee of the Adolescent Program Managers and has been operating independently for over a year.
- Foster Care: charged with recommending system improvements and coordinating the implementation of statewide change initiatives relative to the placement of children and youth in foster care.
- Early Childhood: charged with coordinating statewide change initiatives to ensure that policy development and statewide practice changes are implemented relative to the topic of early childhood.
- Nursing: charged with being a leader in providing compassionate and respectful care to CT children and their families directed by the most current nursing research and the standards of nursing best practice.
- Fatherhood: charged with the development and implementation of strategies for promoting the inclusion of fathers and their extended kinship networks in the child welfare process.
- Quality Improvement/Quality Assurance (QI/QA): charged with reviewing and implementing projects to ensure standardized quality practice in all regions, facilities, and the central office as part of the DCF quality improvement plan.

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

In 2014, the Department continued to advance the implementation of key practice changes

that were guided and informed by the Change Management process including:

- Implementation of a new supervisory model
- Child and Family Permanency Teaming
- A number of new and revised policies and practice guides that reflect practice changes
- Developing recommendations to enhance practice in key areas, such as fatherhood engagement, working with the adolescents including those involved with the juvenile justice system, and in early childhood.

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

#### Differential Response

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

In 2013, the Department implemented a QA Case Review to help evaluate our Family Assessment Response (FAR) practice. The findings of the case reviews were intended to help inform policy and practice changes to enhance service delivery.

In addition, the review helped to determine the following:

- consistency in case practice;
- fidelity to model;
- identify areas requiring further clarification; and
- identify regional training needs.

In January 2014, the FAR Quality Assurance Report was completed and disseminated to staff. The findings prompted some fairly significant practice/policy changes designed to enhance the quality of FAR assessments, including policy clarification regarding commencement, documentation, required case contacts, collateral contacts, supervision, and frequency of contact with the family during the assessment process, as well as establishing timeframes for completion of work. FAR Policy and Practice Guides were modified as a result of this review.

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

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

For the remaining 72 hour reports, the track is determined based on an assessment of the family following face-to-face contact, not on the presenting allegations at time of the call to the Careline. This approach promotes informed decisions around track determination based on a more thorough assessment of safety, risk, and needs of the family, and gives families increased access to services in the community to meet their needs. These changes became effective on June 1, 2014.

Last year, CT was averaging about 35% of CPS Reports designated as a FAR. When the change

in rule outs occurred in June, the reports designated as FAR increased to 43% and continued to increase for the remainder of the calendar year. According to data for the first quarter of 2015, we are averaging about 50% of the CPS reports designated as a Family Assessment Response. As a result of these changes in rule outs, the Department has noted a slight increase in the number of changing track from FAR to investigations. This will continue to be an area of focus for the Department this upcoming year.

In 2014, 11,987 FAR cases have been completed; 8% were transferred to investigations; 3% were transferred to ongoing DCF services; and 16% were transferred to the Community Support for Families Program for continued support. The other cases were closed following completion of the assessment.

Since March 2012, of the 26,590 reports designated as FAR, 69% of families have **not** had a subsequent report.

Representatives from the Careline and Area Office staff continue to meet monthly to address policy/practice issues relative to our intake practice. Currently a workgroup has been established to review our existing assessment tools, conduct research and develop specific recommendations to enhance the quality of our assessment process. This will be an area of focus this upcoming year.

In April 2012, funding was allocated by the legislature to provide continued support to families within their own community. Community Partner Agencies were selected through a statewide procurement process in all six DCF regions to further support families and connect them to an array of community supports and resources designed to promote the safety and well-being of children and their families. The program was designed to engage families who received a Family Assessment Response and connect them to concrete, traditional and non-traditional resources and services in their community. This inclusive approach and partnership, places the family in the lead role of its own service delivery. The primary role of the Contractor is to assist the family in developing solutions, identify community resources and supports based on need and help promote permanent connections for the family with an

array of supports and resources within their community, utilizing a Wraparound Family Team approach and philosophy. Contracted agencies have access to regional wrap funding to help families meet their basic, concrete needs. In July 2012, additional funding was appropriated by the legislature to increase statewide capacity of the program. In two of the six regions, one additional provider was added to provide this service to families within the region. Since the rule out change, the program is observing some changes in the population of families being referred to the program. Many families are presenting with significant mental health, domestic violence and substance use issues; many of whom have prior CPS history. This will continue to be an area of focus this upcoming year and a plan will be established (inclusive of training) to further support provider staff in meeting the needs of families.

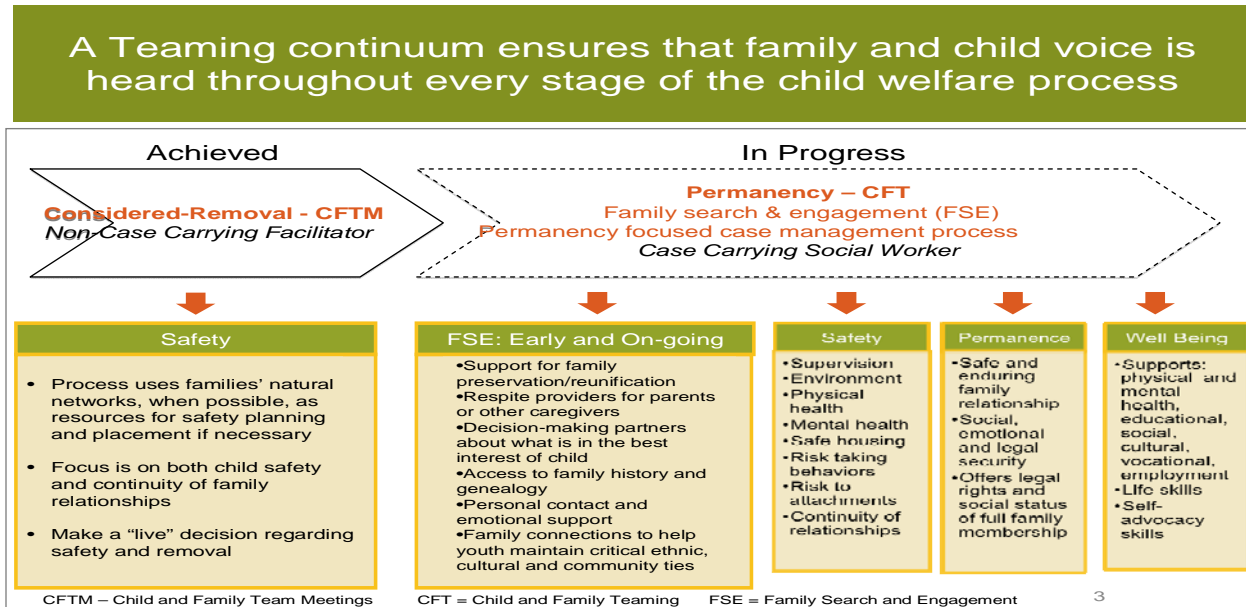
The University of Connecticut's (UConn) School of Social Work continues to function as the Performance Improvement Center (PIC) for the Community Support for Families (CSF) Program. Much of their focus has been on improving the quality of data entered by CSF staff into the Provider Information Exchange (PIE). Both PIE and LINK data extracts continue to be sent to UConn on a quarterly basis. The Department has recently expanded the current Memorandum of Agreement to have the PIC evaluate all our FAR data. This will allow us to compare outcomes for families and target specific interventions based on evaluation findings. This upcoming year, UConn will be more regionally focused and will be providing data reports for each region. Over the last several months, the Department has been working with providers and DCF staff to refine the Scope of Service and Performance Measures for the program within the RBA framework. Once the revisions have been completed, a presentation will be made to SARA for approval. The Department recently purchased the NCFAS-G which will be added to their scope of work to provide a more consistent assessment statewide and inform service delivery. Referrals to the program have averaged 17% for the 1<sup>st</sup> quarter of this current fiscal year.

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

activities relative to the program.

### CT's Teaming Model

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



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

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

### **Phase 1**

The implementation of **Team Decision Making-Step Down** meetings (TDM) for youth in



congregate care settings. TDMs were utilized for youth in congregate care settings to determine if children/youth could be returned to family or transition to a less restrictive setting. This teaming approach helped to ensure early discharge planning and appropriate lengths of stay.

## **Phase 2**

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

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

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

- Meetings are held prior to removal of a child (based on the identification of an SDM Safety Factor) from the home unless the family situation requires an emergency removal to ensure child safety;
- If child has been removed as a result of an emergency placement, a meeting will occur within two (2) business days, prior to the filing of a Motion for Order of Temporary Custody. By policy, every child who enters DCF care will have a Considered Removal Child and Family Team Meeting.
- A trained facilitator (non-caseload carrying) leads the team meeting;
- The focus of the meeting is on child safety and making a “live” decision regarding a child's removal from the home. Given the limited time and often emergent

circumstances of the meeting, in-depth case planning is not the focus or goal of the meeting;

- The voice of the youth or child is represented at the table; and
- Parents, family members, professionals and interested community members are involved in safety planning and removal-related decision making.

On February 11, 2013, the Department implemented CR-CFTM statewide. Monthly consultation days with the CR-CFTM Facilitators and Casey were held for one year post implementation for coaching, training, and case consultation. All Area Offices are staffed with trained facilitators and back up Facilitators. In October 2013, Annie E Casey conducted a Train-the-Trainer session using Training Academy staff and a number of CR-CFTM facilitators as trainers to ensure sustainability and identify additional back up facilitators in the regions to help support the work. An additional TOT session was held this year to promote adequate coverage in all regions.

This past year, a workgroup was established to assess our implementation of CR-CFTM and identify recommendations to improve practice. All regions were represented in the workgroup which included CR-CFTM Facilitators, Office Directors, Intake Managers, and Central Office staff.

The workgroup reviewed CR-CFTM data from January – July 2014 and identified strengths and challenges related to our CR-CFTM practice. The following represents a brief summary of our findings:

- Overall offices have embraced teaming as vital aspects of practice;
- The majority of meetings are held prior to a child's removal;
- Recommendations for removal are low- attempts being made to preserve families;
- Staff are using relatives and kin in safety planning;
- When removal is recommended, relatives/kin are the primary recommended placement resource for children;

- Success in bringing mothers and fathers to the table;
- Staff are effectively managing intra-meeting conflict;
- Offices have created warm and friendly spaces for meetings;
- High levels of creativity and critical thinking in planning for children and families;
- CR-CFTM is building the foundation for Permanency Teaming;
- Skill building opportunities for staff who participate;
- Building partnerships for shared understanding and responsibility in safety planning;  
and
- Meetings are viewed as a way of helping families.

This process identified a number of challenges in our practice in four distinct areas:

#### 1. Model Fidelity

- a. Many of the CR-CFTM Supervisors have not been trained on the model
- b. Pre-meetings were not consistently being held to review safety factors and discuss non-negotiables
- c. Varied implementation in staffing and trigger for meeting
- d. Low youth participation in meetings

#### 2. Workforce Development

- a. Some staff, at all levels, have not embraced teaming (lack of buy-in)
- b. Varied application in use of Family Arrangement
- c. Organizational issues: staff turnover, high caseloads

#### 3. Quality Assurance

- a. Current system does not allow an opportunity to evaluate outcomes of CR-CFTM longitudinally
- b. No statewide QA Plan has been developed to assess CR-CFTM practice

#### 4. Data

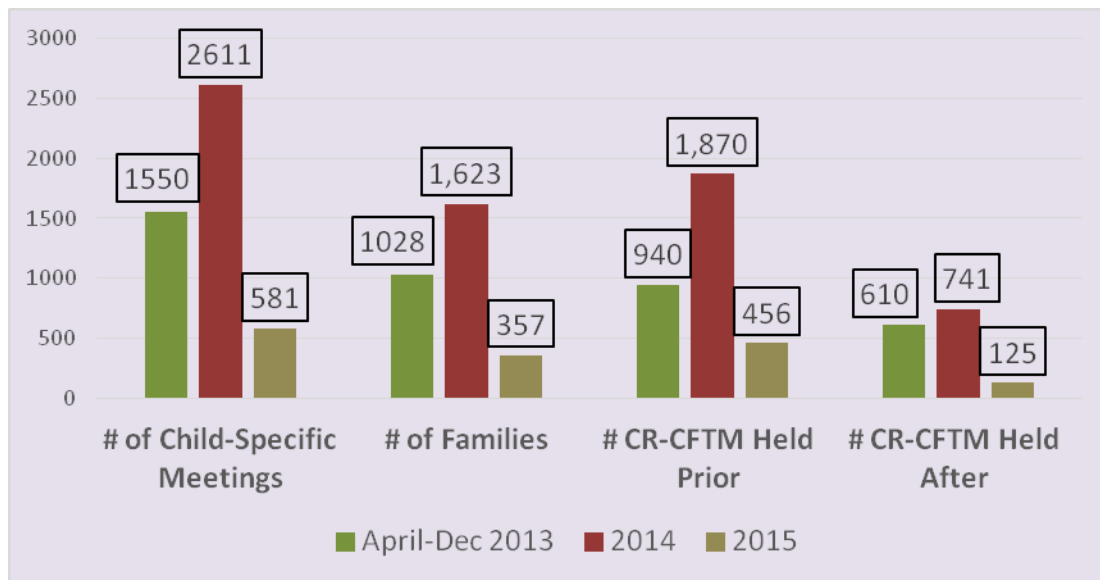
- a. Current system does not allow us to fully evaluate the efficacy of the CR-CFTM process.
- b. Current build limits ability to aggregate data to assess child and family outcomes
- c. Inconsistent documentation and data entry

An implementation workplan was developed to address the challenges/issues identified through this process. This has been the primary focus of our work. The following activities occurred this past year:

- Area Office trainings conducted by CR-CFTM Facilitators to increase staff's understanding of the model and benefits of the CR-CFTM process, importance of youth and relative participation in meetings, engaging parents in the CR-CFTM process, clarify roles/responsibilities, the trigger for meetings, the importance of pre-meetings, identifying the non-negotiables, and the importance of a "live decision" and being open to the various options that might be presented.
- CR-CFTM Practice Guide was updated to clarify practice
- A LINK User Guide was created to increase consistency in documentation
- CR-CFTM Facilitators led discussions with Area Office staff to develop strategies for greater youth participation in meetings
- Collaborating with the QI/QA Community of Practice to develop statewide QA Plan, inclusive of a case review tool
- Maintain quarterly CR-CFTM Facilitator meetings led by the central office lead.

### CR-CFTM Data

The chart below represents CR-CFTMs documented in LINK since April 2013. The data represents the full calendar year of 2014 and the 1<sup>st</sup> quarter of 2015. These are child specific meetings and includes children who may have had more than one meeting.

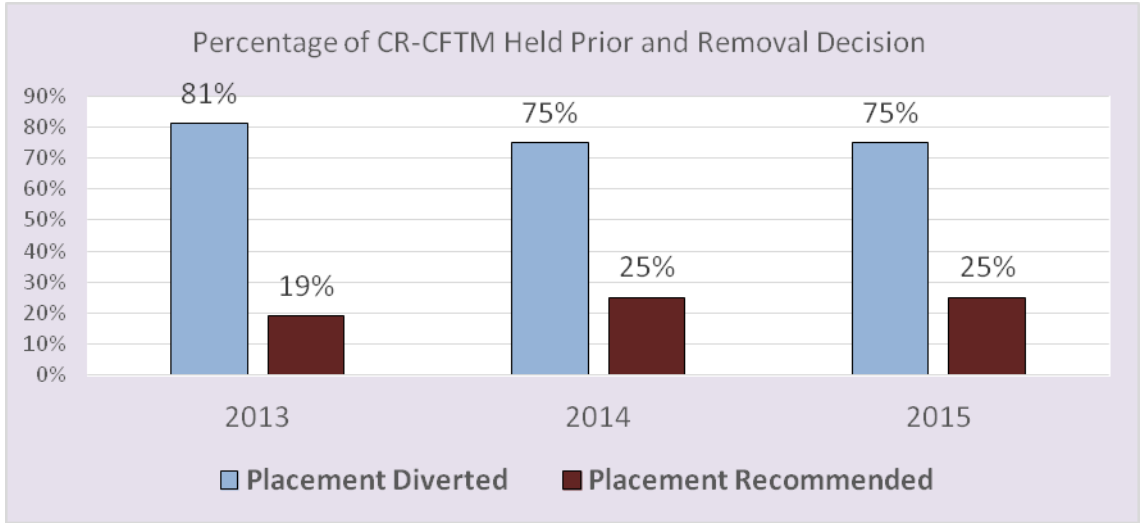


In 2013: 61% of meetings occurred prior to removal; 39% occurred after child's removal.

In 2014: Total of 2,611 child specific meetings, involving 1,623 families; 72% of meetings were held prior; 28% occurred after removal.

In the 1<sup>st</sup> quarter of 2015, the trend continues – 78% occurred prior; 21.5% occurred after child's removal.

The chart below represents the percentage of CR-CFTM Held Prior and Removal Decision. The data includes CR-CFTM that occurred prior to removal within the same timeframe described above.

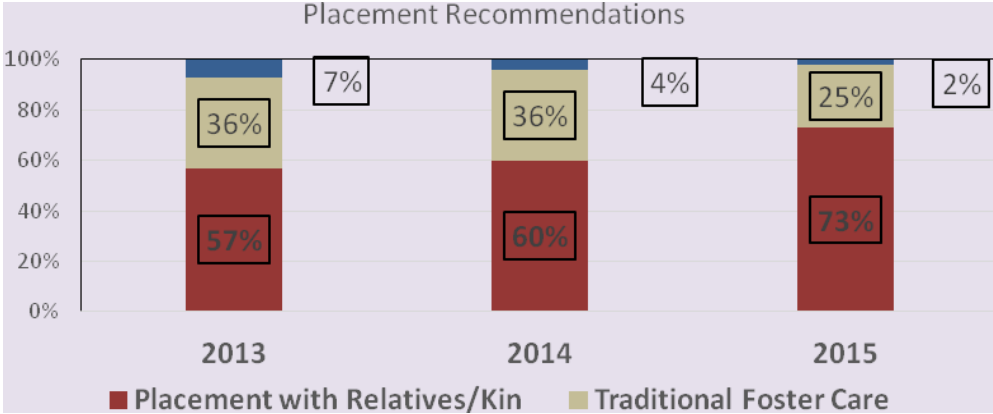


In 2013, of the 940 children who had a meeting prior to removal, removal was not recommended for 764 children.

In 2014, of the 1,870 children who had a meeting prior to removal, removal was not recommended for 1,411 children.

For the 1<sup>st</sup> quarter of 2015, of the 456 children who had a meeting prior to removal, removal was not recommended for 342 children.

This chart represents the CR-CFTM held prior to removal since April 2013 through the 1<sup>st</sup> quarter of 2015.

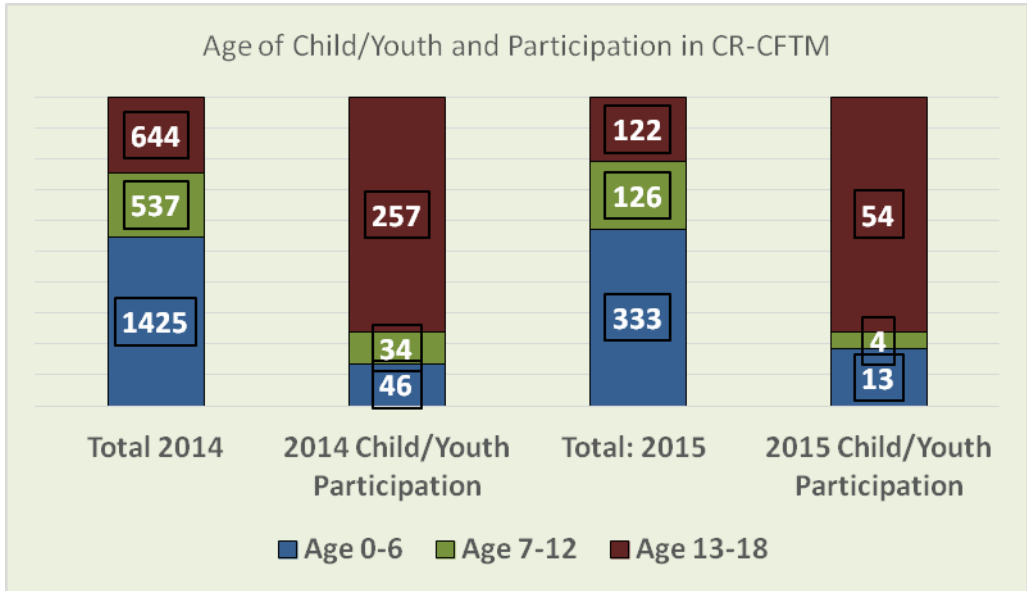


If meetings are held prior to removal, children are more likely to be placed with relatives/kin.

For meetings that occur following a child's removal, children are more likely to be placed in traditional foster care settings.

The Department also compared the recommended placement versus the actual placement of the child and found that the recommended placement made during the meeting is consistent with the child's actual placement.

The chart below represents the age of the child/youth and their participation in a CR-CFTM. It includes 2014 data and the 1<sup>st</sup> quarter of 2015.



More CR-CFTM are held for children ages 0-6.

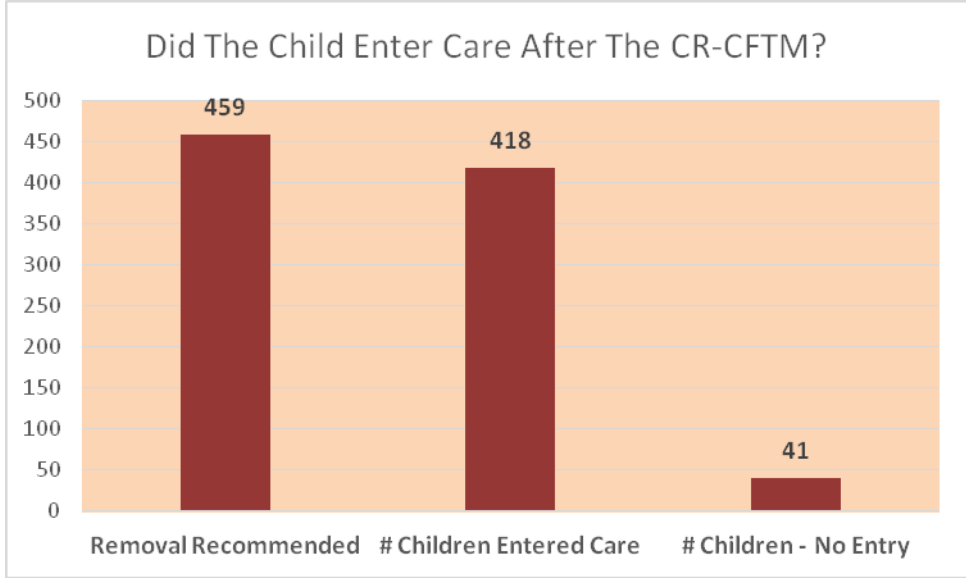
The child/youth participation continues to be low.

