State of Connecticut

Annual Progress and Services Report
2018

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

By:
Department of Children and Families

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Commissioner

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A. Background

Introduction

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

Mission and Vision

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

Cross-cutting themes:

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

Overarching Strategies:

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

9. Improve revenue maximization and develop reinvestment priorities and methods

This mission is grounded in a core set of beliefs that encompass the Department's vision for how to provide services to Connecticut's children and families. We believe that children do best when living safely at home with their family of origin. When living at home with a parent is not reasonably safe, the best alternative is to live with another family member who can provide a safe and nurturing home. If no family member can provide a suitably safe home that meets the child's needs, the child should receive care and services in an appropriate foster home until timely permanency can be achieved through reunification, transfer of guardianship or adoption. Foster care should only be used as a short-term intervention. While in foster care, regular and ongoing contact with parents and siblings is maintained. Finally, all youth are to exit the Department's care with legal and/or relational permanency.

Congregate care, such as group homes and residential treatment centers, should not be used for the vast majority of children. They are designed to address specific treatment needs. For older youth, treatment in congregate care is s expected to be used in a targeted manner with extensive family involvement in the treatment process.

Services should be individualized and 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 and developmentally 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.

The Department has continued to focus on identified agency-wide Performance Expectations with associated performance measures.

B. CFSP/APSR Continued Integration

2017 Performance Expectations

Some specific requirements for development of the 2017 performance expectations include the following:

Each team was requested to include three specific areas of concentration in the strategies developed for each of the five performance expectations, including racial justice; specific inclusions of clients involved in the juvenile justice system; and workforce stability/skills/support as they relate to each team's ability to achieve the performance expectations.

Development of overarching strategies that impact multiple performance expectations was encouraged; as was development of at least one strategy for each performance expectation in conjunction with another region, facility or division.

Performance Expectation 1: Exit from the Juan F. Consent Decree
(Common Performance Measures)

- Achieve outcome measures not yet pre-certified
- Sustain outcome measures that are pre-certified
- Assure the community –based service system is effective and meets the needs of the community

Performance Expectation 2: Ensure that children reside safely with families whenever possible and appropriate

- Increase the proportion of children who are served in their homes; reduce the number of children in care
- Increase the use of a preferred permanency goals
- Sustain the proportion of children in kinship care to 45 %
- Increase the proportion of children in placement with a family to 90%
- Assure congregate care services are brief, family-engaged, connected to the community and include discharge planning that begins at admission

Performance Expectation 3: Achieve Racial Justice across the entire DCF system

- Reduce disparities for children served by Child Welfare services
- Reduce disparities for children served by the Juvenile Justice system
- Reduce disparities for children served by Behavioral Health services
- Reduce disparities for children served by educational services

Performance Expectation 4: Prepare Children and Adolescents in care for success

- Ensure children and adolescents in care are connected to permanent relationships
- Provide quality education and support services that lead to educational success
- Provide formal and informal life skills

- Ensure children and adolescents in care receive appropriate health services

Performance Expectation 5: Prepare and support the workforce to meet the needs of children and families

- Create stability in the workforce
- Train managers and supervisors in supervisory and management skills
- Support regions, facilities and communities in their work on behalf of children and families

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 including trend data and the causes/dynamics that impact current performance are presented to the Commissioner's team by each management team on a regular basis, and performance is reviewed, and recommendations for improvement are established.

Strategic Plan and use of Results Based Accountability

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

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

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

SAFE

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

HEALTHY

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

STABLE

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

- Families Without Enough Money for Food

FUTURE SUCCESS

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

Further, the Department has just completed Round 3 of the CFSR and submitted its Program Improvement Plan (PIP) on June 21, 2017. The Department has crossed walked the APSR with its PIP to assure that they are complementary and supporting the desired improvements as identified by the CFSR and other review processes in which the agency engages.

The APSR will be used to further the following improvements and Core Goals identified in Connecticut's PIP:

Areas for Improvement

1. Timeliness and Quality Of Child Safety and Risk Assessments
2. Accuracy and Quality Of Needs Assessments
3. Timeliness of Addressing Needs
4. Child and Family Engagement
5. Safe and Timely Permanency
6. Adequacy and Effectiveness of the Service Array

Core Goals

1. Ensure Safety for Children and Families Served by the Department
2. Strengthen Cross-System Service Provision to Improve Quality and Produce Positive Safety, Permanency and Well-Being Outcomes.
3. Support Timely and Safe Permanency for Children
4. Enhance Engagement with and Connections For Children, Youth and Families