In 2014: For youth ages 13-18, only 40% participated in their CR-CFTM. This is important because when youth participate in their meetings they are less likely to experience a recommendation for removal.

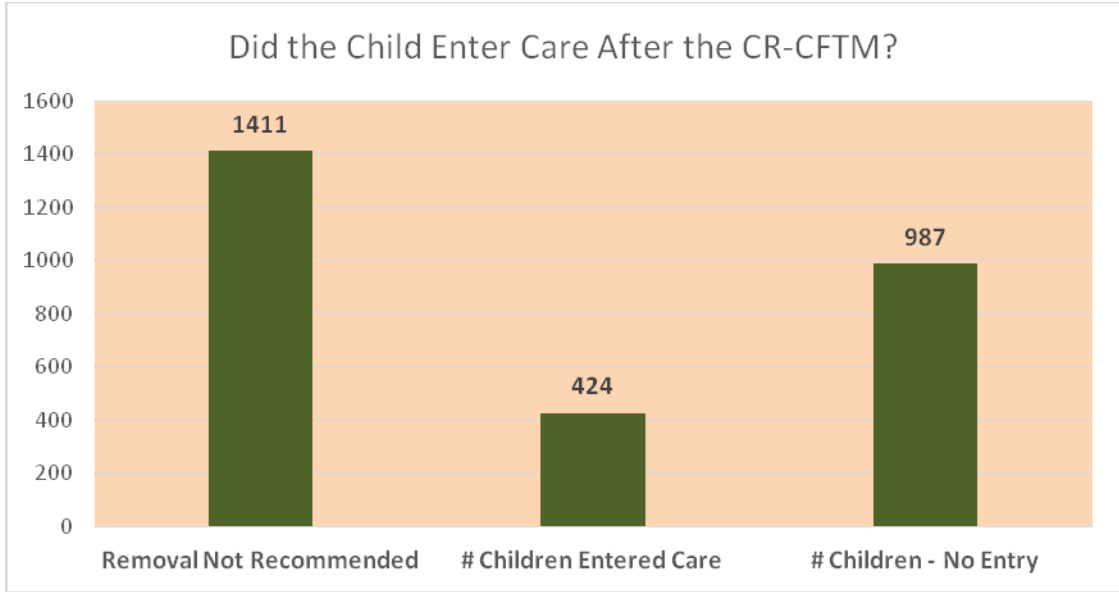
Increasing youth participation in meetings will continue to be an area of focus for the Department this upcoming year.



The two charts below represent 2014 data and includes CR-CFTMs held prior to a removal.



Removal was recommended for 459 children; 418 children entered care; 41 did not enter care.



For children in which removal was not recommended (1411), 424 children entered care; 987 children did not enter care.

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

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

### **Phase 3**

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

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

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

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

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

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

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

- involves a team and a social worker facilitator;
- is customized to fit the child/youth's needs;
- uses Family Search and Engagement to reconstruct a child's/youth's relationships over time and in locating family members and others who will participate in Permanency Child and Family Teaming. In the case of in home situations, it is designed to develop and support the family's natural support network;
- uses outreach to maximize participation of youth and family members;
- shares responsibility for planning and decision making among team members;
- addresses safety, permanency and well-being;
- identifies a permanent legal parent for each child/youth to provide day-to-day parenting that is safe and emotionally secure;
- reflects a sense of "urgency" (child's sense of time) in accordance with ASFA timelines and agency case practice standards;
- utilizes a concurrent planning framework;
- includes a blend of individual, joint and large team meetings;
- prioritizes relationship-building between and among team members, especially the youth, family members; and caregivers and other adults significant to the youth

- continues as long as a child/youth is receiving DCF services and has not achieved legal permanence

This approach is consistent with the essential elements of a trauma-informed system as it attempts to minimize disruptions to safe, healthy relationships as well as separations from attachment figures, thereby supporting children exposed to trauma and reducing potential secondary trauma.

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

The focus this year has been predominately to build internal capacity of regional staff to support full implementation of Permanency Teaming. The following represents a summary of our work this past year:

- Disseminated Permanency Teaming Policy and Practice Guide and held regional meetings to review/clarify practice
- Permanency Teaming has been identified as a regional strategy in the achievement of the Department's Performance Expectations (quarterly meetings held with administration to review progress)
- Monthly calls held focused on permanency teaming practice
- Identified regional staff to function as coaches to support implementation efforts
- LINK Release deployed to document Large Team Meetings
- Facilitation and Permanency Preparation training offered through the Training Academy to Regional Staff
- Permanency Exchange Specialists assigned to each region to provide technical assistance/support to regional staff. Their scope of work includes child-specific

recruitment, family search and engagement activities, including intensive case mining, outreach and engagement of relatives/kin, and consultation

- Regional case consultation sessions facilitated by Casey
- Permanency Preparation training offered to Congregate Care, Therapeutic Foster Care and PPSP providers by national model developer
- Brown bag lunches scheduled between each area office and their respective Superior Court partners at the local level

The Permanency Teaming Training has been completed for all staff. Make up sessions will be offered and an abbreviated session has been created to ensure central office staff and providers have a basic understanding of this approach.

The Department, in collaboration with Casey, is conducting an implementation study designed to assess our implementation of permanency teaming. Staff from two regions were identified to participate in the study. Staff participating in the study completed a survey prior to training focusing on family search and engagement strategies to produce a baseline of practice and the same survey was distributed three months following training to determine whether there have been any changes in practice as a result of the training. Data was collected covering a period of 2 months. Focus groups were conducted with staff, youth and family members designed to gauge practice changes. Staff provided feedback around what worked well, what some of the challenges were, and recommendations for curriculum changes. The focus group for youth and family gathered feedback about their experiences and how they view the teaming process. Results of the study are forthcoming.

In April 2015, a Law Forum was held focused on Permanency Teaming. Judges, contracted attorneys, AAGs, court staff and DCF staff were in attendance. The purpose of the forum was to inform the legal community of the Department's practice change and the importance of assuring children and youth exit the system with strong permanent supports that will sustain them throughout their childhood and into adulthood. Following the morning session of national speakers, a youth panel, and an overview of CT's Teaming Continuum, regional

breakout sessions were held to reflect on the morning session and to have a discussion around the strengths, barriers, and strategies to enhance permanency outcomes for children/youth. A follow up session was scheduled for June 11, 2015 with court staff, DCF and provider staff to address some of the issues/challenges identified in the Law Forum. Following a brief overview of the model, a youth panel, two regions focusing on practice and implementation of permanency teaming and a provider panel convened. Regional breakout sessions occurred in the afternoon to discuss what is working well and the challenges they face within the region regarding permanency teaming. The regional groups were also charged with developing recommendations to address barriers/challenges identified as well as identify data they would like to review for the region. The regions will continue to be meeting locally with providers and court staff to further the work and partnership in this area.

#### [Permanency Roundtables:](#)

In July 2013, the Department of Children and Families (DCF) utilized the Permanency Roundtable (PRT) methodology developed by Casey Family Programs as an opportunity to put further emphasis on permanency outcomes primarily for older youth in care. One hundred and thirty six youth were reviewed through the PRT experience, supported by Central and Regional office staff, private providers and multiple consultants from across the country. Eighty-four percent (84%) of the youth had a permanency goal of Another Planned Permanency Living Arrangement (APPLA) while the remaining 16% had goals of either reunification or adoption. Those youth who were the focus of this effort were on average 15.8 years old.

Permanency Roundtables (PRT) is an event driven process involving professionals and including the youth's Social Worker (SW) and Social Work Supervisor (SWS) along with a host of other professional stakeholders who review cases through a structured and facilitated process. This served as a precursor to the Department's implementation of Child and Family Permanency Teaming (CF-PT). Unlike Roundtables, CF-PT are ongoing team meetings that focus on the process and create a sense of urgency inclusive of children/youth, their families and natural networks of support, in addition to the professional team.

Several of the recommendations from the Roundtables have been implemented to align with the agency's commitment to Child and Family Permanency Teaming including:

- Significantly limiting the use of OPPLA as a permanency plan and a need for additional attention on concurrent planning. The Department has adopted a working definition of permanence and established guidance and developed a protocol around the consideration of OPPLA. In addition, recent legislation has been introduced to comply with Public Law 113-183 further limiting its use for youth under the age of 16.
- A number of cases revealed a historical lack of outreach to father's and paternal relatives. This is a trend experienced nationally and one that is beginning to gain attention. DCF has invested in a robust database that will assist in the location of relatives and is also accompanied by important practice changes to further support comprehensive outreach, including issuing practice expectations related to fatherhood engagement, the development of a Fatherhood committee charged with developing practice recommendations to promote and measure fatherhood engagement and the use of Considered Removals to examine important supports to minimize the need for out of home placements when kin may be available. The implementation of permanency teaming will further these efforts.
- Subsidized Guardianship currently provides a permanent plan for children in the care and custody of the Department of Children and Families (DCF) who are placed by DCF with licensed relative caregivers and who cannot return home due either to the death of a parent or the inability to provide a home within the foreseeable future. There were many examples where the achievement of permanency was limited due to the eligibility requirement of the caregiver being related, excluding those individuals who are part of the youth's natural network but do not meet the threshold of "relative". In this recent legislative session DCF submitted a proposal to eliminate the requirement that the caregiver be related to broaden the pool of potential resources, honor the fictive relationships that exist among people and increase positive permanency

outcomes for youth. This proposal was accepted and will go into effect in the fall. A transfer of guardianship would afford a youth full family membership without legally severing their ties to birth parents.

- Staff and youth have repeatedly expressed interest in maintaining connections after their case is either closed or their case has been reassigned. In partnership with DCF's Human Resources Department, DCF has drafted policy language to develop a review and approval protocol to consider these types of situations.
- In order to assure key contracts reflect the continuum of permanency options contract revisions have been completed for the Permanency Placement Services Program (PPSP). The revisions highlight service delivery to families formed through adoption, reunification and now guardianship as well and further emphasize key practice elements relative to permanency preparation.

### Reducing Out of State Placements

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

### Efficient Use of Congregate Care

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

The Department made practice and policy changes that promoted placement of children in



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

From January 2011 to April 2015:

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

#### [Limit the use of OPPLA](#)

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

- Utilizing the permanency roundtable methodology
- Developing and implementing an OPPLA protocol
- Working group to further limit the use of OPPLA both in practice and statute
- Implementation of a Child and Family Permanency Teaming approach that puts the youth and family in the center of the teaming process.

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

Trauma Informed Continuum:

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

- To date DCF has trained all of our staff in the NCTSN Child Welfare Trauma Training and continue to train new hires.
- Laura Lipsky, author of Trauma Stewardship, conducted a two day conference in the fall of 2014. The first day for 350 staff and the second designed specifically for 90 staff connected to our Health and Wellness work.
- CT is actively involved in the New England Convening on building a Trauma-Informed Resilient Child Welfare Agency hosted by the NE Association of Child Welfare Commissioners and Directors.
- Regional and facility Health and Wellness teams develop activities and opportunities to support staff wellness and reduce secondary trauma
- The CONCEPT core team reviews all agency policy to assure a trauma informed lens is applied. To date having reviewed and revised 23 separate policies.
- Screening has been a very involved process where the agency has benefitted from our partnership with Yale and the Child Health and Development Institute (CHDI) in testing different tools and arriving at the current tool – a 10 item screen that has been embedded into the Multidisciplinary Evaluation completed for all children 7 and above when they enter care. For younger children there is a screening tool that asks questions of the caregiver.
- One of DCF's Area Office's is also engaged in a pilot – identifying a cohort of children where screening is completed and re-administered at the time of the Administrative Case Review (ACR)
- A pilot study to validate the shorter screening tool is underway in partnership with Yale Child Study Center that involves the screening of children at intake.
- The dissemination of Evidenced Practice Models has continued including: the start of

a learning collaborative in October 2014 for The Child and Family Traumatic Stress Intervention.

- In years 2 and 3 of CONCEPT TF-CBT dissemination continued and included service to the Juvenile Justice population.

### [Relative/Kinship Care and the Child Welfare Group Strategy Work](#)

History of progress and accomplishments since 2010:

In 2010, there was a change in structure and oversight of foster care with management shifting primarily to the DCF regions. In that same year, DCF staff completed a literature review of current Safety and Risk Assessment Tools used on foster parents and relative caregivers at critical points in time including but not limited to: point of licensure, investigations, support visits and placement of a child. The Department worked closely with the Children's Research Center to develop Structured Decision Making Assessment Tools. Implementation of these tools however, was deferred due to staffing concerns and the number of competing initiatives the Department was pursuing at the same time. The Department will assess the feasibility of implementation in the future.

The Department consulted with Annie E. Casey Foundation's Child Welfare Strategy Group (CWSG) to conduct a data driven assessment of our work to generate ideas about how we can make additional sustained improvements in achieving permanency and improving well-being for children and youth in our system. The areas of assessment included a review of strategies for foster/adoptive/kinship parent recruitment and support, treatment foster care, congregate care, and overall practice. Assessing the safety and risk of our foster families and relative caretakers was included in this process. CWSG conducted individual and group interviews/observations with a wide spectrum of stakeholders including DCF staff, resource families, birth families, youth, and community partners.

Without question, placement of children with relatives has been a priority for DCF since 2010; and placement in non-relative care has been considered an exception. To this end, in early 2011, DCF streamlined procedures to assess and approve relatives for placement.

These efforts included the following:

- Staff were designated in each region to conduct emergency assessments of relative homes;
- The waiver process was modified for relatives. This allowed for a more thorough assessment of strengths;
- Reduced the number of DCF staff required approve requests for waivers;
- A comprehensive database was created to track the number of placement requests for relative care and the potential barriers for licensure;
- Monthly data provided to the DCF regions documented requests and the percentage of children within each region placed with relatives.

The second phase of CWSG scope of work in 2011 included the following areas:

- Recruitment and Support of Relatives and Other Resource Families - streamlined the structure for recruitment, development and support of resource families;
- Communications Capacity Building - increased DCF's capacity to effectively communicate to the public and key stakeholders;
- Congregate Care Rightsizing - enhanced the family engagement element of the Strengthening Families Practice Model by implementing facilitated family meetings at all major decision points, involve families of children in congregate care in placement selection, treatment, and discharge planning;
- Financing - conducted a fiscal analysis and provide recommendations regarding how to strengthen the array of services.

In January 2011, DCF requested Casey Family Programs facilitate a Peer Technical Assistance session to develop strategies designed to increase the use of kin at time of placement. Teams from Pennsylvania's Department of Human Services and Tennessee's Department of Children's Services came to Connecticut to share their experiences with the use of kin and kin engagement. The Department gathered protocols and manuals from other jurisdictions that demonstrated success utilizing relative resources for children requiring out of home

placement. As a result of these facilitated discussions, the Department identified concrete strategies on how to more effectively utilize kin, including streamlining procedures for approving relatives for placement. In addition to the Peer Technical Assistance, the CWSG conducted Business Process Mapping in the Bridgeport DCF Area Office to identify practice limitations and/or barriers with the initial placement of children into relative care. This analysis identified several barriers and inconsistencies in our practice in the following areas: identification/exploration of relatives, licensing process, use of waivers, communication, and lack of support. Case reviews were conducted to identify systemic issues that could be modified to increase use of relative placements. Also in 2011, the Department established a partnership with the CT Chapter of the NAACP to conduct relative care forums and to promote the need for relative resources.

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

Results of these coordinated efforts and expectations are clear. From January, 2011 to April, 2014 our Department has seen a decrease in children in placement by 17% (from 4770 to 3971). Also since 2011, we have seen an increase in relative/kin placement from 21.1% to 35.7% (April, 2014). We have reduced out-of-state congregate care placement from 363 to 12 youth. The percent of our youth in congregate care has also been reduced from approximately 30% to 16.2% (as of April, 2014). In 2013, Regions establish "firewalls" (i.e., specific staff who approve all non-relative and kin placements prior to a youth coming into state custody). This individual's responsibility was to ensure that prior to a child going into non-relative or kinship care, all possible relative and kinship care supports and placement options were pursued. This "firewall" staff is a manager within each Region outside of the decision making chain of command for that specific case. As of May, 2014, the Commissioner has directed that for any DCF Area Offices whose congregate care placement rate is greater than 15%, any non-family based placements must be approved by her.

As a result of all of these efforts, during the calendar year 2012, the Department increased

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

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

In spring 2014, the Adoption Resource Exchange Unit underwent a name change to better represent the significant contributions they were making to the Department's permanency work and reflect the mission and goals of the Department. They are now known as Adoption/Permanency Resource Exchange (APRE). In 2014 there were 100 preadoptive families available and today there are 53 available to these children as potential resources. We believe that these numbers are dropping as more prospective adoptive families begin their adoptive journey as foster parents and adopt those children whom they foster.

Photo listing on AdoptUsKids website, A Family for Every Child website, and on the DCF website where photos and videos of the child are posted and made available to the public.

#### **4. Service Description**

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

The following chart represents our Services Continuum:

<p><b>Adolescent Community Reinforcement Approach / Assertive Continuing Care (ACRA-ACC)</b> – This is an evidence-based outpatient behavioral therapy for substance using adolescents and their caregivers. When the recovery goals are attained through ACRA, the adolescents can then be referred to the recovery support ACC portion of the service. ACC also provides case management services to assist with accessing other needed services.</p> <p>Category: Family Support service          Population Served: Substance using youth between 12-17 years old          Geographic Area: Statewide          Estimated Families Served: 432</p>
<p><b>Adopt A Social Worker</b> - This is a statewide, faith based outreach service linking an "adopted" DCF Social Worker with a faith-based or other "covenant organization" to assist with meeting the basic material needs of DCF involved families (those with protective service Social Workers as well as foster, adoptive and kinship care families). Meeting the needs of children with, for example, beds, cribs, clothing and household furnishings, will help achieve stabilization of families and permanency for the children.</p> <p>Category: Family Support and Family Preservation services.          Population served: All DCF involved Families          Geographic area served: Statewide.          Number of children and families being served: Unavailable</p>
<p><b>Care Coordination</b> - This service provides high fidelity "Wraparound" through the use of the Child and Family Team process. Wraparound is defined as an intensive, individualized care planning and management process for youths with serious or complex needs and is a means for maintaining youth with the most serious emotional and behavioral problems in their home and community. The Wraparound process and the written Plan of Care it develops are designed to be culturally competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision.</p> <p>Category: Family Support Services service.          Program uses the 4 family focused fluid stages of Hello, Help, Healing and Hope. There will training this year in this new construct.          Population served: Families with a youth with a behavioral health diagnosis for whom DCF is not involved.          Geographic area served: Statewide.          Number of children and families being served: Approximately 1200</p>
<p><b>Care Management Entity (CME):</b> designed to serve children and youth, ages 10-18, with serious behavioral or mental health needs who are returning from congregate care or other restrictive treatment settings (emergency departments/in-patient hospitals) or who are at risk of removal from home or their community. The CME will provide direct services and administrative functions. At the direct service level, the CME employs Intensive Care Coordinators (ICCs) and Family Peer Specialists (FPS) who use an evidence based wraparound Child and Family Team process to develop a Plan of Care for each child and family. At the administrative level, the CME assists DCF in developing local and regional networks of care, which includes the CONNECT federal System of Care grant activities.</p> <p>Category: Family Support Services and Family Preservation service.          Population: Any child residing in a congregate care setting and child and youth who are frequent users of Emergency Departments and In-Patient settings.          Geographic Area served: Statewide          Number of children and families served: 150 to 160</p>
<p><b>Caregiver Support Team</b> - This service is designed to help prevent the disruption of foster placements and increase stability and permanency by providing timely in-home interventions with a child and family. For kinship families, this intensive in-home service is provided at the time the child is first placed with the family. The service will be available at critical points for the duration of the placement when additional supports are deemed necessary.</p>
<p><b>Child Abuse Pediatricians (CAP)</b> – This service will provide support and consultation regarding child safety, child abuse and neglect identification and confirmation, and safety planning and decision making. The CAP contractor will also review a subset of non-accepted reports for infants younger than 12 months of age (highest risk group). Additionally, the CAP contractor will deliver education to Area Office and Careline staff regarding abuse and neglect prevention, early identification, recognition, and intervention.</p> <p>Category – Family Preservation / Family Support          Population served – any child who comes to the attention of the DCF Careline for whom the Careline manager has questions. This project is specific to support primarily to Careline after hours and weekends.          Geographic area – statewide          Number of children/families served – we are in the 4<sup>th</sup> month of an 8 month project. 47 specific cases have been discussed.</p>

**Child First Consultation and Evaluation** - This service ensures provider fidelity to the Child First model which provides home-based assessment and parent-child therapeutic interventions for high-risk families with children under six years of age. To that end, the service delivers training, provides reflective clinical consultation, analyzes data, provides technical assistance, insures continuous quality improvement, and certifies sites that have met Child First model standards.

Service Category: Family Support

Population(s) to be served -Children ages 0-6

Geographic areas: Statewide

Estimated number of individuals and families to be served in 2016: 350

**Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**: is a skill based, group intervention aimed at relieving symptoms of Post-Traumatic Stress Disorder (PTSD) and general anxiety among children and youth who have experienced trauma. This school based treatment model will enhance the school's mental health service array to support student's learning potential and build resiliency. CBITS is designed to minimize developmental disruption and promote child recovery and resiliency for student participants through a cognitive-behavioral therapy approach that involves components of psycho-education, relaxation, social problem solving, cognitive restructuring and exposure.

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

Population(s) to be served -Children ages 6-17

Geographic areas: Bridgeport

Estimated number of individuals and families to be served in 2016: 360

**Community Based Life Skills** - This service, through the use of a DCF approved curriculum along with DCF approved experiential learning approaches, provides youth with a set of skills necessary to assist in their transition from DCF care to self-sufficiency.

This service includes life skills assessment services followed by 80 hours of classroom educational service to the clients followed by 30 hours of 1:1 educational services. Service provides youths with life skills assessment and instruction components (for skill development and acquisition).

Category: Family Support.

The population served is committed youths 15 and older.

Geographical area served: Statewide

Number of children and families being served: -196

**Community Support for Families** - This service will engage families who have received a Family Assessment Response from the Department and connect them to concrete, traditional and non-traditional resources and services in their community. This inclusive approach and partnership, places the family in the lead role of its own service delivery. The role of the contractor is to assist the family in developing solutions, identify community resources and supports based on need and help promote permanent connections for the family with an array of supports and resources within their community.

**Community Support Team** - This service is provided in conjunction with the DCF New Haven Area Office and focuses on assessment, treatment and support for children and youth in out-of-home levels of care transitioning back to the community. Services include but are not limited to: in home clinical interventions and supports; delivery of therapeutic services that facilitate and support family problem solving; family education and guidance; and linkage to natural support systems.

**Community Targeted Re-Entry Pilot Program (CTRPP)** - -This service provides pre-release and post-release services for male youth at the Connecticut Juvenile Training School (CJTS) including social and life skill building, vocational and career development, psycho-educational programming including character development and leadership and recreational opportunities. In addition, the Boys & Girls Club offers services on the campus of the Connecticut Juvenile Training School.

**Community Transition Program** - This service is provided in conjunction with the Norwich Area Office and does assessment and care planning for children / youth who are transitioning from out-of-home levels of care to the community. Services are also provided to keep children/youth who are in the community from being placed in out-of-home care.

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

Category: Family Support and Family Preservation

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

Geographic Area: Statewide

Estimated Families Served: 4000 calls first operational year

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



the child.

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

Service Category: Family Support

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

Geographic areas where the services will be available -Statewide

Estimated number of individuals and families to be served in 2016: 350

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

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

Category: Family Support Services and Family Preservation service.

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

Geographic Area served: Statewide

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

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

Category: Family Support Services and Family Preservation service.

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

Geographic Area served: Statewide

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

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

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

Population served: Ages 5-17

Geographical Area: Statewide (19 sites)

Number of Children Served: 1073

**Family Based Recovery** - This service is an intensive, in-home clinical treatment program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance abuse. The overarching goal of the intervention is to promote stability, safety and permanence for these families. Treatment and support services are provided in a context that is family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance abuse treatment for the parent(s) and attachment-based parent-child therapy to the parent-child dyad.

Category: Family Support Services and Family Preservation service.

Population served: An infant (birth – 3 years) who is at risk of an out-of-home placement due to parental substance abuse. A parent who has used substances within past 30 days

Geographic area served: Statewide

Number of families to be served: Annual Capacity: 240 Clients (Length of service is variable 7 - 18 months, depending upon needs of the family)

**Family and Community Ties** - This service is a foster care model that combines a wraparound approach to service delivery with professional parenting for children with serious psychiatric and behavioral problems. This service is differentiated from other foster care services by (a) the frequency and intensity of clinical contact and (b) flexibility in providing "whatever it takes" to preserve the placement of a child in a family setting. Within this program, foster parents will serve as full members of the treatment team and will complete intensive training in behavior management.

Category: Adoption Promotion and Support Services service.

Population served: Children with serious psychiatric and behavioral problems

Geographic area served: Statewide

Number of families to be served: Approximately 53.

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

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

Category: Adoption Promotion and Support Services service.

Population served: All licensed families (all license types)

Geographic area served: All areas of the state

Number of families to be served: All licensed families (all license types)

**Foster Care and Adoptive Family Support Groups** - This service provides both avenue and child care for support group meetings for foster care and adoptive families as a means to aid in the retention of foster homes and placement stability within foster and adoptive family settings. Childcare is also provided to the licensed families at these support groups.

Category: Adoption Promotion and Support Services service.

Population served: All licensed families (all license types)

Geographic area served: All areas of the state

Number of families to be served: On Average there is approx. 6 to 10 licensed individuals at the support groups.

**Foster Family Support** - This service provides a variety of support services to children in DCF care who are living with foster and relative families in Bloomfield. The support services include, but are not limited to: individual, group and / or family counseling; crisis intervention, social skills development; educational activities; after school and weekend activities.

Category: Adoption Promotion and Support Services.

Population served: All licensed families (all license types)

Geographic area served: Waterbury and Torrington

Number of families to be served: 20 per month. The Contractor will maintain the capacity to serve at least 20 foster parents per support group meeting and provide for child care and child activity programming for up to 20 children per support group meeting, while the licensed foster and adoptive parents are meeting.

**Foster Parent Support for Medically Complex** - This service, largely through the organization of a group of volunteers, provides foster care recruitment, respite and support focused on maintaining and growing the number of foster and adoptive parents who work with medically complex children in the Waterbury and Torrington area office towns. There is a child care/activity component to the program and a limited amount of money is available for participating foster parents. There are two yearly celebrations, a holiday party and annual picnic.

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

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

Service type: Family Support, Family Preservation

Target Population: DCF youth, male and female, ages 15 through 19 years old, who are residing in the region and who are committed as delinquent.

Exceptions will be made on a case by case basis for: 1) those younger than 15, as well as, 2) adolescents involved with the department who present with delinquency issues but are not committed as delinquent.

Geographic Area: Statewide

Estimated Families Served: 297 slots contracted FY 15

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

Category: Family Support and Family Preservation service.

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

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

Number of families to be served: 557

**High Risk Infant Program** - This service is a long term, residential substance abuse treatment program for pregnant and parenting women and their children. This service is licensed by the Connecticut State Department of Public Health to accommodate eight women and seven children in residence. It is a structured, drug-free residential and program environment composed of various components to meet each resident's individual, medical, emotional and specific treatment needs. The parents receive education and skills training in order to understand and have positive interactions with their children.

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

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

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

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

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

**HOMEBUILDERS** - This service is an evidence-based model designed to strengthen families, keep children safe and prevent unnecessary out-of-home placement or safely reunify children with their family following a removal from home. This service an intensive, in-home crisis intervention, counseling and life-skills education for families who have children at imminent risk of out of home placement or have children in placement that cannot be reunified without intensive services. HOMEBUILDERS provides a short-term (4 week) intensive service intervention and family treatment program designed to keep children and families safe, prevent the unnecessary out of home placement of children, and to safely reunify children and families.

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

Population Served – The target population includes only those families whose children are in imminent danger of out of home placement or cannot return home without intense services. Families to be served include biological and adoptive families referred by DCF and includes DCF active families only.

Geographic Area – This is a pilot program in Region 5 and serves the Waterbury, Torrington and Danbury DCF geographical areas.

Estimated number of Individuals and Families to be served – A minimum of 45 families will be served annually.

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

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

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

Geographic Area: Statewide

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

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

Category: Family Preservation service.

Population Served: The target population for this service includes DCF active in-home cases only. This service is delivered when there is an emerging removal concern for children from birth through 17 years of age.

Geographic Area: Statewide

Estimated number of Individuals and Families to be served – A minimum of 1,062 families will be served annually.

**Intensive In-Home Child and Adolescent Psychiatric Services IICAPS - (Consultation and Evaluation)** - This service provides program development, training, consultation, and clinical quality assurance for all Department of Children and Families (DCF) approved Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) service providers. The IICAPS statewide providers work with children and youth who have returned or are returning home from out-of-home care and who require a less intensive level of treatment, or are at imminent risk of placement due to mental health issues or emotional disturbances.

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

Target Population: Children and adolescents ranged in age from 4-18 years with complex psychiatric disorders

Geographic Area: Statewide

Estimated Families Served: 2100-2250 annually

**Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)** - This service is a curriculum based treatment model designed to divert children and adolescents, i.e. those who have a DSM-IV Axis I diagnosis and who exhibit complex behavioral health needs, from psychiatric hospitalization or to support discharge from inpatient levels of care. This is an intensive, home-based service designed to address specific psychiatric disorders in the identified child while remediating problematic parenting practices and/or addressing other family challenges that effect the child and family's ability to function. This service offers five levels of intervention, from as little as 1-3 hours per week to as much as 12-20 hours per week.

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

Target Population: children/youth with psychiatric disorders who have been hospitalized

Geographic Area: Statewide

Estimated Families Served: 2100-2250 annually

**Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE)** - This service provides a comprehensive and multidisciplinary out-patient assessment to assist in treatment planning for children and youth that are involved in the Juvenile Justice System. The unit of service for this program is a CORE EVALUATION that includes full intelligence testing, personality assessment, substance abuse screening, home visit and family assessment, and evaluation of educational problems and/or learning disability and a report completed within 28 days. These children/youth need a comprehensive, forensic evaluation that focuses on biopsychosocial factors that impact the child/youth's ability to remain in the community. DCFIE are for children/youth, ages 7 through 19, who are both DCF-involved and also involved in the juvenile justice system. These children/youth need a comprehensive mental health evaluation which can be completed in a community-based setting.

During breaks in the daily evaluation process, there are recreational and group activities for the children / youth.

Category: Family Preservation and Family Support.

Target Population: JJIE are for court-ordered children/youth, ages 7 through 19, with priority given to children/youth who are currently in a CT Juvenile Detention Center or have been recently released from detention.

Geographic Area: Statewide

Estimated Families Served: 164

**Juvenile Criminal Diversion** - This service provides a range of case management, group activities and family supports for youth "at- risk" for juvenile delinquency, school drop-out and gang involvement. Referrals are sent from DCF as well as Juvenile Court staff, local schools, police, community providers and parents. An initial assessment and individualized service plan are done prior to start of services. Some programs have a 5 - 6 week summer camp component.

#### **Juvenile Review Board (JRB)**

The Juvenile Review Boards (JRB) are organized groups of community volunteers such as police, youth service bureaus, schools, and agency professionals that work to divert children and youth from the juvenile justice system. Children and youth between the age of 7 and 17 that are first time misdemeanor offenders or that qualify under the Families with Service Needs (FWSN) statutes are eligible for JRB services.

Service type: Family Support, Family Preservation

Target Population: Ages 7 through 17 who have been referred to the Juvenile Review Board (JRB), are first-time offenders and have committed a misdemeanor offense or referred to court for behaviors under a Family with Service Needs ("FWSN") petition.

Geographic Area: Hartford, New Haven and Bridgeport

Estimated Families Served: 600 slots contracted FY 15

#### **Juvenile Review Board Support and Enhancements**

Juvenile Review Board Support and Enhancement provides funding to local Juvenile Review Boards to create, support and enhance services delivered to youth served by the Juvenile Review Board (JRB).

Service type: Family Support, Family Preservation

Target Population: Ages 7 through 17 who have been referred to the Juvenile Review Board (JRB), are first-time offenders and have committed a misdemeanor offense or referred to court for behaviors under a Family with Service Needs ("FWSN") petition

Geographic Area: Norwich, Willimantic, Middletown, New Britain, Meriden, Waterbury, Torrington, Danbury

Estimated Families Served: Unknown-, new service. Each JRB will request funds

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

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

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

Geographical Area: New Haven and Milford

Number of Children Served annually: 91

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

Category: Family Preservation; Family Support

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

Geographic area served – Statewide

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

**Modular Approach to Therapy For Children – MATCH**

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

Category: Family Preservation, Family Support

Target Population: DCF referred children 7-15 years old

Geographical Area: Statewide

Number of Children Served annually: 100

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

Category: Family Preservation service.

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

Geographic Area – Statewide

Estimated Individuals and Families to be served: 961

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

Category: Family Preservation service.

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

Geographic Area – Statewide

Estimated Individuals and Families to be served: 961

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

Category: Family Support, Time-Limited Family Reunification

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

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

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

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

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

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

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

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

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

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

Category: Family Support and Family Preservation.

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

Geographic Area: Statewide

Estimated Families Served: Annual Capacity: 96

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

Category: Family Support and Family Preservation.

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

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

Estimated Families Served: Annual Capacity: 30

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

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

Category: Family Support and Family Preservation service.

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

Geographic location: Statewide

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

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

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

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

**Parent Project-** This service is a highly structured, 10-16 week parent training program under the nationally recognized trade mark *Parent Project*®, designed specifically for parents/caregivers of youth/adolescents who engage in risky behaviors such as running away from home, truancy or "pre-delinquent behaviors".

Service type: Family Support, Family Preservation

Target Population: Youth/adolescents, ages (12) through (17), are exhibiting truancy and/or school defiance and/or runaway behaviors and are involved in or are at risk of becoming involved in the Juvenile Justice system.

Geographic Area: Bridgeport, Danbury, Stamford/ Norwalk, Hartford, Waterbury, New Britain, Manchester, Middletown, Norwich, Willimantic

Estimated Families Served: 240 slots contracted FY 15

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

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

Category: Family Support and Family Preservation service.

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

Geographic Area served: Statewide

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

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

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

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

Geographic area served: Statewide.

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

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

Category – Family Preservation

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

Geographic area – statewide

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

**Positive Youth Development** - This service provides psycho- educational programming, opportunities for experiential learning and life skill building for youth. Among the topics addressed are: peer support, conflict resolution, employment skills, anger management, leadership and the encouragement of empathy. These are discussed and taught in a variety of venues from group discussions to team supports and other supervised play activities. It includes after school programs for all children, after school/in-school program for children with behavioral health issues and family support programs through a 2 generation model, Strengthening Families in and surrounding communities and Strengthening Families 10-14 in others. The children's programming includes opportunities for building social-emotional skills through a variety of venues from group discussions to team supports and other supervised play activities.

Category: Family Support and Family Preservation

Target Population: Children aged 6-13 and their families.

Geographic Area: Enfield, Hartford, Manchester, New Haven, Torrington, West Hartford, West Haven and Willimantic

Estimated Families Served: This service will be re-procured following a discussion regarding the direction of prevention programming in the department.



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

Category: Family Support and Family Preservation

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

Geographic Area: Statewide

Estimated Families Served: 62

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

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

Category: Family Support.

Target Population: DCF involved parents and caregivers

Geographic Area: Statewide

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

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

Category: Family Preservation and Family Supports.

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

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

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

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

Category: Time Limited Family Reunification and Family Supports.

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

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

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

**Residential Substance Abuse Treatment - Children's Center of Hamden** - This service provides brief residential substance abuse treatment for mixed gender adolescents aged 12 - 17 involved with juvenile or adult court.

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

Category: Family Support.

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

Geographic Area: Statewide

Estimated Families Served: 72

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

Category: Family Support and Family Preservation.

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

Geographic area served: All regions except region 3

Number of families to be served: 224

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

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

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

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

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

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

Geographic Area – Statewide

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

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

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

Category: Family Support and Family Preservation.

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

Geographic Area: Statewide

Estimated Families Served: 80

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

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

**Specialized Group Home with Behavioral Health and Support Services** - This service is a continually staffed congregate residence located within the community serving multiple youth and young adults, ages 16 through 21, with serious emotional disturbance and their families through the provision of comprehensive, coordinated care and clinical treatment by specially trained staff.

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

Category: Family Support and Adoption Promotion and Support Services.

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

Geographic area served: One contract Statewide for non DCF involved families  
Number of families to be served: The number served is not quite clear as they work training large groups, engage communities with the FSM positions and serve over 600 with the Advocates.

**Supportive Housing for Families** - This service provides subsidized housing and intensive case management services to DCF families statewide for whom inadequate housing jeopardizes the safety, permanency, and well-being of their children. Intensive case management services are provided to assist individuals to develop and utilize a network of services in the following areas: economic, social, and health. Housing is secured in conjunction with the family and the Department of Housing (DOH) provides a Section VIII voucher. Priority access is determined by the chronological order of referrals.  
Service Category: Family Support  
Population to be served: DCF involved families with housing barriers who are homeless or at risk of homelessness.  
Geographic area served: Statewide  
Estimated number of individuals and families to be served in 2016- over 500

**Supportive Work, Education & Transition Program (SWETP)** - This service is a community-based stand alone, staffed apartment program that serves adolescents, age 16 and older, who are committed to DCF. The program focuses primarily on the developmental issues associated with the acquisition of independent living skills, including but not limited to: inter-personal awareness; community awareness and engagement; knowledge and management of medical conditions; and maximization of: 1) education, 2) vocation, and 3) community integration. There is on site, awake supervision, 24 hours a day, and seven days a week. Activities involving resident youth are supervised and managed at a level consistent with the nature of the activity and the individual needs of the involved youth.  
Service Category: Family Support  
Target Population: Youth 16 or older and Committed Abused, Neglected or Uncared For or Dually Committed to DCF  
Geographic Area: Statewide  
Estimated Families Served: 26

**Therapeutic Child Care** - This service offers a range of support services for children in a child care facility, including parent-child programs and an after school program. The target population is children ages birth to 8 years old. The primary activity is the teaching of parenting skills as parents participate with their child in the child care setting. With new understanding and skills on the part of the parents, DCF is less likely to become involved and children are less likely to be removed from the home.  
Category: Family Support, Family Preservation, Time-Limited Family Reunification categories  
Population(s) to be served: Children aged 0-5 with behavioral issues transitioning to regular day care or kindergarten  
Geographic area to be served: Bridgeport and Waterbury.  
Estimated number of families to be served: Currently the number of children being served is approximately 7.

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

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

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

**Triple P** - This service utilizes the evidenced-based model, Triple P (Positive Parenting Program®) of the University of Queensland, to provide an in-

home parent education curriculum along with support and guidance so that parents will become resourceful problem solvers and will be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Within the multi-tiered Triple P system, this service will use Triple P's Level 4 Standard and Level 4 Standard Teen courses. In addition to Triple P, this service will provide short term case management supports to help parents fully utilize the parenting services.

Category: Family Preservation; Family Support

Population(s) to be served - Parents with children 0-17 years of age. Priority is given to parents involved with DCF or Community Support for Families. Caseload permitting and in consultation with the DCF area office, providers may serve parents referred by other community providers.

Geographic area served – Statewide

Estimated number of families to be served : 2113 families annually

**Work To Learn Youth Program** - This is a youth educational/vocational program providing supportive services to assist youth, ages 14 - 23, to successfully transition into adulthood. The program provides training and services in the following areas: employment skills, financial literacy, life skills, personal and community connections, physical and mental health, and housing. Youth also have the opportunity to take part in on site, youth run businesses. The program provides youths with training and services in the following areas: employment skills, financial literacy, life skills, personal and community connections, physical and mental health, and housing.

Category: Family Support and Adoption Promotion and Support Services.

Target Population: Committed youths ages 14 to 23.

Geographic Area: .Hartford, Norwich, Bridgeport, Waterbury, and New Haven

Estimated Families Served: The agency contracted for 364 slots during SFY 15

**Zero to Three – Safe Babies** – the Zero to three Safe Babies Project, provides for the coordination of services to parents and children younger than 36 months in order to help speed reunification or another permanency goal when the children have been placed by court order outside of their homes for the first time. These coordination efforts involve facilitating communication and cooperation among a "zero to three team" of stakeholders (e.g. court services, infant mental health, protective services, developmental screening) and the parent(s) to develop and expedite a case specific plan of action.

Category: Family Preservation; Family Support, Time-Limited Family Reunification, and Adoption Promotion and Support Services

Population(s) to be served - parents, foster parents, and adoptive parents in the New Haven and Milford DCF area office service areas.

Geographic area served - the New Haven and Milford DCF area office service areas.

Estimated number of individuals and families to be served – 40 children 0-3 years of age annually

## Service Grid

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

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

The following charts represent our **2016 Spending Plans:**

**Stephanie Tubbs Jones Child Welfare Services – Subpart I- FFY2016**

<b>Services/Activities</b>	<b>Total Funding</b>
Children Services Positions - Solnit South	\$1,013,006
Office Assistant Positions	\$156,786
JRA Consulting - Racism	\$90,000
CCMC	\$220,500
Central Office Staff	\$143,376
The Connection	\$200,000
Triple P America	\$105,550
Travel/Conferences	\$10,000
Domestic Violence Supports	\$110,000
CT Council on Developmental Disabilities	\$7,500
KJMB Solutions	\$115,000
Total:	\$2,171,718

**Promoting Safe and Stable Families – Subpart II – FFY 2016**

<b>Service Description</b>	<b>Total Funding</b>
Reunification Services	\$1,173,245
Community Collaboratives	\$284,700
FAVOR	\$50,000
UConn -Adoption enhancements	\$300,000
Easter Seals Support Group	\$20,000
Homebuilders Pilot	\$57,297
UConn PIC Expansion	\$129,420
Adopt a SW program	\$95,275
KIPS	\$4,875
Visit Coaching	\$1,726
Total	\$2,116,538

## Chafee FFY 2016

Service Description	Total Funding
Personnel Expenses	\$38,450
One on One Mentoring	\$322,013
Community Based Life Skills	\$398,430
Work to Learn	\$518,699
Youth Advisory Board Stipends	\$50,000
Total	\$1,327,592

ETV (See Section E).

### **Service Coordination**

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

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

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



families that are served by the Department. Additionally, the Contract Management Unit supports a variety of other Department units and is responsible for a number of other activities as described below.

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

1. Program Development and Oversight Coordinator Training:

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

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

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

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

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

An initial review of the agency's contracts library showed that almost every service type had an outcome section as part of the contract, but on closer inspection, many of the items identified as outcomes, did not meet the standard for RBA performance measures: the amount of services delivered; the quality of the work; and whether anyone was "better off

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

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

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

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

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

### 3. The Tier Classification System:

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

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

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

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

### Populations at Greatest Risk of Maltreatment

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

AGE GROUP	DEMOGRAPHIC	VICTIM	POPULATION	Rate / 1000
0-3	ALL	2063	163169	12.64
	MALE	1055	83642	12.61
	FEMALE	993	79527	12.49
	Hispanic	678	38067	17.81
	Non-Hispanic, Black	402	19599	20.51
	Non-Hispanic, White	755	95386	7.92
	Non-Hispanic, Other	228	10117	22.54
4 - 17	ALL	4780	580615	8.23
	MALE	2245	296699	7.57
	FEMALE	2512	283916	8.85
	Hispanic	1470	128843	11.41
	Non-Hispanic, Black	1010	65008	15.54
	Non-Hispanic, White	1840	343642	5.35
	Non-Hispanic, Other	460	43122	10.67
0 - 17	ALL	6843	743784	9.20
	MALE	3300	380341	8.68
	FEMALE	3505	363443	9.64
	Hispanic	2148	166910	12.87
	Non-Hispanic, Black	1412	84607	16.69
	Non-Hispanic, White	2595	439028	5.91
	Non-Hispanic, Other	688	53239	12.92

Noting that young children seem to more vulnerable to fatalities and other poor outcomes, the Department embarked upon a case control study. The Department reviewed 124 fatalities involving children ages 0-3 that occurred from January 1, 2005 - May 31, 2014. A sample of 124 DCF involved cases from the same period, which did not have a fatality, were also reviewed for comparative purposes. Some factors that the study, released this past January, identified as being more greatly associated with an increased risk for a fatality are as follows:

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

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

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

**Caseworker Visits with Parents:** Cases in which there was sufficient frequency of visits between the caseworker and parent were less likely to result in a fatality. This suggests that a sufficient frequency of parent-caseworker visitation may have a

protective effect against child fatality. Therefore, it is recommended that efforts continue to ensure cases have a sufficient frequency of parent-caseworker visitation particularly for homes with children ages 0-3.