University of CT Public Policy Interns

Since 2013, DCF has benefitted from the support of masters level public policy interns. In 2016, five interns, worked in a variety of different subject areas. Highlights of the work included the following:

- Worked with the DCF Chief of Staff on grant and development activities for the Department, including grant writing to support agency priorities and programs; coordinate the development of grant applications with agency staff, contracted providers, and other public and private

agencies; develop and maintain online grant resources for agency staff and other partners; and assist with interagency collaborative efforts;

- Worked with Office for Research and Evaluation staff, and DCF educational staff, to support implementation of educational data development. This included updating and maintaining a map of performance, discipline, and attendance data of Connecticut schoolchildren, developing education data dashboards, informing the Connecticut State Department of Education database, and assisting with a research study on youth in care and academic performance;
- Worked with stakeholders to develop specifications for new reports based on DCF's provider information exchange datasets for the purposes of automating Results-Based Accountability (RBA) reporting, and/or specifications for new datasets to be posted on the CT Open Data Portal, and provided written summaries and oral presentations orienting stakeholders to the use and results of those reports;
- Under the direction of the Multicultural Affairs and Immigration Practice Director, the racial justice intern helped support the agency racial justice initiative; and
- Worked with DCF's Director of Performance Management on coordination of agency performance expectations, and continued agency-wide implementation of RBA.

Section C. APSR Requirements

Stephanie Tubbs Jones Child Welfare Services – Subpart I- FFY2017

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 2016 and FFY 2017. 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/Categories	Total Funding	Family Preservation	Family Support	Time-Limit Family Reunification	Adoption Promotion & Support	Other Service Related Activities	Admin Costs
Triple P America	$109,860	$36,620	$36,620				
Office Assistant Positions	$166,193	$41 548		$41 548			
JRA Consulting – Racism	$19,650	$4,912	$4,912	$4,912			
Joyce James	$45,900	$15,300	$15,300	$15,300			
CCMC	220,500	$110,250	$110,250				
Central Office Contract Management	$118,424						$118,424
Solnit North Positions	$1,073,787					$1,073,787	

The Connection	200,000	$100,000		$100,000			
KJMB Solutions	$115,000	$23,000	$23,000	$23,000	$23,000		
CT-AIMH Membership	$210	$42	$42	$42	$42		
CT Parents with Cognitive Limitations	$4000		$2,000				
Travel/Conferences	10,000	$2,000	$2,000	$2,000	$2,000		
Totals	**$2,083,524**						

SERVICE DESCRIPTION-STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM

Triple P America - Parenting Support Services (formerly Triple P)

Parenting Support Services (PSS) is a statewide program for families with children 0-18 years-of-age to support and enhance positive family functioning. Families receive one or more of the PSS interventions along with case management services using the Wraparound philosophy and process. PSS offers the evidenced-based model, Level 4 Triple P (Positive Parenting Program®) and the Circle of Security Parenting© intervention. Triple P helps parents become resourceful problem solvers and to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Circle of Security Parenting (COS) is designed to build, support, and strengthen parents' relationship capabilities so they are better equipped to provide a quality of relationship that is more supportive of secure attachment. Federal funds were allocated to PSS to offer two week-long Level 4 Standard and Standard Teen Triple P trainings in 2017. A total of 24 new PSS staff members were trained and accredited. This allocation supports ongoing training opportunities for provider staff to ensure no interruption in the provision of services.

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 to identify and locate potential relative resources, and assure grandparent and relative notification as required.

JRA Consulting: After an extensive review of DCF racial disproportionality and disparate outcomes data on children of color in care, in February 2012 Commissioner Katz committed the Department to focus deeply on addressing racial inequities in all areas of our practice. A decision was made to contract with *JRA Consulting, Ltd* to guide the agency with this effort. This was done by examining and addressing

issues of racial injustice and disproportionality in the areas of racial, health, and educational disparities., The agency also developed a comprehensive approach to this work with the goal of ensuring that all of our agency policies and practices are reviewed with a racial/cultural justice lens, such that we can revise them as needed and the inequities in services and outcomes that currently exist begin to disappear. The Department is committed to keeping this an open and transparent process not only within the agency, but across the community as well.

Joyce James: To build on the work of JRA Consulting, Joyce James is assisting the department specific to the racial justice performance expectation and has worked closely with teams from the regions and provider stakeholders.

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

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

Central Office Staff Position:

Funding was utilized to support a staff position within the Departments Fiscal Division.