As a means to potentially reduce fatalities, the Department has recently entered into an agreement with the Eckerd Foundation to implement Rapid Safety Feedback (RSF) in Connecticut. RSF is a qualitative review and predictive analytics approach to identifying children who may be at increased risk for a critical or lethal maltreatment related outcome. The Department will be focusing this approach on its In-home cases and those investigations where a family has three or more accepted reports. RSF should begin early Fall 2015.

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

##### **Child First**

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

- *Capacity:*
  - Child First currently has annual capacity to serve 1,004 children and their families per year in CT. Child First affiliate sites were strategically placed in all DCF Regions such that there is an affiliate serving each DCF Area Office. This includes nine sites funded through DCF (Bridgeport, Hartford, Middlesex County, New Haven, New London County, Northeast CT, Norwalk, Stamford, and Waterbury), five full and three expansion sites funded through a 2012 federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) competitive grant (Ansonia/Derby, Bloomfield, Bristol, Danbury, East Hartford, Meriden, Northeast CT, and Torrington), and New Britain, funded through Project LAUNCH, for a total of 39 Teams (Clinician and Care Coordinator) in 15 sites. In some affiliate sites, philanthropic funding has increased capacity. Current funding covers 88 of 169 CT towns, although sites have been flexible when there has been a family in great need in a neighboring town. Child First just received funding from a new 2015 MIECHV competitive grant (through the Office of Early Childhood) which will further expand capacity by adding another seven teams in the highest need areas (Hartford, New Britain, New Haven, and Waterbury). This will bring statewide capacity to 1,182 children and their families. It is important to note that Child First data shows that with each child served, an average of four family members receive direct services.
  
- *Referrals and Numbers Served:*
  - From January through December 2014, Child First received 1, 075 new referrals, according to the Child First Metric database.
  - From January through December 2014, Child First served 1,025 children and their families, according to the Child First Metric database.
  - The major referral sources for Child First were DCF, self-referral, pediatrics, early care and education, other home visiting programs, adult and child mental health providers, and Birth to Three.

- The racial and ethnic breakdown of Child First children and families was 18% African-American, 1% Asian, 47% Caucasian, 17% Latino, and 16% other or missing.
  - The age breakdown for children who participated in Child First services were 45.6% under 3 years of age and 54.4% between 3 and 6 years.
  - As of December 31, 2014, Child First waitlist was 288 children, even with active triaging of children and families to other less intense services whenever possible.
- *DCF Children and Families Referred and Served:*
    - From January through December 2014, the overall percentage of open children with current and/or past DCF involvement, as directly reported by the Clinical Directors, averaged 72% across all sites.
    - From January through December 2014, the overall percentage of open children with current DCF involvement, as directly reported by the Clinical Directors, averaged 52% across all sites. Other agencies also referred children who were DCF involved. Only 28% of referrals came directly from DCF. Regardless of referral source or funding of affiliate site (including all MIECHV, Project LAUNCH, and philanthropically funded teams), all DCF children are given priority and assigned a Child First team within 24-48 hours.
    - Of all children referred by DCF to Child First, 94% were engaged and began services.
    - The Child First RCT (*Child Development*, 2012) demonstrated that the Child First intervention was able to decrease DCF involvement by 39% at 12 months and by 33% at three years.
  - *Training, Consultation, and Supervision:*
    - Child First provides very comprehensive training in the model through a 12 month Learning Collaborative, where all new staff come together for four, in-person, interactive trainings.
    - All affiliate sites receive on-site reflective, clinical consultation from the Child First CT Clinical Director. During the first six months of a Learning Collaborative, this is



on a weekly basis. After that time period, the meetings are biweekly and are ongoing.

- All Clinicians received trauma-informed Child-Parent Psychotherapy training by a certified CPP trainer, which includes three in-person trainings and 18 months of supervisory conference calls.
  - All Child First staff receive weekly, individual, Team, and group reflective supervision.
  - Child First is in the process of developing a Distance Learning curriculum in collaboration with the Erikson Institute in Chicago. This curriculum is web-based with both synchronous and asynchronous components. It will be blended with our on-site Learning Sessions, which will be used for new cohorts in CT and nationally, and will also be used for new staff training.
  - Additional trainings include Specialty trainings, New Staff Training, and our Child First Annual Conference. Our 2014 conference featured Alicia Lieberman, PhD, and our 2015 conference featured internationally renowned child psychiatrist, Charles Zeanah, MD, focusing on Early Childhood Trauma and Attachment.
  - Child First Cohort 3 training (March 2013 – June 2014), was conducted with 51 staff in attendance. In July 2014, Child First will be conducting Cohort 4 training, including all seven new Teams and any staff that had not had Cohort 3 training, anticipated to be 45-50 staff.
  - In June 2015, a two day Clinical Directors training will be offered for anyone who is new to this position.
- *Child First Outcomes*
    - Child First conducts a comprehensive assessment with all children and families receiving services. This assessment is repeated at 6 months and at the time of discharge. Child First has been collecting data since implementation with Cohort 1 in 2010. The following Assessment outcome data represents improvement in the Child First children and families who had problems at baseline, served from January through December 2014:

Measure

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- Child First is in a planning stage with RTI (Research Triangle Institute, an international research organization) to develop a second RCT that will include a broader age range (birth to age six years), across multiple sites, including additional outcomes, and following longitudinally. This will be funded by a philanthropic organization. It is required by DCF for Medicaid reimbursement.
- *National and State Recognition and Replication*
  - Child First has had significant media coverage over the past year, including an article by the New York Times, CT Sun, Huffington Post, and National Public Radio (NPR Hartford Office).
  - Darcy Lowell, MD, Child First CEO has been invited to speak at many national conferences – most recently the Pew Home Visiting Summit, Pay for Success conference, and Society for Prevention Research – as well as conferences in other states – including Florida, North Carolina, Massachusetts, Rhode Island, and New York.
  - Child First will soon be replicating in both Florida and North Carolina, with inquiries from over 25 states.
  - Dr. Lowell has given invited testimony about Child First and home visiting to the Congressional Ways and Means Committee in Washington DC.
  - The Coalition for Evidence-Based Policy has given Child First their select “Approved” status for evidence-based models.
  - Child First has been invited to participate in the Coalition of Home Visiting Models (a select group of six of the 17 evidence-based models) and the Pew Data Improvement Project. Dr. Lowell was invited to participate in the “Health Equity and Young Children Learning Center,” sponsored by the national Child and Family Policy Center, and the Zero to Three Expert Advisory Committee for the new “Quality Improvement Center for Research-Based Infant-Toddler Court Team.”

CT's **Early Childhood Consultation Project (ECCP®)**, Advanced Behavioral Health, Inc., funded by the DCF, is a nationally recognized, evidence based early childhood mental health consultation program designed to meet the social-emotional needs of infants, toddlers, and

preschoolers, ages 0-5. Mental Health consultation is an intervention that builds the capacity of families, providers and system to prevent and treat social-emotional issues in young children.

The ECCP service model is 12 weeks long, with 4 to 6 hours of classroom-based consultation per week provided by one of several supervised masters-level consultant supported by ECCP, plus a week-16 follow-up visit. The intervention is manualized and menu-driven based on individualized needs of teachers and classrooms. ECCP provides both classroom-specific consultation (focusing on improving teacher-child and teacher-teacher interactions, classroom behavior management, and overall program quality, including teacher and director supports) and child-specific consultation (focusing on improving teacher classroom behavioral and social-emotional strategies, parent partnerships, and community service referrals for specific children).

A process evaluation of ECCP, conducted during the programs first year of operation, indicated good fidelity to the program's goals in both child- and classroom-specific services, as well as high levels of teacher satisfaction.

In SFY 2014, ECCP served 1230 children, 113 centers, and 321 teachers and assistant teachers. 98.55% of children who received Child-Specific services were not suspended or expelled at the one-month follow-up visit after completion of services.

ECCP continues to be seen as the nation's "Gold Standard" for early childhood mental health consultation services, particularly due to its manualized approach, information system, training, delivery strategies; and random controlled trials. A recent evaluation of ECCP noted reductions in preschool target child behavior problems, improvements in social competence in toddler peers who were not actively targeted by the intervention, and improved home-school communication and family involvement in both toddlers and preschoolers. These positive impacts were observed using the most rigorous methods possible of random-controlled evaluation and most of the findings above were replicated across multiple evaluations and time points. Furthermore, these positive impacts were observed following a

relatively brief, but intensive, three-month ECCP intervention. As measured by the most rigorous methods possible, ECCP is a highly successful and impactful intervention for improving child behavioral outcomes and improving family involvement in early care and education programs.

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

The case manager for the program is affiliated with Lawrence and Memorial Hospital in New London, CT, where most incarcerated mothers will deliver their babies. In some circumstance mothers deliver their babies at UCONN Medical Center or Yale New Haven Hospital. These are special circumstances when deliveries are considered high risk or there are mental health or safety concerns regarding the birth mother.

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

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

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

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

**Therapeutic Child Care**, operating within a licensed child day care program, is designed to promote, develop and increase the social emotional development and cognitive capacities of young children affected by abuse and neglect and who also have serious behavioral health issues by providing a specialized therapeutic and trauma-informed program for these young children and their families. The target population is children ages birth to 8 years old. The program is offered in two area offices in different regions in the state and serves approximately 30 children per site. These programs differ in service delivery, staffing, and funding. The Department is currently modifying the contract to create greater consistency in scope of work and outcomes. The Department is interested in expanding this program statewide.

**Circle of Security Parenting (COS P)** is an internationally acclaimed, evidence-based program shown to help parents promote secure attachment with their children. It helps infants and children develop the important building blocks of trust, security and safety in their own personal development. *Circle of Security* uses the concept of a safe base to give parents an understanding of how to support their child's ongoing development. It is based extensively upon attachment theory (from the work of John Bowlby and Mary Ainsworth) and current affective neuroscience. The program is designed to help parents better understand and respond to their child's emotional needs; help their child manage their

emotions and behaviors; and increase parent's understanding of the importance of secure attachment for healthy growth and development.

COS P is a basic protocol that can be used in a variety of settings, from group sessions (20 weeks) to family therapy to home visitation. The common denominator is that all of the learning is informed around the following themes:

- Teaching the basics of attachment theory via the Circle of Security™
- Increasing parent skills in observing parent/child interactions
- Increasing capacity of the caregiver to recognize and sensitively respond to children's needs
- Supporting a process of reflective dialogue between clinician and parent to explore both strengths and areas of parent difficulties (i.e., being "Bigger, Stronger, Wiser, and Kind," supporting exploration, and supporting attachment)
- Introducing parent to a user-friendly way to explore defensive process

To date, over 500 people in CT have been trained to offer COS P, and there is current interest in bringing an attachment focus into preschools, family child care settings, and to K-12 schools. Although the Department does not fund COS, we recognizes the value in training providers and individuals working with young children around attachment and is interested in providing additional training opportunities statewide.

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

The trainings were designed to create a shared knowledge base for staff, to promote a unified approach for working with families with complex needs and to enhance working

relationships among staff from the various disciplines. In addition, the training provided an opportunity to participate in reflective supervision/consultation where participants learned about reflective practice, how to promote reflection in others and practice reflection through a series of activities. Reflective Consultation/Supervision is one of the infant mental health competencies and is recommended for all persons working with infants/toddlers and their families. The training provided to DCF/EHS staff by the Connecticut Association for Infant Mental Health seeks to integrate information about the relationships between infant/toddlers and their caregivers in a practical way. The goal of the training is to understand more about parents and their young children who are not well integrated into their communities, to understand their relationships and to reflect on what that means for one's own work. The information is presented from a strength-based perspective. The eight full day training series has been delivered to DCF staff and Community Providers in 5 regions and will be offered in the last region, Milford and New Haven. The training's focus is on working with young children and their families who are dealing with unresolved loss and trauma and how that impacts relationships, particularly their relationships with their infants and toddlers. The topics will be related to the Competencies for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

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

The response to the training series has been overwhelmingly positive. The CT-AIMH and the Department are exploring ways in which to continue offering these trainings statewide.



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

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

**Three Guiding Principles:**

1. *Promotes a **Holistic Perspective***: considers all aspects of children’s development (physical, social, emotional, cognitive and behavioral health);
2. *Fosters an **Ecological Framework***: Development influenced by family, home, environment, school, and neighborhood
3. *Employs a **Public Health Approach***: Works to ensure all children have the skills needed to achieve developmental milestones.

**Key Elements:**

*FAMILY CENTERED      CULTURALLY AND LINGUISTICALLY COMPETENT*

**Prevention and Promotion Strategies:**

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

**Five Key Strategies:**

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

- Screening and Assessment

**Project Launch Outcomes:**

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

**Key Staffing:**

*Young Child Wellness Expert      Young Child Wellness Partner*

*Young Child Wellness Coordinator*

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

**DCF Partners:**

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

**Goal 1: Coordinate an enhanced and integrated primary care, behavioral health and early care/education system for children birth to 8 year olds and their parents/caregivers.**

Assess the capacity of primary pediatric and early care and education providers to provide comprehensive screening connected to physical wellbeing.

- Identify and outreach to primary pediatricians who are not currently providing developmental screening and educate them on the importance of screening
- Collaborate with CT-ECPL core team to train primary pediatric staff on use of ASQ, ASQ-3

- Develop workflow and referral process to link families to resources

Expand Early Childhood Consultation Project (ECCP) services from infant, toddler, preschool, to include kindergarten- grade 3 for early care and education settings in the Dwight neighborhood.

- Provide Mental Health Consultation services to parents/caregivers, educators and families from birth to grade 3.
- Promote capacity building of caregivers and educators in the areas of social and emotional health through provision of trainings, resources, and consultation.
- Facilitate effective partnerships and networking to include, administrators, teachers, families, and providers.

**Goal 2: Ensure all professionals working with young children and their parents/caregivers have core knowledge of infant and early childhood mental health and family systems.**

Train pediatricians, medical professionals, school based health clinics and medical support staff in relevant Educating Practices in the Community (EPIC) modules in the Dwight neighborhood and Greater New Haven.

Provide infant mental health training for home visiting professionals.

- Develop IMH training series curriculum for Home Visiting (HV) agencies/programs and deliver training
- Share lessons learned from the training with the state to inform statewide rollout.

Create a workforce development plan that guides professionals toward endorsement for Culturally, Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

- Identify state and local partners to join the CT-AIMH Professional Development Advisory Committee to develop a workforce development plan
- Establish linkage with the Department of Children and Families (DCF) Region II CT-AIMH training

- Meet with CT-AIMH Advisory Committee to develop workforce development plan.
- Coordinate follow-up meetings with first IMH home visiting training participants to facilitate the development of individual Endorsement® plans.

Provide Trauma Informed Child/Parent Psychotherapy (TI-CPP) training to New Haven area clinicians in coordination with Child FIRST.

Build the capacity of parents/caregivers, educators, and providers of young children perinatal through age 8 to support the social/emotional and behavioral health and wellbeing of children in their care.

- Identify the training needs of parents/caregivers and educators in the areas of social and emotional health.
- Promote and leverage social and emotional health training opportunities for parents/caregivers and educators.
- Provide state and/or local presentations on social/emotional health.

**Goal 3: Promote parent/caregiver capability to assume shared authority and responsibility for their child’s overall health and wellbeing.**

Expand opportunities for parents/caregivers to increase their knowledge and leaderships skills in order to be the primary care coordinator for their family.

- Identify existing parent/caregiver leadership and training opportunities
- Engage local community and faith based organizations with active caregiver involvement to learn what skills parents/caregivers want to enhance and/or develop.
- Outreach to local providers currently supporting paternal relationships to facilitate the engagement of fathers
- Assess opportunities for professional development training in Strengthening Families and Parent Cafes

- Explore opportunities to develop a program that provides training for parents/caregivers to help other families find the services they need and navigate the system of services.

Formalize Collaboration with MOMS Partnership.

- Hire and train a Community Mental Health Ambassador
- Work with CT-ECPL core team to devise a systematic referral system
- Cross-train CT-ECPL and MOMS staff on trauma 101 and maternal mental health

Align, link and coordinate existing family strengthening programs in the New Haven Community.

- Convene all family strengthening program providers to assess current reach of services, particularly in the Dwight neighborhood
- Identify opportunities to align and expand reach of current programs
- Work with providers across the community who are engaging families in family strengthening programs on defining the system of support that can be shared back with Help Me Grow/CDI

Increase parent/caregivers engagement in Project Launch related activities and strategies.

- Outreach and provide information on Project Launch to community organizations and city leaders
- Develop a Project Launch “parents/caregiver information brief” to encourage interest and active participation in Project Launch activities.
- Identify and train parents/caregivers to participate as Project Launch participation mentors
- Recruit and support parents/caregivers to serve on the NHECC-Wellness Committee
- Develop collaborative partnerships to support leadership, co-learning, team building between parents/caregivers and CT-ECPL core team.

**Goal 4: Facilitate linkages and coordination between state and local level entities and coordinating bodies focused on promoting optimal outcomes for child health and wellness.**

Integrate LAUNCH scope of work into the State Young Child Wellness Council.

Create a Wellness committee of the New Haven Early Childhood Council (NHECC).

- Recruit parents/caregivers who represent the target population to serve on the NHECC-Wellness Committee
- Collaborate with OEC and State Wellness Council including local representative on state council and bring together annually for joint review of data, and update strategic plan

Expand LAUNCH's involvement in other community collaborative groups and initiatives.

- Distribute visually appealing, easy to comprehend quarterly reports to community listservs
- Develop data sharing agreements

Assess linkage opportunities for Help Me Grow/Child Development Infoline with the New Haven community.

- Work with Help Me Grow/CDI to assess current efficiency and efficacy around linking families to family strengthening programs in the community
- Work with providers across the community who are engaging families in family strengthening programs on defining the system of support that can be shared back with Help Me Grow/CDI

**Goal 5: Implement a social marketing and public awareness campaign.**

- Work with families in local community to identify topical areas to promote the health and wellness of children and their families.
- Develop consistent messaging by topic to increase public awareness and understanding of PL values/goals.

- Identify messaging and distribution plan at the local/statewide level
- Develop mechanisms for local participation in shaping the public health campaign.
- Utilize social media in promoting and educating the public on ECPL.

The focus this year has been primarily around planning and preparation for implementation of the LAUNCH work which includes the following activities:

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

Over the next several months, the Core Planning Team will be establishing priority areas and establishing protocols and systems to track data and outcomes.

#### [Early Childhood Community of Practice](#)

The Department of Children and Families supports healthy relationships, promotes safe and healthy environments and assures that the emotional and social needs of children 0-5 are met. In an effort to align the vision of the agency with current practice, the Department established the Early Childhood Community of Practice. The community of practice is comprised of agency staff across offices and levels who have an inherent interest in this particular population or whose work is directly connected. Since the group's inception, the members have been charged with the following:

#### [Development of Policy and Practice Guide in response to Special Act 14-22](#)

In July 2014 Special Act 14-22, required the Department of Children and Families to maximize enrollment of eligible preschool aged children into eligible Preschool Programs for children in the Care and Custody of the Department of Children and Families. As a result of

Special Act 14-22, a Policy and Practice guide were created. The Policy and Practice Guides were drafted with input and recommendations from the Early Childhood Community of Practice (which includes the Office of Early Childhood), partners from the CRTs Head Start Program and other supports within the Department.

In SFY 14, there were 251 children that met the criteria as eligible preschool-aged children. Of those, the LINK data shows 147 (59%) were in some form of educational setting at the time of their entry into DCF care. Sixty-six (66) of them were already in either Kindergarten or 1<sup>st</sup> Grade, with another 81 in either B-3, Head Start or some other type of Preschool program.

<b>GRADE</b>	<b># Entries</b>	<b>% Entries</b>
Birth to Three	2	0.8%
Head Start	26	10.4%
Pre-K	53	21.1%
Kindergarten	54	21.5%
1st grade	12	4.8%
NO DATA	104	41.4%
<b>Grand Total</b>	<b>251</b>	<b>100.0%</b>

- Provide feedback regarding visitation standards for the 0-5 population
- In conjunction with the DCF Academy developed a four day Early Childhood Training Series entitled “Promoting Health and Wellness for Infants, Toddlers, and Preschoolers involved within the Child Welfare System.” This training was offered to DCF staff and Head Start providers. The four day training series included attachment and engagement, assisting children with transitions, societal issues that may lead to delayed development and cultural competence to name a few.



- Agency policy review related to this population
- Conducted random case reviews of children 0-5 for the purposes of collecting data related to their educational status
- The group is currently working on the development of an Early Childhood Framework that would include but is not limited to the following categories: policy/practice guide (inclusive of assessments) data, and communication. This will be an area of focus for the Department this upcoming year.

The Department remains committed to support Infant Mental Health Training for staff.

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

#### **The Adoption Assistance Program (AAP):**

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

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

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

In 2014, AAP served the following families/children:

- 434 Intake Calls
- 236 Consults only
- 198 Cases Opened
- 62 Cases Referred to Case Manager
- 27 Cases Referred to PPSP

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

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

## 5. Program Support

### Staff Training

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

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

### Post Masters Certificate Program

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

The Certificate Program is a collaboration of the University Of Connecticut School Of Social Work (UConn-SSW), Southern CT State University (Southern), DCF, and the Adoption Assistance Program at the UConn Health Center. This evidenced-informed training consists of thirteen class sessions held monthly from March to October, which alternate between the two universities. In addition to the classes, six case consultation sessions are provided to enhance the transfer of learning and additional case specific support. The program focuses on cutting edge practices used on a national level to improve services to children and families dealing with a myriad of issues related to permanency. Cross training between DCF staff and providers also creates an opportunity for collaboration and the creation of a shared vision of practice. The feedback from this training program is overwhelmingly positive and has received national attention. The Center for Adoption Support and Education recently requested that this model be used as a demonstration site for the implementation of Training for Adoption Competencies (TAC) program in an effort to create national standards for training on adoption. The 2014-2015 cohort consisted of fifteen DCF employed staff and ten community providers. The TAC students are asked to assess their pre-and post-training

levels of competency on thirty-five core competencies. The training is designed to move students from beginning levels of awareness and knowledge to regular, effective application in practice. Feedback reflects consistently positive ratings of TAC quality and relevance.