Solnit North Positions: The Albert J. Solnit Psychiatric Centers' North Campus is a facility run by the Connecticut Department of Children and Families. It provides brief treatment, residential care and educational instruction for abused and neglected children between the ages of 13 and 18 from 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 youth'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.

The Connection: The Supportive Housing for Families program provides permanent housing and intensive case management services to DCF families. The program began over 17 years ago, to help families recovering from substance use. 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 Housing (DOH). The DOH 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. Services are also provided to families where housing is a barrier to the reunification process.

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. This vendor provides all development, maintenance and support for the Provider Information Exchange (PIE) web-based application. This website 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:

- Re-branded the system to PIE (formerly known as PSDCRS)
- Breaking down previously required silos between providers and de-duplicated person-level data
- Enhanced the Duplicate Client report and added a Merge Client wizard
- Added the first stage of an Event/Incident reporting framework that provides data collection and reporting on incidents that meet the definition of the Prison Rape Elimination Act (PREA). Data collection for other incident types (such as emergency safety interventions, significant events, critical incidents, and serious occurrences) will be added in the future
- Completed the transition from data collection of DSM-IV to DSM-V
- Added federally required client level data elements and associated conditional logic to ensure data quality,
- Expanded the outcome measures collected and reported, and enhanced several existing reports to show break-outs by age, race and gender
- Implemented and supported additional programs/projects
- Enhanced security protocols

CT AIMH Membership: Funding is provided for membership for central/area office staff to attend CT-AIMH conferences at a discounted rate promoting key competencies in the workforce.

Parents with Cognitive Limitations: The Department of Children and Families 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 available to social workers. Two trainings have been held to date with an average of 30 participants attending each training and two additional trainings are scheduled to be completed by September 30, 2017.

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

Promoting Safe and Stable Families – Subpart II – FFY 2016

The figures provided in the table below reflect anticipated expenditures. The programs are funded at levels that exceed the award amount. These programs are being supported through multiple year awards, including FFY 2016 and FFY 2017. The Community Collaboratives, FAVOR (Foster Care Consumer Advocate), The University of Connecticut's Adoption Assistance Program, Easter Seals Adoption Support Group, Adopt a Social Work Program, National Council on Crime and Delinquency,

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

Services/Categories	Total Funding	Family Support	Family Preservation	Family Reunification	Adoption
Reunification & TFT Services	$1,173,245	347,146	337,184	488,915	
Community Collaboratives	$284,700				$284,700
FAVOR	$50,000	$25,000	$25,000		
UCONN -Adoption enhancements	$300,000			27,163	$272,837
Easter Seals Support Group	$20,000	$10,000			$10,000
Adopt a SW program	$95,275	$31,758	$31,758	$31,758	
UCONN SSW PIC	$129,420	$64,710	$64,710		
CT Association for Infant Mental Health	$39,382		$19,961	$19,961	
Child First	$75,000	$37,500	$37,500		
NCCD – CRC SDM Work	$250,000	$83,334	$83,333	$83,333	
Totals	**2,417,022**				

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

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

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

- Review/explore safety concerns and risk factors that may impact child safety with the family and DCF;
- Assess family functioning, skills, parental capabilities, and parent's motivation to change;
- Identify family strengths and needs;
- 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
- Preserves and restores the parent/child attachment, and reduces the child's sense of abandonment and loss
- A family driven service that is, culturally and linguistically sensitive, individualized, and occurs in the least restrictive, most homelike setting possible.
- Facilitates permanency planning and emphasizes continuity of relationships.

Community Collaboratives: The Department continues to support Community Collaboratives, designed to recruit, strengthen and support neighborhood-based culturally competent foster/adoptive resources for children for many years. They are responsible for engaging new partners to broaden community ownership for planning and implementing activities that recruit and support foster and adoptive families. Funds are distributed through a fiduciary (Advanced Behavioral Health) and used to support meeting costs, planning efforts and activities implemented by the collaborative for the purpose of recruiting and retaining foster and adoptive families. These activities may include, but are not limited to: special family events, appreciation dinners, media/advertising, promotional items, brochure development and printing, program supplies and training. While Collaboratives have been established historically each of the six (6) Regions makes independent decisions about how to spend their allocated

recruitment and retention dollars. The decision whether to have a formal Community Collaborative is revisited periodically based on the recruitment and retention needs identified in that Region.

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 Program Directors, DCF staff and the CT Behavioral Health Partnership (BHP), with formal reporting and supervision provided through the Contractor. They are required to promote family driven and youth guided practices throughout the local and regional service system and to support the identification, recruitment, and participation of families in behavioral health system analysis, planning and service provision. They provide leadership in the local and regional behavioral health system development from the family perspective while providing technical assistance and support to local systems of care including their governance.