### MSW Field Program

The MSW Field Program began in 2004 in response to a need for additional staff development opportunities for those DCF employees seeking an MSW degree. The program is a replacement for the SWIP (Social Work Internship Program), which is now defunct. First and second year students as well as advanced standing students have benefited from the program. Priority is given to students seeking their second-year field placement. The intent of the program is to foster support of our social workers by allowing them to meet their university requirements for 20 hours of field instruction within their regular 40-hour work week. In essence, no additional field instruction hours are required outside of the regular work week.

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

Additionally, the program prepares students to look for opportunities to provide service "above and beyond the norm;" identify gaps in service delivery and provide solutions; and gain better understanding of DCF as a whole. All of this is accomplished by adhering to a

strength-based perspective in keeping with the agency's mission. To date, the program continues to be successful. It has been heralded by social work supervisors, participating universities and students, as they appreciate the new perspectives on cases and learning opportunities for students.

Through a competitive interview process, in 2014-2015 four students participated in the program and successfully completed their field placement. In 2015-2016, eleven students interviewed and ten students will be accepted into the program.

### DCF Stipend Program

Internship programs are one of the most effective recruitment strategies used by many professions. These programs are mutually beneficial to both the students and the agency, as the on-the-job experience is a perfect opportunity to determine suitability for the job. Special emphasis has been placed on marketing the internship program as a recruitment tool for child protective service workers. In the fall of 2010, the Academy launched its first student stipend program for external students interested in employment at DCF. In this competitive program, students in their final year of a BSW or MSW program are selected to participate in an internship process in a regional office where they receive orientation, training and real-time experience handling child welfare activities. Students receive a \$3,000 stipend to offset the cost of their education and are required to meet agency practice standards. Upon graduation and receiving a recommendation from their field supervisor, students must repeat a background check and an interview process. If successfully completed, students are prioritized in the hiring process. If no positions are available three months after their graduation date, students are released from any obligation to wait for employment or repay the stipend. To date, 44 students have successfully completed the program. Unfortunately, due to a significant decrease in hiring in the past, only nine students from the program have been offered employment to date. However, the hiring process has resumed in the last two years and the Department's efforts to increase the applicant pool is expected. The Academy has developed a process to streamline the students' applications to the Department's Division of Human Resources who has agreed to prioritize hiring to this intern cohort. This strategy will increase the number of students who apply to the Department and increase the

number of qualified applicants being considered for employment.

### NCWWI University Partnership

The DCF Workforce Development Academy, in partnership with the UCONN School of Social Work, is the proud recipient of the National Child Welfare Workforce Institute - CT Partnership for The Child Welfare Excellence grant. The CT Partnership offers the opportunity for the UCONN-SSW and the DCF to collaborate with the goal of refining and strengthening foundational and child welfare-related curricula content to reflect the knowledge and skills that address the increasingly complex needs of diverse families and children served by public child welfare agencies; thereby enhancing competency levels of the CT Partnership trainees and other students alike. In addition, it provides the opportunity to collaborate on mutual objectives of addressing the need to increase the knowledge, skills, abilities and diversity of the public child welfare workforce by targeting recruitment for masters level trainees from within populations under-represented (Hispanic, male, linguistically diverse) in the current DCF welfare workforce; and to increase the pool of masters level, professionally trained social work graduates as one key strategy that can improve the quality of public child welfare practices and outcomes.

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

### Graduate Education Support (GES)

The Graduate Education Support (GES) Program is an educational program to assist DCF employees with two or more years of employment in obtaining either an undergraduate or graduate degree in the field of Social Work/Child Welfare. This program offers employees the opportunity to work a 32 hour work week and 8 hours of work time to devote to their

internship. The internship placement can be either external to the Department or at a DCF location other than the current worksite. GES recipients are obligated to complete two months of employment of service for every month of participation in the GES program, equivalent to eighteen months. The 2014 cohort included six employees that applied and were accepted, of which one student withdrew from her educational program and did not participate in the program. The 2015 cohort includes ten employees located across six area offices.

#### Training for new workers to ensure competencies

The DCF Academy offers a series of mandatory training modules over the course of 10 months to all new social workers hired to conduct child welfare-related case activities in the regional offices. The pre-service program is designed to prepare each staff member for effective protective service/child welfare practice. There are several components to the pre-service program: classroom training at the Academy, supervised casework experience in a training unit in the regional office, and practice level activities aimed at enhancing the transfer-of-learning process. Each new hire attends 35 classes.

This year the Academy is in the process of training 137 new social workers hired by the agency. The Academy has been successful in integrating new concepts into training related to racial justice, safe sleep, health and wellness, and permanency teaming.

#### In-service training for caseworkers

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

Per agency policy, all staff must attend five days of in-service training annually. It is noteworthy that there is currently no infrastructure in place to determine staff training needs or monitor compliance with this policy. The Department is in the process of designing a new computerized database system, which will allow for enhanced tracking of this policy. The projected launch date of the new system is 2017.

From 2014 to the present, the primary in-service priority of the Academy has been to ensure that staff is trained in the Permanency Teaming Model. To date, over 3,000 staff and providers have received the two-day training. The training overall has been met with positive response. Staff are able to grasp the model and share a common belief around the positive impact that teaming will ultimately have on the lives of the children DCF serves. As a mechanism to assist with implementation, the Academy has begun to hold monthly permanency conference calls with staff across the state. These monthly calls focus on a different topic related to permanency teaming, ranging from adolescents to implementation to foster care. The conference calls provide an avenue for staff to discuss strategies necessary to embed this model into practice.

### Certification Programs

The DCF Academy has moved away from using the term “Certification Programs;” and instead refers to specialized, multiple-session training as a “Training Series.”

From 2014 to the present, the Academy has continued to offer the Differential Response System (DRS) Training Series to social work staff from across the area offices and Careline. The DRS Training Series was offered on three occasions, with 89 unique staff participating. Components of this series included a strong emphasis on the following:

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

In response to the large influx of newly hired social workers and social worker supervisors, the Academy offered the TRUST Series (Training Unit Supervisory Training) to training



supervisors in the area offices. The training series is designed to provide new training supervisors with the necessary competencies needed to supervise new trainees.

Components of this series included a strong emphasis on the following:

- Human Resources
- Learning Styles
- Secondary Trauma
- Managing Up

Over recent months, there has been a large emphasis placed on the adolescents in DCF care and ensuring they have the skills and supports necessary to be productive and successful adults. The starting point has to be the social worker and ensuring that they have the knowledge and competencies necessary to work with this population. The Academy will be holding a ten day training series for social workers who maintain caseloads of youth between the ages of 13-23. Some of the topic areas included in this training series are:

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

### In-Service for Supervisors

The DCF Academy continues to support the critical role supervision plays in child welfare practice, and has partnered with Yale University to provide a two-day training entitled “Strengthening Supervision.” The “Strengthening Supervision” model includes three phases of supervision (engagement phase, work phase, and ending & transition phase), which encompass four functions (quality of service, administration, support, and professional development). Supervision purpose, content, frequency, length, and documentation are significant components of the two-day training. Additionally, a large component of the model

is grounded in the utilization of group supervision. Group supervision allows for diverse conversation, critical thinking, and effective feedback to play a role in critical case issues. The Academy's efforts to support group supervision are discussed further below. To date, the "Strengthening Supervision" training has been provided to 328 agency social work supervisors.

Furthermore, the Department has entered into a partnership with the National Child Welfare Workforce Institute (NCWWI) to offer supervisors an opportunity to participate in the Leadership Academy for Supervisors (LAS). The LAS is a web-based leadership training for experienced child welfare supervisors. The curriculum consists of six online modules each based on the NCWWI Leadership Model. The LAS provides 21 contact hours of self-directed online learning, with two tracks to enhance learning transfer: a personal learning plan to develop leadership skills and a change initiative project to contribute to a systems change within the agency. The LAS will be offered to supervisors in October 2015.

#### Coaching for Regional Supervisors

The Academy has continued to offer coaching to regional supervisory staff, specifically in an effort to support the implementation of the group supervision model. Academy staff inclusive of the assistant director, one program manager, and several child welfare trainers provided coaching to supervisors through a structured, two-day process. Each coaching session occurred in the supervisors' area office, and involved individual conversations about the model, highlighting the benefits and risks of group supervision; the case discussion method; phases of group development; and other key considerations. Individual conversations between "coach" and supervisor were followed by actual group supervision sessions with the supervisors' assigned staff, first facilitated by the "coach" and on the second day of the process, facilitated by the supervisor. Following the facilitated group supervision sessions, "coach" and supervisor shared feedback, questions, and recommendations for improvement. To date, 24 coaching sessions have occurred across 11 area offices, with 25 supervisors participating.

#### In-Service for Managers

Managers from the area offices, central office, and the facilities participated in one of several two-day events on “Strengthening Supervision” offered by consultants from the *Yale Program on Supervision*. The purpose of the program was to support current organizational development work by increasing managers' competency in structuring supervision to undergird the current organizational change process. The training program has received both buy-in and feedback from leadership throughout the agency. Feedback from the training sessions continue to be very positive with managers specifically noting that the opportunity to brainstorm ideas, share, and learn from colleagues was extremely valuable. In 2014, an agency policy on supervision was fully implemented requiring all supervisors and managers to conduct and document supervision on a regular basis. Specific practice guidance has been developed for area office staff and efforts to develop a similar guide for central office employees is in progress.

In 2014, the Academy successfully launched the Connecticut Leadership Academy for Middle Managers (LAMM). Mirrored after the national leadership program developed by the National Child Welfare Workforce Institute, this program is designed to enhance the ability of middle managers to apply leadership skills to the implementation of sustainable systems change aimed at improving the lives of children and families. This series of facilitated dialogues and structured learning experiences provide middle managers with an unprecedented opportunity to self-reflect and share their experiences as an affinity group. The leadership competencies emphasized in the training include: Leading Change, Leading for Results, Leading People and Leading in Context. A basic working assumption of this model is that a flexible structure is necessary for creating the opportunity for each manager to explore and build on his or her own strengths and professional development needs. The process begins with assessing participant’s leadership style and strengths. Participants then incorporate performance management, results-based accountability and organizational development tools to support the learning process. Like the national LAMM, each manager is required to identify a Change Initiative ideally to be at least partially implemented prior to the completion of the four month learning experience. Each participant is assigned to a “Super Coach” to provide support, leadership and guidance necessary to successfully implement their Change Initiatives. The 6 “Super Coaches” include four executive level

agency staff, a Casey Family Program Strategic Consultant and a former DCF Deputy Commissioner. Additionally, each participant receives individual and group coaching from Academy staff and the Chief of Quality on an as-needed basis.

This program has far exceeded the expectations of the Department resulting in statewide changes in the system as a result of several successfully implemented Change Initiatives. To date, 18 managers have successfully completed the program and 17 managers are currently enrolled.

The Department arranged for training of private providers in 3-5-7 (permanency preparation, family engagement), in violence prevention/reduction (Six Core Strategies) and in a trauma informed foster parent training program.

#### Technical Assistance

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

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

Early Childhood (OEC) and the State Department of Education (SDE) systems in support of building an infrastructure to prevent and intervene on problems related to Fetal Alcohol Spectrum Disorder (FASD) and Neonatal Abstinence Syndrome (NAS). In addition, the DCF and DMHAS already have braided funding to hire the first-ever FASD Statewide Coordinator to oversee the development of statewide FASD and NAS policy and practices, and to serve as the primary point of contact for IDTA.

During the 18-month IDTA project CT will:

- **Establish a FASD/NAS statewide coordinator,**
- **Complete a shared values inventory** with project partners to identify mutual priorities related to the six IDTA goals (screening and assessment, engagement and retention in treatment, data and information sharing, joint accountability and shared outcomes, services for pregnant women and substance exposed infants, and safety, permanency and well-being of children and families),
- **Assess the state's capacities and needs** related to FASD/NAS that will serve as the architecture for establishing policy and developing infrastructure for prevention and intervention services including workforce development, and identification and implementation of best-practice models,
- **Develop a statewide plan** to address FASD and NAS in a coordinated fashion to offer a continuum of services to vulnerable families, including prevention, early intervention and intensive intervention, and
- **Conduct financial mapping** to identify and maximize fiscal resources to support ongoing FASD/NAS efforts.

CT's IDTA project will mark the state's first attempt at a coordinated cross-agency effort to address substance exposure among infants and problems related to FASD/NAS. In fact, currently CT has no formal working group, legislation or practice guidelines that specifically target this population. CT's IDTA project will be implemented as a statewide infrastructure development program to address FASD/NAS that will include a financial mapping component

to identify opportunities for financial support for workforce development, policy and practices recommended by the inter-agency collaboration during the planning process.

Annie E. Casey Foundation/Child Welfare Strategy Group continues to provide Technical Assistance for statewide implementation of Child and Family Teaming, which included considered removal (pre-removal meetings), and permanency teaming. Casey has been actively involved in planning meetings and has provided training to Administration, Regional Managers and provided support to Training Academy Trainers around the model. They have provided regional case consultation and have facilitated coaching sessions for regional staff to enhance competencies of our staff. Since July 2013, Casey has been co-facilitating the Permanency Teaming Steering Committee designed to support the development and implementation of permanency teaming. Casey has actively participated in planning and helped to sponsor the Law Forums on permanency teaming. Their contract is expected to end this year.

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

## 6. Consultation and Coordination Between States and Tribes

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

The CARELINE screens for MPTN involvement according to a select few case addresses

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

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

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

There is a longstanding Memorandum of Understanding between the State and the MT. There is no similar agreement with the MPTN.

There are ad hoc meetings scheduled with the MT. The content of the meetings is oriented to the Memorandum of Understanding. This includes case specific discussion of State interventions with MT members. The State notifies the MT of all accepted reports regarding their members. Discussion is held in a confidential meeting at tribal offices. The meetings

are also used as an opportunity to advise the Tribe of new State initiatives; recent past and present discussions have included Structured Decision Making, Differential Response System and Considered Child and Family Team Meetings for Considered Removals.

Regarding the MPTN, while no formal arrangement is in place for regular meetings, there is a well noted single point of contact, their Director of Child Protection. The State continues to have a positive working relationship with the Director.

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

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

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



There have been no ICWA compliance issues identified with the MPTN or MT over the last six years. Some DCF area offices have undertaken recent training efforts on ICWA. Newly hired Social Workers are trained on ICWA during pre-service training. Participation in a monthly, country-wide telephone conference also occurs with either the Norwich Area Office Principal Attorney and/or Program Manager for Intake. This has served to keep the office/agency abreast in any changes to ICWA as well as create awareness for training opportunities.

Other activity with the tribes included a 2015 invite for participation in the development of a Substance Exposed Infant (SEI) and the Fetal Alcohol Spectrum Disorder (FASD) prevention and identification initiative.

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

A copy of the State's most recent Annual Report will be provided to the tribes post submission.

## 7. Monthly Caseworker Visitation

Plans are currently underway to expend the monthly caseworker visitation funds. A portion of the funding will be used to sponsor a conference for youth and their social workers. Funding has been allocated to each region to develop plans designed to promote monthly caseworker visitation. All regions have decided to utilize funding to promote our permanency teaming practice, specifically focusing on engaging youth in the case planning process. It is anticipated that funding will be fully expended by the end of the federal fiscal year.

CT continues to do well in relation to monthly caseworker visitation. Frequency of visitation continues to be discussed and monitored in supervision. The implementation of permanency

teaming will further enhance the quality of worker/child visitation as the model is designed to promote discussions around the child/youth’s need for safety, permanency, and wellbeing.

**8. Adoption and Legal Guardianship Incentive Payments**

Connecticut has not received adoption incentive payments.

**9. Child Welfare Waiver Demonstration Activities**

Connecticut has no Child Welfare Demonstration Activities.

**10. Quality Assurance System**

See page 78.

**Section D: Child Abuse Prevention and Treatment Act (CAPTA)**

**CHILD ABUSE AND PREVENTION TREATMENT ACT (CAPTA) FFY 2015**

The figures provided in the table above reflect anticipated expenditures. The programs are funded at levels that exceed the award amount. These programs are being supported through multiple year awards, including FFY 2014 and FFY 2015. The Contractors for the MDT’s and Domestic Violence Services were selected through a procurement process.

<b>Services/Activities</b>	<b>Total Funding</b>	<b>Fam Sup</b>	<b>Prot Svcs</b>	<b>Fam Pres</b>	<b>Reun Svcs</b>	<b>FP Recruit/Trng</b>	<b>AP Recruit/Trng</b>
Multidisciplinary Teams	\$175,000		\$175,000				
Domestic Violence Services	\$50,262	\$12,565	\$12,565	\$12,565	\$12,565		
CT Association for Infant Mental Health	\$37,667		\$37,667				
Dad’s Matter Event	\$1,600		\$1,600				
FAVOR	\$36,828	\$7,365	\$7,368	\$7,365	\$7,365	\$7,365	
Total:	\$301,357	\$19,930	\$234,200	\$19,930	\$19,930	\$7,365	\$0

## DESCRIPTION - CHILD ABUSE AND PREVENTION TREATMENT ACT (CAPTA)

Multidisciplinary Teams (MDT): The Governor's Task Force on Justice for Abused Children, first established in 1988, identified the need for greater coordination of agencies involved in the investigation, intervention and prosecution of child sexual abuse and serious physical abuse cases. The development of multidisciplinary teams that coordinate the early stages of an investigation has provided a means of maximizing community resources that strengthen and improve interagency response and interventions.

The purpose of Multidisciplinary Teams is to improve the investigation and prosecution of serious physical and sexual abuse cases while minimizing secondary trauma to the child. Connecticut has continued to recognize the inherent value of this collaborative effort. These teams have had a positive impact on the quality of work provided to child victims throughout the member disciplines. Connecticut utilizes state funding and the Basic Child Abuse Grant to support our Multidisciplinary Teams.

The development of teams has strengthened the joint DCF/law enforcement response and has promoted the use of trained forensic interviewers. The creation of additional teams has allowed prosecutors to have access to at least one multidisciplinary team in every judicial district in CT.

The following teams are funded under the CAPTA grant:

- Child Guidance Center of Southern Connecticut – Stamford
- Middletown Police Benevolent Association – Middlesex County
- Lawrence and Memorial Hospital – New London County
- Day Kimball Hospital – Windham County and portions of Tolland County
- Community Mental Health Affiliates – New Britain
- Charlotte Hungerford Hospital – Torrington
- Waterbury Youth Services System – Waterbury
- Clifford Beers Clinic – New Haven County

Statewide, a Program Quality Coordinator provides managerial and administrative oversight of MDT contracts and addresses issues or concerns related to service provision. The Department of Children and Families designee to the Governor's Task Force on Justice for Abused Children currently functions in this capacity.

Integrated Family Violence Program: Integrated Family Violence Service is an in-home service for families where domestic violence has been identified. It is designed to provide a coordinated intervention to the entire family including the batterer, the survivor and children emphasizing cross-system coordination. Core services include safety planning for the survivor and the child, batterer interventions, trauma focused work with children, and dyad-based interventions focused on repairing and healing relationships. Six providers are currently delivering the service to seven Area Offices. These programs have been supported by both federal and state funding. This service has been redesigned and a new model - IPV-FAIR has been created. Three providers were selected through a procurement process and will be delivering the new service statewide, beginning July 2015. (See Description for IPV under Services Continuum).

CT Association for Infant Mental Health - See description under Promoting Safe and Stable Families.

Dad's Matter Event: The Department of Social Services, Department of Children and Families and the City of Waterbury co-sponsored an Inaugural Fatherhood Awareness Day 5K Race, 1 Mile Walk and kids fun run entitled "Dads Matter Too". The event focused on raising the awareness on the importance of fathers in the lives of their children and in our society. The day featured food, beverages, family friendly activities, face painting, games, vendors, resource booths for fathers and families, giveaways and live entertainment. Federal funding was used to provide T-shirts for all participants and the purchase of two bicycles to offer as a raffle prize.

Citizen Review Panel Support: There are a number of parent advocacy groups in the state that are designed to review Department practices specifically in the areas of behavioral

health. FAVOR is a statewide Family Advocacy Organization for Children’s Mental Health. Their mission is to enhance mental health services for children with serious emotional disorders by increasing the availability, accessibility, cultural competence and quality of mental health services for children through family advocacy. This organization agreed to broaden their focus and responsibilities and function as two of Connecticut’s three Citizen Review Panels. In order to support and encourage parental participation, the Department has agreed to allocate funding for members to receive stipends for transportation and daycare costs, as well as to assist FAVOR for associated meeting costs. The Executive Director of FAVOR continues to facilitate and coordinate meetings and oversee the work produced by the panels.

The State Advisory Council (SAC) receives funding from the Department to support its CRP work. FAVOR functions as the fiduciary for the SAC.

[CAPTA Spending Plan FFY 2016 \(Proposed\)](#)

<b>Services/Activities</b>	<b>Total Funding</b>
Multidisciplinary Teams	\$175,000
Intimate Partner Violence-FAIR	\$50,262
FAVOR	\$36,828
Total:	\$262,090

[Preventing Sex Trafficking and Strengthening Families Act, P.L. 113-183](#)

The Governor's Task Force for Abused Children has focused efforts on the critical issues of Commercial Sexual Exploitation of Children (CSEC) and Domestic Minor Sex Trafficking (DMST) beginning in 2013. Each team was charged with coordinating training for their team with a goal to have every team trained in one year; as of January 20, 2015 all teams have been trained. In addition to the rollout of the training the Co-Chair of the Executive Committee has visited every team in 2014 in an effort to meet the various team members,

understand the local challenges and discuss the Human Trafficking initiative ensuring commitment across the state. As of July 2014 each team has been reporting monthly on the number of associated cases and outcomes to the Governor's Task Force: of the 94 unique CSEC/ DMST referrals in 2014 to DCF 21 referrals were reviewed by an MDT. There has been team restructuring to ensure the leads of this effort are grounded in DCF regions and the local MDT's; new structure supports intensive case management, local service development and law enforcement collaboration. The HART Leadership Team has been restructured to include all the DCF HART Liaisons, 3 MDT Coordinators and the Director of the Connecticut Children's Alliance with specialty membership based on current team efforts. The HART Team has been restructured and is now tri-chaired including one DCF HART Liaison and one MDT Coordinator. The coordinator for the GTF is now a member of the Department of Children and Families (DCF) Human Anti-Trafficking Response Team (HART) and DCF local HART liaisons are accessing the resources of their local MDT teams. DCF received a new grant on September 30, 2014, Grants to Address Trafficking within the Child Welfare Population, Connecticut's Human Anti-trafficking Response Team (HART) Project providing the first trafficking related funds to support these efforts. The grant included a full-time HART Coordinator hired through the Village for Children and Families; entity providing the GTF Coordinator. The two Coordinator positions allow for optimal coordination and collaboration ensuring all aspects of these efforts are seamless.

The new HART grant has financially supported subcontracting with an independent evaluator, ICF Incorporated, LLC, evaluating our HART Project by completing a state-wide Needs Assessment and supporting the development of long-term project outcome measures. In addition, funds have been designated to enhance DCF's data collection system, Provider Information Exchange (PIE), with the ultimate goal at the end of the 5-year project to be fully automated; current indicators being collected manually.

The newly revised HART webpage went live in April 2015. The new site ensures state and national sharing of information and direct connections to the teams doing this work on a daily basis.

**<http://www.ct.gov/dcf/cwp/>**

The state of Connecticut recently passed legislation that went into effect on October 1, 2014 requiring MDTs to review human trafficking cases - Public Act 14 -186: An Act Concerning Department of Children and Families and Protection of Children allows HT victims classified as “uncared for” so CTDCF’s Multidisciplinary Teams (MDTs) can provide immediate services to victims and training to law enforcement on DMST. A new piece of legislation was submitted for the 2015 session: HB 6849, An Act Strengthening Protections for Victims of Human Trafficking:

- Section 1 expands the services currently provided by the Department of Public Health, including counseling regarding HIV and acquired immune deficiency syndrome, HIV-related testing, and referral services, to victims of trafficking in persons and other commercial sexual exploitation of children acts;
- Section 2 expands the membership of the Trafficking in Persons Council to include public members who work with child victims of commercial sexual exploitation and child trafficking victims;
- Section 3 permits a minor who has incurred a criminal record as a result of being trafficked to expunge the records immediately or, at latest, upon turning 18 years of age;
- Section 4 eliminates the requirement that force or threat of force, fraud, or coercion be used in sex trafficking of a minor under age 18. This section also expands trafficking in persons to include those who have knowingly assisted, enabled, or financially benefited from domestic minor sex trafficking;
- Section 5 expands crimes for which wiretapping can be authorized to include trafficking in persons, promoting prostitution in the first degree, aggravated sexual assault of a minor, enticing a minor, and employing a minor in an obscene performance;
- Section 6 makes an exception for commercially sexually exploited minors under the age of 18 from the listed ineligibility factors for filing an application for compensation, award of compensation and amount of compensation.

This legislation addresses all of the gaps identified by the Shared Hope Protected Innocence Challenge: State Report Cards from 2014. This legislation is currently on the House calendar;

public hearings occurred in April 2015.

Trainings on CSEC and DMST have increased in Connecticut including but not limited to: 1) Introduction to CSEC and DMST, 2) Day 1 Basics of CSEC and DMST, 3) Day 2 Responding and Interventions, 4) Demand, 5) Boys and DMST, 6) CT POST training for law enforcement and 7) new foster care model. Over the year more than 40 trainings have been conducted training hundreds across the state for multiple audiences including but is not limited to Child Welfare staff, Probation staff, court personnel, law enforcement at all levels, legal representation at all levels, service providers, schools, medical providers including school nurses, universities including schools of social work and medical students and multiple community organizations including the faith based community. Several Training of Trainers (TOT's) have occurred and/or are scheduled to increase capacity ensuring state-wide coverage: 1) Introductions to CSEC and DMST, 2) Not a #Number, 3) My Life My Choice and 4) POST Certified Law Enforcement Training.

Service provisions for this population have increased now including Rapid Responses and the Survivor Care Program. The Rapid Response is a 1 time intervention with a youth to engage, safety plan and provide basic resources much of which is included in the Backpacks they receive during the intervention. The Survivor Care is a long-term service that is best described as a combination of intensive case management and 1:1 mentoring by a person specifically training in CSEC/DMST. The process of "training up" our service provider network continues allowing CSEC/ DMST referrals based on staff competencies. The new foster care model is in the middle of rollout; 12 agencies across the entire state have been trained and the training for the foster parents is scheduled for the end of May 2015. Specialized mentoring resources exist in two regions in the state; training of all mentoring providers will occur in May 2015 and a specialized training and curriculum will begin. Existing resources are being explored for this population such as Community Housing Assistance Program (CHAP) focused on transitioning youth into post-secondary education and Community Housing Employment Enrichment Resource (CHEER) focused on supporting transitioning youth to gainful employment.



There have been no changes in state law or regulations relating to the prevention of child abuse and neglect that would affect the state's eligibility for the CAPTA state grant.

### Citizen Review Annual Reports

No Annual Reports from Connecticut's CRPs have been received. In May of 2015 the CRP's supported by FAVOR were reformed under new leadership and planning is in place to issue reports in July 2015. The Department will work with FAVOR to produce a final report and will provide a formal response when it is submitted.

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## Section E. Chafee Foster Care Independence Program

### **Serving Youth Across the State**

Connecticut is a state-administered child welfare agency with six regions. Contracting for services is a centralized function that ensures services are available across the state to all youth. Unique services can also be purchased locally through wrap-around funding if there are local gaps in the service array for youth. Connecticut's Chafee services serve youth through the age of 21. DCF have statutory authority to keep young people voluntarily in the care of DCF past their 18th birthdays and have recently expanded the services that are available to transition-aged youth. There are no systemic barriers in the state that preclude

us from serving youth of various ages and at various states of achieving independence. In the 2015-2019 implementation period, DCF will be adopting a new independent living assessment and curriculum that is currently in use by the adult Department of Mental Health and Addiction Services (DMHAS). This assessment will be administered to all youth before they participate in Independent Living Skills training and post-training help prepare youth for success.

DCF utilizes both state and ETV funds to provide services to youth who have left foster care for kinship guardianship or adoption after attaining the age of 16. Through ETV funds, DCF oversees a grant program that provides up to \$5,000.00 per academic year to youth involved in a post-secondary program. In accordance with the Chafee ETV Program, DCF utilizes the cost of attending an institution of higher education (as defined in section 472 of the Higher Education Act) to determine costs allowable under the Connecticut ETV program. DCF will continue to oversee the state's ETV program in the upcoming planning period.

#### [CFCIP Program Improvement Efforts](#)

The Department has a strong network of Youth Advisory Boards (YABs) that operate in each of its six regions. The YABs are comprised of young people in the Department's care who meet on a regular basis to provide feedback and recommendations about DCF's service array and practices. Representatives from the regional YABs convene quarterly at a statewide meeting with senior leaders at the Department, including the Commissioner. Over the next five years, we will continue to use this structure to gather input from the young people in our care about the service array available to them.

#### [National Youth in Transition Database \(NYTD\)](#)

The NYTD Survey data is being reviewed to determine where the Department can provide specific information/training to our staff, youth and stakeholders that will better assist foster youth with a more successful transition to adulthood. One example is with health insurance. Current foster youth need to know their present health care plan and, that for the vast majority of them, that coverage will continue until their 26 birthday. When the department is

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surveying former foster youth who report having no health care coverage, the department makes youth aware of their current coverage and possible continued eligibility and how to access this benefit.

Additionally, survey data provides the department with information that may lead to additional program development and/or program modification. One example is with employment. Low employment (part/full time) rates, especially for older youth in care, needs to be addressed in order for youth to have better outcomes. Employment training programs funded by the department need to be reviewed for utilization and outcome data and additional employment training opportunities need to be explored for youth to leave care with both work experience and a savings account.

Lastly, review of the survey data has alerted the department of the need to clarify for staff and youth, questions that will lead to more accurate data collection. An example is with the question that asks if the youth is in foster care. Depending on the staff and/or youth's definition of "foster care" the resulting data may be very inaccurate. To address this issue, the department (CO IL and IS) reviews the surveys completed each reporting period to ensure youth are correctly identified as "In Foster Care" and corrects answers accordingly. NYTD Independent Living Services data is available but unfortunately is not being used for service delivery improvements nor being shared with stakeholders. Data elements collected for this report are based on several Adolescent Services Payment codes attached to youth that are available in LINK and do not include nor accurately represent many services that are paid for by the department through contracts or by fee for service. DCF provides services through "fee for service" payments as well as through contracts for many independent living services that provide one or more of the elements identified in the "Independent Living Services" data report and these are not reflected in this data, thus negatively skewing the number and type of services youth receive.

While there is a 'snapshot' format of the NYTD data, it can be used as a resource to talk with youth, providers, the courts, and other stakeholders about service and youth transitioning out of foster care. The Department addresses the above issues by providing technical

assistance and training to the staff who are assisting youth with completing the surveys so more accurate data can be gathered. Central office staff regularly contacts area office staff to alert them of surveys needing to be completed and assists with questions related to these surveys in order to better capture quality survey data. Additionally, the Department is in the process of redesigning the State SACWIS and this new system will allow for additional services to be captured by linking services to individuals in order to better capture the many independent living services provided to Connecticut foster youth.

[How CT provides youth with certain documents when they age out of foster care:](#)

The department provides youth 18 and older who are discharging from care copies of the following documents: educational records; medical records including medical history of family members, to the extent known and obtained from the case records, as the law allows; original birth certificate and an extra copy; original social security card and an extra copy; passport; immigration and/or citizenship papers.

[How CT includes youth age 14 and over more fully in case planning:](#)

The department invites and encourages youth to participate and if possible to attend the Administrative Case Review (ACR). Accommodations are made to hold the review at a time and location that is convenient to the youth. At age 16, the department develops a Transitional Plan for each youth in the department's care for the purpose of permanency planning and preparation for discharge from care. The plan is youth-driven and based on the youth's identified needs prior to and at the time of discharge. The Transition Plan is reviewed at the first Administrative Case Review after the youth's 16th birthday and reviewed and revised at subsequent ACR's as long as the youth remains in care. The implementation of CR-CFTM and Permanency Teaming will promote active engagement of youth's involvement in case planning and decision making activities.

[Describe any planned use of funds \(Chaffee\) to support engagement in age or developmentally appropriate activities](#)

The Department builds into the Chaffee grant funding for developmentally appropriate activities as well as annually providing funding to each Regional Youth Advisory Board for such activities.

**Education and Training Voucher Program**

Annual Reporting of Education and Training Vouchers Awarded

Name of State: State of Connecticut Department of Children and Families

	<b>Total ETVs Awarded</b>	<b>Number of New ETVs</b>
<b><u>Final Number: 2013-2014 School Year</u></b> (July 1, 2013 to June 30, 2014)	(164 computers distributed + 52 students summer intersession + 4 Students of adoption/guardian + 8 over budget +6 Loan reimbursement <hr/> 234 recipients)	165 (164 computers + 1 new ETV recipient)
<b>2014-2015 School Year*</b> (July 1, 2014 to June 30, 2015)	178 computers to be distributed + 33 students summer intersession +2 students over budget +3 Students of adoption/guardian <hr/> 216 awarded	Anticipating a total of 210 (200 computers + new ETV recipients)
2015-2016 School Year Anticipated projections for the next school year		

Narrative:

The Connecticut Department of Children and Families (DCF), utilizes some of the Education Training Voucher funds to support 2 Pupil Services Post-Secondary Education Consultant positions (one full time, and one part time) since 2006. The Post-Secondary Education Consultants assist Social Workers, community providers and foster youth with transition and retention in PSE programs and into adulthood/out of DCF care. To fulfill a need regarding PSE data, DCF hired a durational Children’s Services Consultant in November 2012. This position focused on creating and maintaining a data base focusing on foster youth transition, enrollment and retention in PSE. This durational position ended in October 2014. Data collection and maintenance for PSE in Connecticut DCF has remained an ongoing challenge for the department. There is currently a restriction on hiring due to a budget deficit, all new positions for education have not been approved.

The Education Training Voucher (ETV) has been offered to youth who are in the foster care system and enrolled in a post-secondary education program, for youth who have had their guardianship transferred from the Connecticut Department of Children and Families to

another caregiver after the age of 16 (either subsidized or unsubsidized) or a youth who has been adopted after the age of 16 and is enrolled in a post-secondary education institution. During the year July 2013 - June 2014, CT DCF covered tuition expenses for 52 youth in foster care who are taking summer courses. It is anticipated that foster care students enrolled in a post-secondary education institution will take advantage of this opportunity offered again this school year. Currently, the Post-Secondary Education unit has received 13 applications for summer funding. The deadline for submitting funding requests is June 18, 2015. We are anticipating more applications from youth to benefit from the summer course funding for this year. The summer courses are toward the completion of a degree, or certificate program. During summer 2014 the Department funded 33 foster youth who requested funding for summer courses, and recently received an additional 13 funding requests, totaling 46 summer course funding provided this school year (July 1, 2014 - June 30, 2015).

There were 2 youth who requested and received special permission to utilize ETV funding for post-secondary education expenses outside of their annual budget in the school year of 2014-2015.

The Department continues to make available vouchers for Education and Training program and expenses to youth who have aged out of the foster care system or who after attaining the age of 16 have left the foster care system due to being legally adopted or who are in kinship subsidized transfer of guardianship care. From July 2013 - June 2014, the Department awarded 4 Education and Training vouchers with one being a new recipient. During this school year July 2014 - June 2015, the Department has paid for 3 ETV grants to this population. In addition, 73 applications were mailed out to eligible youth to benefit from the ETV grants available to adopted and guardianship transferred youth in May 2015. Applications are due back to the Department by August 1, 2015. Any applications received prior to June 30, 2015 by the Department for eligible youth prior to end of this school year (2014-2015) will be paid in this school year as well.

The Department continues to purchase computers, printers and supplies for students in the foster care systems that are in a Post-Secondary Education program. July 2013 - June 2014, the Department purchased 203 computers for anticipated eligible youth who would enroll in

a post-secondary education institution in the fall of 2014. Of the 203 anticipated eligible youth, 53 became ineligible for the computers, printers and supplies due to not enrolling in post-secondary education for various reasons such as an extended year through their special education school district, not graduating or not actually enrolling in a post-secondary education program by the fall. These 53 remaining computers are still new and have been accounted into this school year's ETV recipients.

Therefore, 164 computers, printers and supplies were distributed to new recipients during the 2013-2014 school year. The remaining 53 computers from last school year (2014-2015) will be distributed to youth who graduate high school or earned a GED in June 2015 and are enrolling in a post-secondary education program in the fall of 2015. This year the Post-Secondary Education Consultants have reviewed academic profiles of 207 youth in the foster care system that are anticipated to graduate June 2015 and enroll in post-secondary education in the fall 2015. The Department purchased 125 new computers and added the 53 left over computers from last year cohort, totaling 178. There have already been youth who have become ineligible for a computer, printer and supplies due to case being closed, not earning enough credits to graduate, extending school year due to IEPs and special education services etc.

The Department awarded a total of 234 with 165 being new recipients from July 2013- June 2014. The total Education and Training Vouchers awarded through the Department of Children and Families from July 2014 through June 2015 is 216 with 178 as new recipients awarded. The ETV grants awarded to adopt/guardianship youth in PSE were all repeat grants awarded during the school year 2014-2015.

### Adoption Recruitment/Retention/Support Activities

Foster and Adoptive Parent Recruitment activities throughout the state:

- Town sporting events: soccer, baseball, football/cheerleading;
- Preschool programs;
- PTA (Parent Teacher Association) meetings;
- Town recreation center activities;
- Hair dressers/barbers – back to school haircuts;
- Radio Interviews;
- WIHS Radio Interviews;
- Bus tail advertisements
- WATR Radio Interviews;
- Statewide Parent Teacher Association Council guest speaker;
- Open Houses;
- Big E – Connecticut Day (September of each calendar year), front foyer exhibit space;
- Heart Gallery Display (photos and brief biographies of youth);
- Social Media posts about foster care and adoption needs, highlights, etc.: Facebook, Twitter, CT Parent web site;
- 211 Information Line; staff phone operators have information about foster care and adoption needs in CT to share with callers who are interested in learning how to become a foster/adoptive parent or a resource for a child.

In 2009, a recruitment and retention plan was developed to increase the number of African American and Hispanic foster and adoptive parents. In addition, recruitment and retention plans specific to the communities of and populations served by the Department's local area offices set forth specific goals and targets for the recruitment of culturally, racially and linguistically diverse homes.



In 2009 and 2010, in conjunction with AdoptUsKids, DCF conducted a "market segmentation" plan. This plan was supplemented and expanded by the DCF Office of Research and Evaluation (ORE), which helped further refine the data and added a geo-mapping component to create a more comprehensive picture of foster care needs in Connecticut. The data divides the Connecticut population into clusters and then determines which clusters best represent the profile of our current successful foster families in Connecticut. Based upon this data, four segments were identified as providing the greatest foster care recruitment opportunities. This data, while helpful in focusing our work, did not provide the next necessary next step which was to develop a communications plan that would allow us to reach out to perspective foster families with a targeted message on the need for foster families and the benefits of being a foster family. During 2014 and early 2015, the Department has made some shifts to focus greater resources on targeted, specialized and extreme recruiting. This approach is designed to be more thoughtful and intensive, shorten the timeframes to identify families for specific youth, as well as to be more strategic in outreaching to people who are most likely to become foster or adoptive parents. This work will continue to evolve throughout 2015.

During calendar year 2014, the Department successfully licensed 742 new foster and adoptive homes. The breakdown of those new licenses is as follows:

- Foster homes - 113
- Adoptive homes - 72
- Special Study homes - 116
- Independent homes - 25
- Relative homes - 416

The Department will continue to move towards placing children with relative/kin throughout 2015.

In 2014, the Department started Caregiver Support Teams in all six regions. There are 676 slots statewide. Utilization as of April 2015 is at 330 slots, which is up from 227 in January, 2015. The caregiver support team provides much deserved in-home supports to both kin

and non-kin family based placements.

### **The Heart Gallery**

Since 2003, the Heart Gallery continues to bring awareness to the Connecticut public about children in state care that need a permanent family or lifelong family connection. In November 2005, it was expanded to be on display continuously throughout the year in a minimum of two (2) locations. The Heart Gallery has been featured in venues such as the State Capital, children's museums, theaters, art galleries, community centers, libraries, malls, churches, hospitals, and commercial spaces throughout Connecticut.

From 2005 to early 2014, 320 children have been featured in the Heart Gallery, and 116 children have been adopted. Currently, there are 8 youth featured in the Heart Gallery. In 2014, 11 new youth were featured in the Heart Gallery. Also in 2014, 21 children left the Heart Gallery because the Department found either family placements with relatives or non-kin foster families (18 youth), because they aged out (2 youth), or because youth needed congregate care treatment (1).

### **GOOGLE and technology based recruitment:**

DCF continues to recruit on the web via the purchase of a Google ad. Key words entered into a Google Search including "adoption" and other related phrases connecting a viewer directly to the Department's website. This recruitment strategy brings a monthly average of 15 families calling the CT Foster and Adoptive Parent Kid Hero line who express an interest in becoming licensed for adoption. The following results from January 1, 2014 to December 31, 2014 are as follows:

- Total of 386,703 page views
- 68,992 unique visitors
- 96,338 site visits
- 30.5% (117,946) are "new visitors"
- 60.40% (268,758) are "returning visitors"

The visitors viewed an average of 4.01 different pages per visit and spent an average of 2 minutes and 44 seconds on the site. As a result of the "Google" ads, in 2014 a monthly average of 150 families called the CT Association of Foster and Adoptive Parent's Kid Hero line, inquiring about the process to adopt a child.

The Department has a contract with the nationally recognized AdoptUsKids, where DCF features waiting children on the AdoptUsKids web site. DCF Permanency Exchange Specialists use this web site, the Department's website, and A Family for Every Child's website/Heart Gallery, and other web based sites highlighting the children for whom they provide specific recruitment.

DCF continues to recruit on the web via "Google" ads. Key words entered into a "Google" search including "adoption, adopting in CT" and other related phrases connect a viewer directly to the Department's website CTfosteradopt.com.

#### **Photo-listing:**

The Department utilizes web based sites for the purpose of securing permanent adoptive resources. DCF features waiting children on the AdoptusKids web site. DCF Permanency Exchange Specialists are the contact person for children for whom they provide specific recruitment on this web site and on the Department's website.

#### **Wednesday's Child:**

Until 2014 the Department recruited adoptive families for waiting children by featuring a child, sibling group, or a successful adoptive family on a "Wednesday's Child" television segment. WTNH, Channel 8 in New Haven CT continues to provide this service, funded by New Haven based, Casey Family Services and the Connecticut Association of Foster and Adoptive Parents. WTNH aired the Wednesday's Child segments during their noon and evening news programs each Wednesday. The program was managed by the DCF Adoption Resource Exchange. 135 children were featured and 51 children were adopted. In addition to children being featured, an additional 46 segments aired including 31 segments of testimony from successful adoptive families. Other segments included highlights from

November's National Adoption Day celebrations and other adoption related stories. This initiative is no longer operational. However, in 2015 the Department began a regular segment on WFSB's Better Connecticut program for youth who are in need of a home.

### **Wendy's Wonderful Kids:**

A private foster care agency (Klingberg Family Center) was awarded the Wendy's Wonderful Kids (WWK) contract sponsored by the Dave Thomas Foundation in 2006. Via a service agreement with DCF they provide services to achieve permanency for children in state foster care programs nationwide. The WWK social worker has a caseload of 15-20 children and youth in need of permanency. They work with the APRE Supervisor for referrals for their program. This resource was expanded in 2014 and there are now 4 Recruiters in CT doing this work. The program operates at a consistent capacity of 60 active cases statewide.

### **Child-Specific Adoption Recruitment:**

As a part of a child's individual recruitment plan, emphasis is placed on recruitment from a child's perspective; looking first at the child's natural network of important people in his/her life, whether those people are family, kin, or viewed as important as seen from the child's perspective. Emphasis on the need to focus on recruitment within the child's family or origin, kin and community remains constant. A child's case record is thoroughly reviewed as a part of this process. Additional efforts are made targeting areas which are most likely to touch a child's life, finding connections from within a child's community or based on a child's request or interest. Outreach includes: photo displays, child specific presentations or articles and newsletters highlighting specific children include: collaboration with four (4) cable access shows, five (5) children's museums, six (6) newsletter/ magazine or newspaper submissions, various town Parks and Recreation Departments, True Colors initiative and community bulletin boards. Recruitment for children of color has been conducted through collaboration with the Delta Sigma Theta Sorority, Meriden Black Expo, the First Cathedral of Bloomfield, the State of Black CT Alliance (SBCTA), Puertorriqueñísima Radio and the Faith, Family and School Conference.

The DCF Permanency Exchange Specialist reviews the child's DCF case record aka "case

mining" identifying adults who are and were linked to the child youth in the case history. The PES works various adults who are currently connected to the child i.e.: the child's caregiver, DCF Social Worker, clinicians, teachers, etc. Consultants work directly with the child/youth when at all possible for their input throughout the process. Once a family comes forward, the specialist takes a lead role in working and supporting the family until they are able to join a TIPS-MAPP training.

Child specific recruitment activities in 2012-2015 include some of the following; photo displays, child specific presentations, articles and newsletters, collaboration with four cable access shows, community bulletin boards, children's museums, magazine and newspaper articles and ads, events sponsored by True Colors. Child specific recruitment for minority children assigned to the ARE has occurred through collaboration with Puertorriquenisima Radio and the Latino Way. In 2014, these staff in addition those from private Therapeutic Foster Care agencies were trained in Extreme Recruitment techniques.

#### **While You Wait Events:**

Since 2005, DCF's Adoption Resource Exchange staff, continue to manage ongoing training opportunities for pre adoptive families called "While You Wait". Topics include: understanding legal risk issues in adoption, open adoption, managing behaviors which result from the effects loss and trauma experienced by children placed via the state's foster care system, adopting adolescents, and other related parenting topics related to adoption. Multiple sessions are planned for each year. These are held across the state on a regular basis in collaboration with DCF area office foster care and adoption units and CT Association of Foster and Adoption Parents staff. The events/activities listed above are supported through state funding.

#### **DCF Adoption/Permanency Resource Exchange child specific recruitment activities:**

In 2014, the Permanency Exchange Specialists from APRE provided child specific recruitment for 20 children and youth in need of adoptive families.

16 were youth ages 12-17

4 were under the age of 12

8 are African American or Latino children/youth  
10 are Caucasian children/youth  
2 are Bi-racial  
5 have significant medical needs  
10 have significant developmental disabilities  
There was 1 sibling group of two children

Child specific and targeted recruitment include public photo displays, child specific presentations, articles and newsletters, community bulletin boards, children's museums, magazine and newspaper articles and ads and events sponsored by True Colors. Child specific recruitment for minority children assigned to the ARE has occurred through collaboration with Puertorriqueñísima Radio. This work continued in 2014 and into 2015.

### **Technology Based Recruitment Activities in the Adoption Resource**

#### **Exchange/Permanency Resource Exchange:**

Since 2013, the APRE broadened the scope of technology based recruitment to include postings on the agency's Facebook page, Twitter account and the most predominantly used, Heart Gallery web site. Additionally, outreach and partnerships with statewide foster care community collaborative allows the photos and demographic write-ups of waiting children to be showcased on a variety of internet sources. E-mail "blasts" are sent out to the statewide PTA association and various professional company newsletters and quarterly reports. The Department has continued the contract with the nationally recognized AdoptUsKids, where DCF features waiting children on their national website. DCF Permanency Exchange Specialists use this web site, as well as "A Family for Every Child" website located in Oregon to highlight the children for whom we are currently most in need of families. This work continued in 2014 and into 2015.

#### **Minority Family Recruitment:**

DCF has continued to develop its Minority Family Recruitment initiative. The Department is targeting professional organizations that have large minority memberships (e.g., sororities,

fraternities, Urban League, NAACP, Jack and Jill, Connecticut Hispanic Bar Association, Black Social Workers Association, etc.). The goals for this endeavor continue to be:

- Increase the numbers of licensed African-American and Latino Foster/Adoptive parents in the state of Connecticut.
- Achieve permanency and finalization of adoptions for older African-American and Latino children in the agency's care.
- Increase knowledge of and favorable opinion about DCF foster care and adoption in African-American and Latino communities.
- Obtain research, including engage in surveying and focus groups, on adoption attitudes, practices, trends and beliefs in the African-American and Latino communities.

The Department has begun outreach to organizations that represent the broader socio-economic diversity that exists in communities of color and specifically the African American and Latino populations. The intent of the outreach was to establish 5 community forums around the State. These forums were intended to have community leaders, activists, politicians, and family members come and have a discussion with the Commissioner and other members of the Department about the philosophies, barriers, and strategies to increase placement of children with relatives as well as with people of their own race and ethnicity from their own community. One forum occurred during the year and the Department has charged The Continuum of Care Partnership Foster Care Working Group to address this issue and assist in implementing these forums.

**Foster/adoptive provider training:**

Up until 2015, prospective foster and adoptive families received 35 hours of pre-licensing training using the PRIDE curriculum. In 2015 DCF contracted with the Children's Alliance to implement a new trauma-informed statewide training curriculum for foster and adoptive parents called: Trauma Informed Partnering For Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP). TIPS-MAPP will be utilized by the Department and private Child Placing Agencies (CPAs) to create more uniform training practices across the State.

Prospective foster and adoptive families receive 30 hours of pre-licensing training using the TIPS MAPP. This curriculum is designed to help prospective foster and adoptive families develop five abilities that are essential for foster parents to promote children's safety, permanence and well-being. After completion of the program foster and adoptive parents will be able to:

- meet the developmental and well-being needs of children and youth
- meet the safety needs of children and youth
- share parenting with a child's family
- support concurrent planning for permanency
- meet their family's needs in ways that assure a child's safety and well-being

These trainings are held on a regular, ongoing basis, across the State, occurring in a variety of community settings. The trainings are often held in the evening or on the weekend.

Department staff and private therapeutic foster care (TFC) providers convene the TIPS-MAPP trainings. Child care is typically provided to aid families' attendance. In 2014, some regions began piloting additional pre-licensing training curriculum to supplement the required training. This includes a component on Health and Wellness.

The Department is in the process of reviewing the post-licensing requirements and options to ensure that foster parents are able to meet the expectations and develop the competencies they need to care for the children in their homes.

Additional achievements/progress in foster and adoptive parent recruitment and training in 2014 and early 2015 has included:

- Expanded our partnership with the Dave Thomas Foundation, Wendy's Wonderful Kids (WWK). Three more recruiters were added to Connecticut at no cost to DCF (Connecticut has had one recruiter through this Foundation since 2006). This will allow for more focused and child specific recruitment for our most challenging youth. The WWK caseloads stand consistently at capacity of 60 active cases statewide.



- Central Office, DCF Regional staff, partnering state agencies, and private providers have participated in a state sponsored "Lean" process focusing on foster care licensing process. This week long event resulted in concrete suggestions intended to reduce the number of steps required for families to become licensed (i.e., eliminating redundant steps) and reducing the time it takes for families to become licensed. During late 2014 and early 2015 the Department implemented the recommendations generated by the workgroup. These include: 1) improved consistency and standardization of our initial inquiry process through enhanced utilization of our foster and adoptive parent advocacy agency, CT Association of Foster and Adoptive Parents (CAFAP) so they are now the repository for all initial inquiries up through the families' attendance at an Open House in the Regional Office. 2) Updating foster care policy, creating a practice guide and streamlining the forms used. 3) Eliminating home study review by a Program Manager when no concerns are present. 4) Refining the background check process to significantly reduce the amount of time it takes to obtain the requisite checks. The work continues to implement all of these recommendations and continue to assess and refine other aspects of our work.
- Partnered with the Connecticut Association of Foster and Adoptive Parents (CAFAP) to implement a centralized training web list for families.
- Central office staff had duties re-structured and they were deployed half time to the regions to absorb permanency related work. These staff help in family search/engagement, case mining, and family outreach. These Central Office staff, along with private foster care providers and DCF Regional staff, were given training in Extreme Recruitment and Child and Family Teaming from national experts.
- Our contracts with private providers who offer post adoption support to families was adjusted so that the services can be given to transfer of guardianship families. Families who have guardianship of youth will have the same supports in place as families who have adopted.

- Developed a site audit process for therapeutic foster care agencies and the audits will ensure that recruitment and retention plans are in place.
- Central Office staff partnered with CAFAP and DCF Regional staff to expand a foster parent/youth satisfaction survey.
- DCF Regional offices received consultation from the CWSG on their local recruitment and retention plans and goals.
- The Department shifted the oversight of the community collaboratives to the regions. This allows for recruitment to be coordinated at a local level and tailored to local needs.
- The Department consolidated our lengthy hardcopy version of our foster parent manual into a streamlined collection of web links for families. We also translated this into Spanish.
- The Department re-opened the slots for Multidimensional Treatment Foster Care in one DCF region with one private provider. This is a foster care program designed to serve youth in the juvenile justice system. Families will be recruited for specific youth in our care.
- The Department has adjusted written contracts for congregate care providers; these contracts now include clear expectations for family engagement. The hope is that this will increase permanency for youth who reside in group care.

**Permanency Planning Services Program (PPSP):**

The Permanency Planning Services Program (PPSP) provides core contracts with 17 child-placing agencies in Connecticut. In addition to providing specialized recruitment services, an array of other permanency services include the following: services to legally free a child or

sibling group, pre-placement planning for the child or sibling group, assessment and a written home study for a potential adoptive family, transition and placement planning, post placement supervision, post finalization services, assessment services in reunifying a child with family, and assessment services after a child has returned to their identified family. All of these assist the Area Office staff in actualizing the child's permanency plan. Services are accessed by the use of a service agreement with the private child placing agency. In 2014, supports were expanded to cover transfer of guardianship families.

**Out-of-State Permanency Placement Services Program (PPSP):**

DCF Central Office staff provide ongoing assistance to DCF Area Office staff in identifying out-of-state private agency resources and negotiates contracts with out of state agencies upon Area Office request. The availability to quickly access supportive services for families, particularly across state lines, enhances the Department's ability to facilitate adoptive and relative placements for children. The Department utilizes web based sites for the purpose of securing permanent adoptive resources. DCF features waiting children on the AdoptusKids web site. DCF Permanency Exchange Specialists are the contact person for children for whom they provide specific recruitment on this web site and on the Department's website.

[Health Care Oversight and Coordination Plan](#)

In early April, the Department established the DCF Health Standards and Practice Committee (HSPC). Contained in DCF Policy, the Committee's responsibilities include but are not limited to:

- consulting on development of DCF's Health Oversight and Coordination Plan;
- review, recommend and monitor implementation of DCF Health Standards and Practice Regarding Health Care of Children in Care and any new policies and programs for delivery of primary medical or mental health services;
- assess the use of the Health Passport and other health documentation; recommend standards to assess adequacy and appropriateness of medical and mental health services;
- Inform DCF's plan for data development.

Membership on the HSPC includes representatives from Department of Social Services (Medicaid administrator), Department of Public Health, Department of Mental Health and Addiction Services, Department of Developmental Services, State Department of Education, Foster Parents, Child Abuse Pediatrician, CT AAP Chapter including Pediatrician with experience as a medical home, Child Psychiatrist, and a representative from Value Options, CTs Behavioral Health ASO. Initial HSPC meetings included a review of DCF's 2015-2019 Health Oversight and Coordination plan; a review of other states 2015-2019 plans; and a review of the 2008 Fostering Connections legislation. Priorities identified in these early conversations included the need to ensure that DCF's plan is more fully informed by key stakeholders and the critical component of implementation. Next steps for the Committee include education sessions to inform them about DCF initiatives that impact health including trauma-informed practice, permanency, early childhood and early identification of developmental concerns, behavioral health plan, and infant mental health.

#### [Health & Wellness Policy and Practice Guide: Translating Policy into Practice:](#)

DCF continues to work to enhance the health of children in care. A number of initiatives are focused on implementation of DCF's recently issued Health and Wellness policy and practice guide entitled "Standards and Practice Regarding the Health Care of Children in DCF's Care". Education is targeted toward key stakeholders including DCF staff, foster parents and providers and key strategy is to encourage collaboration on achieving best outcomes. Specific initiatives include the following:

- Training of AO staff: DCF's Nursing COP developed materials including a power point presentation and accompanying talking points aimed at educating DCF staff in AO about DCF's Health Standards. Materials focused on the translation of policy into practice and targeted practical applications. RRG nurses have performed trainings in their AOs and have also joined Health & Wellness Division staff in training new SW as part of pre-service and in-take social workers as part of their focused initiatives.
- Training of Foster Parents: Partnering with DCF's Foster Care and Adoption services unit including therapeutic foster care, Health and Wellness Division has revised and

enhanced its approach to educating foster parents. This strategy involves a multipronged approach to educating foster parents that evolves from general education of all foster parents to targeted and more extensive education of foster parents interested in caring for children with complex medical needs. This approach also includes attention to adult learning theory offering both in-person and online formats. Specific components of education include the following:

- Basic education of all foster parents. DCF is in the process of instituting practice that ensures that all foster parents receive education about health that includes a description of the health challenges that children in foster care face and an explanation of DCF requirements including the Health Passport. AO have begun to implement this training called “Fostering Health for Children in Foster Care” as part of their pre-licensure training of foster parents. The curriculum was developed by nursing COP with input from Foster Parents and AO staff. An online version of the training is also being developed using software that will ensure tracking and also permits evaluation and collection of feedback essential to QI/QA. Working with CT Association of Foster and Adoptive Parents (CAFAP), the online training as well as availability of in-person training performed by DCF and TFC staff will ensure that existing FP have an opportunity to get trained.
  
- Training of Relative / Kin who will be caring for children with complex medical needs: DCF is also in the process of revising our training for relatives and kin who assume responsibility for children with complex medical needs. This training is focused on providing them with information about resources in DCF and the Community that can assist them with managing a child’s complex medical needs. These include information about DCF’s Health Advocates, DPH’s “Medical Home Care Collaboratives” located throughout the state and community-based resources. This training is intended to supplement the Fostering Health curriculum and in addition to the in-person training for

relatives, an online version will be available to anyone interested in learning about these invaluable resources.

- Medically Complex Certification for foster parents interested in caring for children with complex medical needs. Included in DCF's practice guide for health is a revised system for classifying children with complex medical needs. This new 4 tiered system is based on the level of care a child requires and moves from classification 1, "potential condition-related risk" through classification 2, "medically at risk", and classification 3, "intensive medical needs" to classification 4, "technology or medically-dependent". Foster parents interested in caring for children in classifications 2-4 must complete a certification course led by nurses in the Complex Medical Unit of the Health and Wellness Division with lectures from community providers familiar with the needs of this complex population. In addition to this certification, prior to a child's placement, FP also receive training about a child's own health care needs entitled "child specific medical training" (CSMT) and age-appropriate CPR.

### DCF's Enhanced Multidisciplinary Evaluations (MDEs)

In addition to these general education initiatives, DCF also continues with some targeted initiatives focused on the Multidisciplinary Evaluation (MDEs) and dental care.

DCF fully implemented the enhanced Multidisciplinary Evaluation (MDE) model in January 2015. Described in DCF's practice guide, the new model includes clarification of components of the MDE, clarification of MDE clinic provider qualifications, standardization of the screening tools, revised and standardization of the MDE Report and standardization of DCF practice. Each of these changes are described here:

- All AO received training and education about the enhanced MDE. The training curriculum was developed by the MDE workgroup and to enhance

relationships, training was performed by teams composed of AO MDE liaisons and MDE clinic staff.

- The MDE clinic staff and clinicians were provided with training about the revised MDE including focused training on the selected screens. This included separate education from the CONCEPT grant team on trauma-informed practice and the 'trauma screen'. Responsive to increased understanding of ACES and other studies of childhood trauma, the goal of the MDE trauma screen is to identify children impacted by trauma who would benefit from intervention including more immediate therapeutic interventions such as CF-TSI and TF-CBT. Collaboration with the CONCEPT grant team also extends into data development and collection, ongoing updates and reviews of the trauma screening tool and inclusion in MDE workgroup discussions. (Further details about this initiative described previously in APSR).
- Of note – While the MDE clinics continue to assess for FASDs and we are encouraging attention to FASD, we found that our initial screening tool lacked specificity and sensitivity and that we promptly overwhelmed our limited resources. DCF's IDTA on Substance Exposed Infants and Fetal Alcohol Syndrome Disorders, will assist us in developing a comprehensive plan and with it, services to support the identification and treatment of children identified with FASDs including a system for screening within the MDE. More immediately we are looking for targeted training on FASDs for our MDE clinicians as well as primary care providers that will allow us to identify strategies and interventions to support children and foster families.
- The MDE policy was expanded and clarified. This included expansion of eligibility to include the expectation that all children entering care will received an MDE within 30 days of placement including repeat MDEs for children who are re-entering care. Policy also included expectation that each AO would develop procedures specific to their offices to ensure completion of tasks

necessary for ensuring quality MDE. Tasks include: description of the specific process and individuals responsible for completion of initial referral to MDE and submission of information about past history including behavioral and medical in advance of the MDE; description of process for reviewing the MDE findings including mechanisms for f/u with MDE clinic as well as mechanism for ensuring review by appropriate RRG staff. The AO procedure also includes a process for ensuring the dissemination of MDE report “Summary and Recommendations” section to child’s PCP and FP as well as a process for incorporating the MDE findings and recommendations into the child’s Case Plan.

- To best support the MDE and optimize this important tool, we are developing a QI/QA process that will allow us to review and inform improvements. Components include surveys of customers and consumers; data collection; audits of MDE reports through random review of representative sample of MDEs using a standardized audit tool and performed by an audit team composed of internal and external experts (ACR staff, mental health experts, pediatricians). Results of the rigorous MDE QI/QA process will be used to inform immediate practice but also inform future RFPs for the service.

### Regional Systems of Care Initiative

DCF is moving forward with our Regional Systems of Care Initiative that focuses on implementation of best practice through local partnerships involving DCF AOs, Foster Parents and Primary Care Providers. As mentioned previously this model, focused on community based providers, reflects recognition that the majority of children in DCF care remain in their community and are best served by providers familiar with them and their families. Steps in this effort include:

- Meetings between the Nursing COP “Provider Workgroup” and CT AAP Chapter Leadership



- The identification of two pilot sites through initial conversations with AO leadership and community pediatricians. These sites include; Region 4 representing Hartford and Manchester and Region 5, Waterbury Area Office. Meetings between AAP and AO leadership are scheduled for May, 2014
- The development of “introductory packets” for dissemination by AO RRG nurses to primary care providers they routinely use. Packets include letters of introduction; contact information for RRG nurses; and fact sheet highlighting key DCF information
- Drafts of power points: “Child Welfare and CT DCF for the Primary Care Provider” and “Pediatrics and Primary Care for DCF Staff”
- Partnership “Activities Grid” which guides conversations and identification of partners respective roles in accomplishing DCF required health standards for children in care

#### DPH Medical Home Care Coordination Collaboratives (HCCC)

DCF continues to participate regularly in the Hartford Care Collaborative with regular representation from AO social workers, RRG nurses, Health Advocates and members of Central Office Medically Complex Unit staff. More recently DCF has participated in the newly formed Care Collaborative in New Haven; one of the 4 additional Regional Care Collaboratives recently funded by DPH. At this initial meeting we shared information about DCF Health Standards, shared information about our participation in the CC in Hartford and identified possible DCF representatives. Our plan is to pursue alliances with each of the new collaboratives building on the success of the Hartford model.

#### Health Information and Documentation

We continue to work to enhance documentation regarding the health of children in DCF’s care. These efforts include:

- Informing planning of the new SACWIS system: Representatives from DCF Health and Wellness and RRG nurses joined other key DCF staff in meetings to inform initial planning of the SACWIS system. Attention was paid to 1) ensuring the creation of a health summary; 2) documentation and tracking of identified health standards and components of care; 3) access to a comprehensive immunization summary; 4) support of the health passport including a provider portal for completion of forms relating to health and a mechanism to alert staff (social worker and/or RRG nurse) to the new information. Forms to include in-take medical questionnaire, MDE report, reports of health visits, immunization records, evaluations and reports. Attention also paid to systems of information collection that will be readily accessible and searchable and permit collection of data on both the individual and in aggregate.
  
- Health Passport implementation and education through the Regional Systems of Care initiative. As a component of DCF's Health Standards, implementation and use of the health passport will be a part of our Regional Initiatives.
  
- The Division of Health & Wellness is developing a Share Point site that will provide access to all the Health Passport forms and information.
  
- Implementation of the Health Passport was identified as a key need by the Health Standards and Practice Committee. At our next meeting we will be asking committee members to identify how the groups they represent can encourage and enhance the use of the health passport. (Please see Health Passport section below)

#### Development of a Data Plan and Dashboard for Health

DCF Health & Wellness Division is partnering with internal and external stakeholders including the ORE on the development of a data plan and dashboard for health. Other key stakeholders include DSS and their ASOs for physical, mental and dental health, the HSPC, and DPH. Responsive to DCF 2015 Performance Measures, the data from this plan will be used to inform agency practice and to focus attention on key areas of practice that impact the health of children in care. Work is currently underway to identify appropriate measures of

health for children in DCF's care and this effort is being informed by national resources including CDC, Child Trends Databank, Healthy People 2020, NCQA as well as state resources such as CT Commission on Children's RBA Report Card; DPH programs including PRAMS, Title V MCHB grant, BRFSS, YRBSS and Medicaid reporting. Attention will be paid to measures that provide for some baseline or comparison and where possible allow attention to possible racial or ethnic disparities. This includes review of currently available data and measures within DCF through PIE, LINK and ROM reports. A preliminary list of possible measures has been developed and will soon be disseminated for comment from stakeholders. Our goal is to have a final plan available by September with a preliminary 'dashboard' available by late Fall 2015.

#### [ACCESS-Mental Health CT](#)

ACCESS-MH CT provides telephonic psychiatric consultations by child and adolescent psychiatrists to Primary Care Physicians in the state for all children under 19 years of age regardless of insurance coverage. The program allows for face-to-face consultations when a telephone consultation with a child psychiatrist and/or clinician is not able to completely address the PCP's questions. Care coordinators and family peer specialists assist in obtaining identified services. This program began on June 16, 2014. The three "hub" providers contracted to provide the services are Wheeler Clinic, The Institute of Living, and Yale Child Study Center. The program is managed by Value Options with DCF oversight. Each hub is comprised of a child psychiatrist, behavioral health clinician, family peer specialist and a care coordinator. The hours of operation will be from 9 a.m. - 5 p.m. Monday through Friday.

Future strategies include:

1. Each hub will conduct a webinar sponsored by the CT- American Academy of Pediatrics on topics identified by the enrolled primary care practices. The webinars will provide CME credits.
2. CHDI, a partner agency will provide ongoing training to the hub teams on training modules that can be provided to PCP offices on the identification, treatment and co-management of psychiatric disorders.

3. Computerized utilization reports and data sharing capacity will be implemented in 2015 and managed by Value Options.
4. Low utilizers of the program and practices that previously did not sign-up for services will be contacted again in order to increase the penetration of the service within the state.

#### Centralized Medication Consent Unit (CMCU)

The CMCU, staffed by a nurse practitioner, child psychiatrists, and a registered nurse, is responsible for making decisions on all psychotropic medications recommended by a provider for a DCF-committed child/youth. In addition the unit maintains the policies, practice requirements and guidelines regarding the use of all psychotropic medications in DCF-committed children. These guidelines and requirements are developed in collaboration with the Psychotropic Medication Advisory Council (PMAC), a DCF-organized council composed of public and private physicians, clinicians, nurses, family members and pharmacists. PMAC meets regularly to: recommend psychotropic medication dosing and monitoring guidelines and requirements; collect and review adverse drug reaction reports; and conduct routine pharmacy utilization reviews.

#### Next Steps:

1. Monitor the use of two or more anti-psychotic medications concurrently, four or more psychotropic medications concurrently and any psychotropic medication use by children age five and under.
2. Integrate the Adverse Drug Report protocol used by the CMCU with the Quality Assurance Unit's monitoring process.
3. Work with the Health and Wellness Unit and the Medical Review Board to revise the genomic testing protocol to improve access to testing when psychotropic medication management indicators are present.

### Health Information and Documentation: The "Health Passport" and Health Reports

It is important that DCF maintains current health records for all children in its care and that they are readily available to best support children. The revised policy and practice guide requires that all placements maintain current health passports which consist of a Health Summary, Report of Health Visits, the child's Medicaid Insurance Card, a copy of the Consent for Routine Care with the instruction sheets explaining the DCF consent process, immunization records and a log of provider visits. As developed, the Health Passport system, including the process for updates through the report of health visits forms, facilitates the monitoring and oversight of all aspects of a child's health including medication details. Representatives from CT AAP assisted with the drafting of the content of the Health Passport and enthusiastically supported the implementation of this tool through the DCF collaborative 'Regional Systems of Care' initiative described above. As envisioned, the new Statewide Automated Child Welfare Information System (SACWIS) system will further support documentation through inclusion of a "health report" system that captures the elements of the Health Passport including the health summary, report of health visit, and immunization record. Pending availability of this new system, DCF nurses will support AO staff in better utilizing and updating the existing LINK (SACWIS) systems Medical Alert template which can be expanded to include information contained in the Health Summary. The expectation is that all placements will have a readily accessible, portable copy of the Health Passport which accompanies the child on every visit and whenever he/she travels.

The foundation of the Health Passport is the "Health Summary," which builds on work of Health Resource and Services Administration's (HRSA) Maternal Child Health Bureau Title V aimed at improving outcomes for children and youth with special health care needs (CYSHCN). Notably, the AAP considers all children in foster care to be children with special health needs. The goal of the Health Summary is to provide a format for capturing information about a child's current medical issues, treatments, medications, as well as provider names and contact information. As with CYSHCN, the goal is to ensure that children get the care they need. AO social workers and nurses are responsible for ensuring that the health summary is current.

The "Report of Health Visit" completed by providers at each health visit informs the placement and AO social worker of any changes in care. Changes in care may require further follow-up, modification of the "health summary" or other action steps. Completed for all health visits, the Report of Health Visit ensures that DCF is informed of all changes and permits tracking of medications, referrals, status of conditions and any necessary follow-up.

The DCF plan for enhancing medical information and documentation includes:

- Educating stakeholders about the Health Passport including immediate strategies for using the existing Medical Alert;
- Informing DCF planning on the new SACWIS/LINK program and planned "Health Report". Elements include:
  - Incorporation of Health Passport elements including Health Summary and Report of Health Visits;
  - A secure portal to permit community providers to make updates to the Health Report and Report of Health Visits;
- Completing development of a data development plan that will ensure a mechanism of ongoing tracking of child specific health information and population health data and outcomes;
- Work with AAP-DCF Regional Care Initiative partners to develop tools for data collection that will permit child, AO and state level review.

### Disaster Plan

The state's disaster plan protocol was activated in January 2015 for a blizzard. All foster homes and licensed facilities were contacted before the storm to ensure they were equipped with supplies, generators, etc. DCF facilities were fully prepared and staff stayed overnight to ensure coverage during the storm. Careline remained operational. There were no disruptions to DCF operations as a result.

DCF's Business Continuity Plan will require updating this year to account for changes in administrative structure.

## Training Plan

No changes to Plan have been identified. See Section 5.

## Section G. Statistical and Supporting Information

### 1. CAPTA Annual State Data Report Items

#### Information on Child Protective Workforce

The official job classifications developed by the State of Connecticut, Department of Administrative Services for child protective service professionals include:

- Social Worker Trainee
  - Minimum requirements for this classification, which is the routine entry level job, is possession of a Bachelor's Degree in Social Work or a closely related field. Closely related field is defined as applied sociology; child development; child welfare; clinical psychology, counseling; human development and family studies; marriage and family therapy; nursing; social and/or human services; education; criminal justice. In practice, the Department screens applicants for this classification and prioritizes applicants with either a BSW or MSW for interview.
  
- Social Worker
  - Applicants for the Social Worker classification must either have completed the Social Worker Trainee requirements, which includes serving two (2) years at the level of a trainee, or successfully completed the competitive examination for Social Worker. Requirements to sit for the Social Worker examination are: Master's Degree in Social Work or a closely related field (as identified in the Social Worker Trainee requirements above) OR a Bachelor's Degree in Social Work or a closely related field (as identified in the Social Worker Trainee requirements above) plus two (2) years' experience in the self-directed use of

case management techniques and counseling to sustain or restore client functioning. Applicants must have successfully passed the exam and appear on a certified exam list for consideration by the Department for hire.

Applicants at this level are also prioritized by possession of a BSW or MSW.

- Social Worker Supervisor
  - Minimum requirements for entry to the Social Worker Supervisor examination are: Master's Degree in Social Work or a closely related field as defined in the Social Worker Trainee requirements above plus two (2) years' experience in the self-directed use of case management techniques and counseling to sustain or restore client functioning OR a Bachelor's Degree in Social Work or a closely related field as defined in the Social Worker Trainee requirements above) plus three (3) years' experience in the self-directed use of case management techniques and counseling to sustain or restore client functioning. Applicants for this promotional opportunity must be on the certified exam list for permanent appointment to this class.

#### [Data on the education, qualifications, and training of such personnel](#)

The educational requirements for staff are minimally a four-year degree in Social Work or a related field as indicated above. Internal prioritization has resulted in the majority of new hires to these classes since 2012 possessing either a BSW or MSW. Qualifications are in accordance with those required to sit for the competitive exams for each classification as cited above. Training of personnel, aside from their post-secondary degree occurs internally and is tracked by the Academy for Workforce Development.

#### [How skill development of new and experienced staff is measured](#)

Training evaluations are distributed at the end of each training offered through the DCF Academy in an effort to gather specific information regarding overall feedback, relevance and application of class content. The DCF Academy also accepts and encourages requests for one-to-one training to be provided to staff when skill development or another area of concern arises.



New employees continue to take a pre- and post-examination at the beginning and end of their pre-service training series. Academy staff have recently enhanced the post-examination to ensure it accurately reflects current competencies and practices from classroom content. Students are given components of an actual case to review. Upon review, they are asked to develop the following tools and documents: a genogram, a Structured Decision Making Family Strengths and Needs Assessment, and a modified case plan document. The oral component of the exam focuses on the group supervision process. This oral presentation allows them to gain more comfort presenting cases in a concise and factual manner.

Academy staff also partner with supervisors and managers of new employees to coordinate the learning process. Bi-monthly meetings are held to discuss skill development and to trouble-shoot any barriers to the learning process. Transfer of learning activities are also built into the pre-service training programs to ensure content is applied to practice.

### DCF Regional Direct Care Workforce 2/28/2015

	TOTAL	TM	TF	WM	WF	BM	BF	HM	HF	OM	OF
C&F Administrator	8	3	5	3	3	0	2	0	0	0	0
Area Director 2	7	3	4	2	3	1	1	0	0	0	0
Program Director	30	9	21	5	15	0	3	4	3	0	0
Program Manager	93	24	69	14	39	4	18	4	11	2	1
Social Work Supervisor	334	87	247	49	133	24	68	12	41	2	5
Social Worker	1181	278	903	143	419	88	291	40	179	7	14
Social Worker Trainee	121	39	82	18	34	14	24	7	23	0	1
Social Work Case Aide	101	33	68	8	26	15	18	10	23	0	1
Total	1875	476	1399	242	672	146	425	77	280	11	22

## Caseload Report Guide

CT DCF Electronic case management system ([LINK](#)) utilizes assignments to determine how many points, if any, each Worker assigned to a case receives depending on their role. The following is a summary of the [LINK](#) caseload reporting process:

The assignment combinations listed below in fig 1 generate **ONE** caseload point for each open assignment. There are 132 different combinations of Type/Responsibility/Role in the Assignment Category table. **ONLY** these fourteen assignment combinations will generate a caseload point.

Any worker with an open assignment of **CPS OOH, N/A, Primary** where no lead assignment exists, will also receive a point for each case participant with an open, approved placement. Any worker with an open assignment of **Permanency Services, N/A, Primary**, where no lead assignment exists, will receive a point for each case participant with an open, approved placement.

If an open **Lead Worker** assignment outlined in **fig. 1.1** exists for a case participant who is in an open, approved placement, then that worker will receive **ONE** point. We have added an assignment combination of **CPS In-Home, N/A, and Primary** that is to be used to designate **In-Home** cases. This assignment combination will carry **ONE** case point and no additional placement points.

**Fig 1.1 - Assignment Category Table**

Assignment Type	Assignment Responsibility	Assignment Role	Case Points	Placement Points	Maximum Points	Percentage Utilization
Adolescent Services	N/A	Primary	1	0	20	5.0%
Adolescent Services	N/A	Lead Worker	1	0	20	5.0%
CPS In-Home	N/A	Primary	1	0	15	6.7%
CPS OOH	N/A	Primary	1	1	20	5.0%
CPS OOH	N/A	Lead worker	1	0	20	5.0%
ICO	N/A	Primary	1	0	49	2.0%
ICO	N/A	Lead worker	1	0	49	2.0%
Family Assessment Response	Area Office	Primary	1	0	17	5.9%
Family Assessment Response	Area Office	N/A	1	0	17	5.9%
Investigation	Area Office	Primary	1	0	17	5.9%
Investigation	Area Office	N/A	1	0	17	5.9%
Permanency Services	N/A	Primary	0	1	20	5.0%
Permanency Services	N/A	Lead	1	0	20	5.0%
Probate	N/A	Primary	1	0	35	2.9%
Probate	N/A	Lead	1	0	35	2.9%
Voluntary	N/A	Primary	1	0	49	2.0%
Voluntary	N/A	Lead	0	1	20	5.0%
FWSN	N/A	Primary	1	0	49	2.0%
FWSN OOH	N/A	Lead	0	1	20	5.0%
<i>Last amended March, 2012</i>						

### Juvenile Justice Transfers

According to the Department of Children and Families' SACWIS system, during state fiscal year 14/15 there were 27 youth who while under the care of the department were committed as delinquent into the custody of the department. This is defined as a youth transferring from one of the following statuses: 96 Hour Hold, Order of Temporary Custody, and Commitment Abuse/Neglect/Uncared For, Commitment Mental Health, Commitment/FWSN or Statutory Parent to either Commitment Delinquent or Commitment Dual status subsequent to a delinquency adjudication.

### 2. Sources of Data on Child Maltreatment Deaths:

Careline (CL) has begun to track all instances of child fatalities and collects data regarding age, nature of the incident, hospital and the region they derive from. This information has been shared with the deputy commissioner for statistical reporting.

Careline has also begun to look at the Critical Incident logs in its current state and see how we might begin to assess trends for the types of cases we are seeing in order to develop training modules to increase our staff's ability to manage demand.

We are currently working with Risk management and ORE in an effort to stream line our process of reporting, so that there is one central repository of information that gets disseminated regarding Critical incidents and Fatalities to all needed parties.

The Connecticut State Department of Children and Families (DCF/Department) is providing comprehensive case analysis and timely systemic consultation in the aftermath of a child fatality and/or life-threatening critical incident. The Fatality Review process and structure is a function of the Division of Quality Assurance, and is led by the Division's Director. The Department's senior leadership team has determined that child fatalities and life-threatening

incidents on open cases and cases closed within one year will be examined by a multidisciplinary Special Review team. The Special Review's emphasis on education and teaching is designed to provide practical feedback and information for professional learning, organizational development and staff support within and across helping systems. The multidisciplinary approach offers a consistent methodology that focuses on relevant fact-finding, and identification of key dimensions in case practice determined to be excellent, acceptable or in need of improvement.

At the Commissioner's discretion, any fatality or critical incident can be examined by the Special Review team. The DCF Special Review team collaborates on a routine basis with the Statewide Child Fatality Review Panel (CFRP) that is Co-Chaired by the Chief Medical Examiner and Child Advocate. The CFRP examines the death of all children and youth under the age of eighteen, including those that are not involved with the child welfare system. The Panel submits data to NCANDS, as does the DCF Careline.

Special Review reports are anchored in the Department's family-centered, trauma-informed and community-based *Mission, Guiding Principles and Practices*. Reports highlight related literature and research across discipline, and link the facts of the case with key findings and recommendations that consider the following core areas:

1. The current goals and status of the Department's Strategic Plan and Organizational Structure;
2. Implementation of family-centered, trauma-informed and community-based services;
3. Quality of supervision and implications for training/workforce development;
4. Relevant policies and procedures; and,
5. Coordination and communication with larger systems (courts, community agencies, healthcare providers, schools, other state agencies, and so forth).

Special Review Reports and processes have led to significant changes in policies and practices within and outside of the child welfare system during the past year, and during the

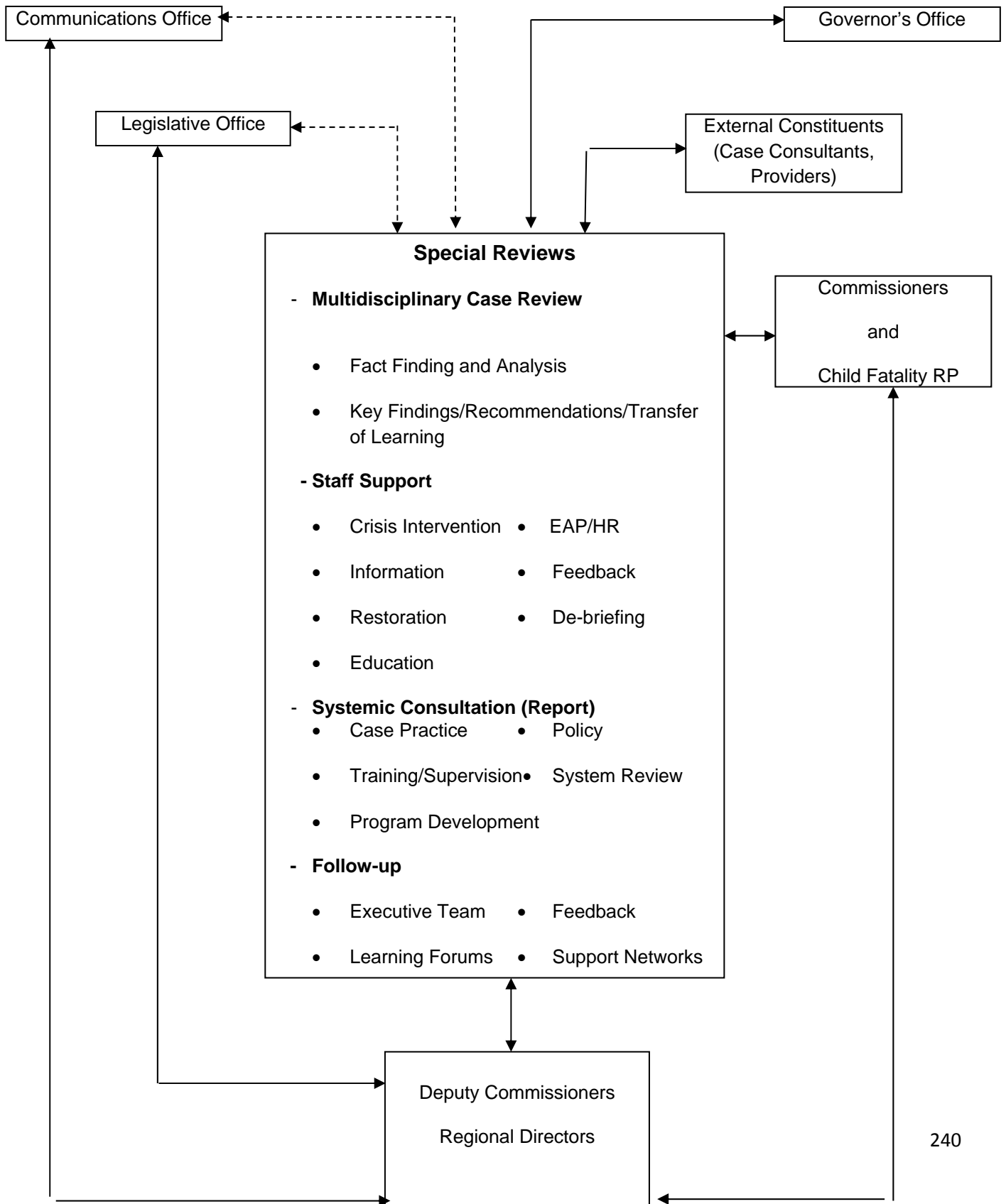
past decade. Although each case is uniquely influential, key changes in policy and practices include:

1. Safe-Sleep education, awareness and protocols;
2. Work with young children 0-3 and their families;
3. Education of Emergency Room and Pediatric personnel on identification of child abuse and neglect;
4. Suicide prevention, early intervention and treatment;
5. Interplay of intimate partner violence, mental health impairments and substance abuse;
6. Engaging with young parents and multi-stressed families across generation;
7. Case Practice Review of our Differential Response System;
8. Juvenile Justice and the dynamic intersection of community involvement, education, public safety and rehabilitation;
9. The profound impact of trauma on clients, communities and professionals; and,
10. Community transitions to and from congregate settings.

During the past year, community partners participated in several Special Reviews of fatalities and critical incidents; expanding learning, enhancing relationships and increasing a transfer-of-learning to other similarly-situated cases. These fruitful activities have led to an increase in cross-program training, multidisciplinary case consultation and more effective service delivery. In the next year, the Special Review process and structure will include expansion of learning forums to the DCF Area Offices, Communities of Practice, Facilities, Regions, and local professional networks.

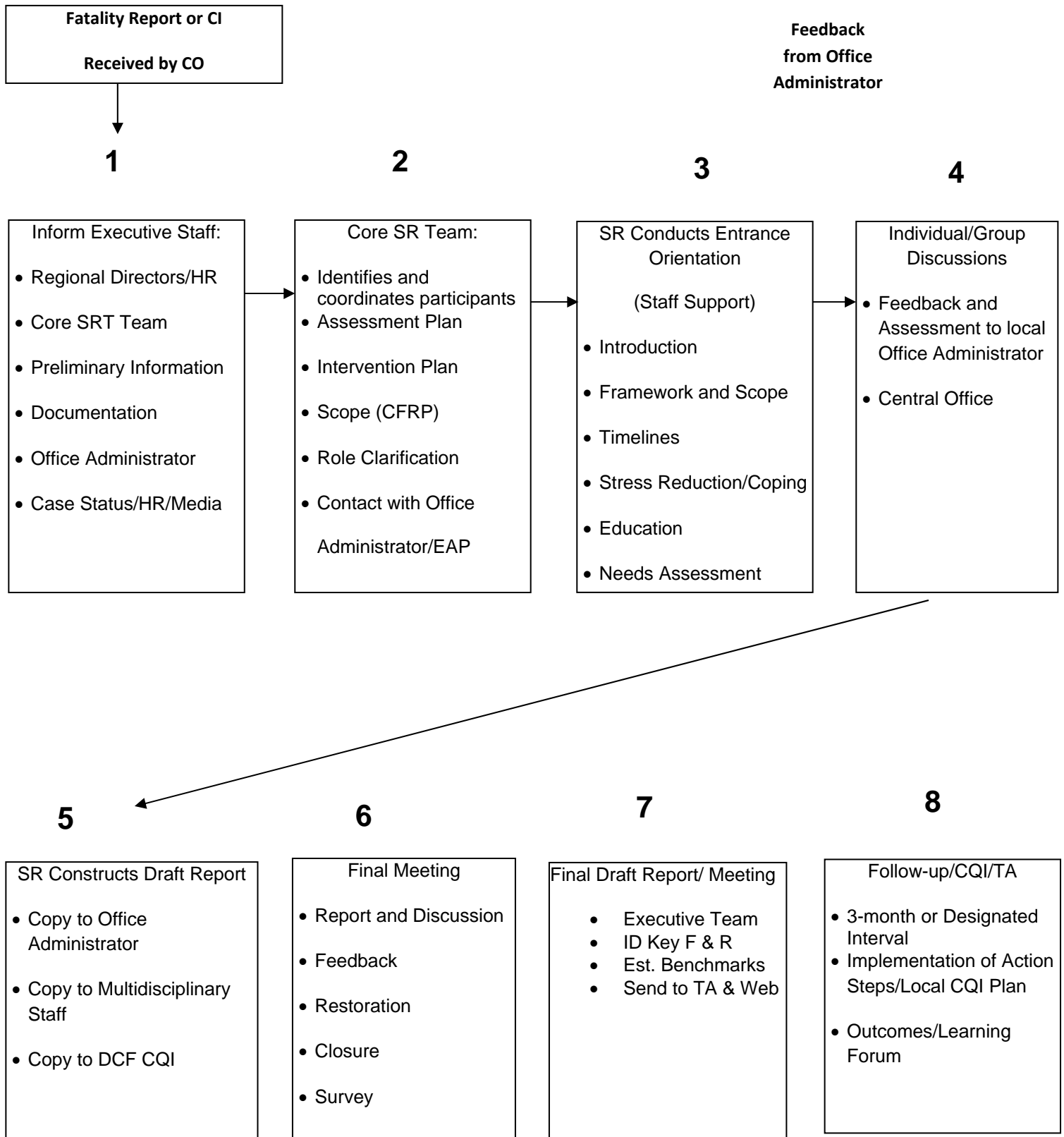


SR/CQI ORGANIZATIONAL STRUCTURE





# SR/CQI COMMUNICATION AND INFORMATION PROCESS



**3. Education and Training Vouchers: See Section E**

**4. Inter-Country Adoptions**

Eight children who had been previously adopted from another countries came into DCF care in 2014.

**5. Monthly Caseworker Visit Data**

The Department will submit our monthly caseworker visitation data by 12/15/15 as required.

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