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

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

UCONN Adoption Enhancements: DCF contracts with the University of Connecticut Health Center to provide post-adoption services to families who have adopted children from DCF's custody or achieved legal permanency through a transfer of guardianship. 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 children with complex medical needs through DCF. The focus was to create a network of support for families providing care to this population. Funding supports associated meeting costs.

Adopt a Social Work Program: This statewide program assists children and families (birth, foster and adoptive) that are DCF involved with supports and donations of goods to help families' secure needed resources. This program has served over 775,000 children and families over the last 25 years.

UCONN SSW PIC: The UCONN School of Social Work has been functioning as the Performance Improvement Center for the Community Support for Families Program, a contracted service designed to provide support to families who received a Family Assessment Response from the Department. 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 and most recently amended again to include investigation cases. This will allow a full evaluation of the agency's overall intake process.

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

Child First: Child First is a two-generation, intensive, home-based, early childhood intervention serving the most vulnerable young children and families, prenatal through age five years. Health and Human Services (HHS) has designated Child First one of the 17 nationally approved, evidence-based home visiting models. The New Britain team was initially funded via a SAMHSA grant. The Department has reallocated unused funds from Therapeutic Child Care program to support this program until state funding could be secured.

NCCD-Children's Research Center: In January 2007, the Department implemented Structured Decision Making (SDM). SDM offers a variety of tools for child welfare workers that promote consistency and accuracy of decision-making at critical junctures throughout the life of a case, as well as targeting resources to families most at risk of recidivism/repeat maltreatment. The goals of the SDM system are to reduce subsequent harm to children and to expedite permanency for children placed in out of home care. The SDM system brings structure and consistency to each decision point in the child welfare system through the use of assessment tools that are objective, comprehensive and easy to use. There have been significant changes to DCF practice since our initial implementation in 2007 including but not limited to: the development of our Strengthening Families Practice model, trauma-informed practice, Differential Response System, and Child and Family Teaming. Over the years, CRC has modified the tools to reflect changes in child welfare practice and the latest research. The Department recognizes the need to update the tools to reflect our practice improvements and advancements in child welfare systems across the nation. The Department is in process of establishing a contract with CRC (effective in June 2017) and intends to include the following components in CRCs contract:

- Update SDM tools, definitions, and corresponding policies used by the Careline (Screening and Response Priority);
- Develop a training program for staff: utilizing a Train the Trainer approach and the development of training modules that integrate the SDM tools into case practice;
- Provide technical assistance and support in DCF's completion of the Risk Validation Study; and
- Create an on-line system that will provide a user-friendly method for workers to complete SDM assessments as well as collect the assessment data for analysis.

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 2017

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

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

SERVICE DESCRIPTIONS - CHAFEE FOSTER CARE INDEPENDENCE PROGRAM

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

One on One Mentoring: DCF continues to provide mentoring services to youth statewide, ages 14 -21, who are committed to the Department and residing in foster care. DCF funds 11 community based providers to deliver mentoring services to 228 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 contracted with 10 community agencies to provide community based life skills in 14 Area Offices, to DCF committed youth placed in community settings. In 2016 the Department used 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. In SFY 17 the Department transitioned the service to a more individualized approach; contracts ended in Dec 2016 and the service was credentialed. This broadened the scope of the service eliminating limits by geographic location.

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.

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

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

ETV

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

Child Welfare Demonstration Grants

Connecticut has not been awarded a Child Welfare Demonstration Grant.

Trainings in Support of CFSP Goals

DCF is committed to strategy-driven and data-informed management. In furtherance of that, the Department has implemented annual performance expectations for all regions, facilities, and central office divisions.

All Leaders in the Department are required to develop detailed operational strategies to achieve the performance expectations. Workforce development is integral to that process. Training and coaching opportunities for leaders is offered on an ongoing basis with emphasis on the development of outcome-focused strategies, use of data to manage performance, and strategy modification based on performance data. These learning opportunities have included but are not limited to:

a. The Data Leadership Training
b. Peer Review Process
c. Striving Towards Excellent Practice (STEP)
d. Leadership Academy for Middle Managers
e. Excel Training
f. Understanding the Numbers for line staff

In addition, the Academy is working to embed greater data and outcome measurement exposure into the pre-service curriculum for DCF Social Worker Trainees. To date, a course entitled "Understanding the Numbers" has been offered 18 times to 136 Social Worker Trainees.

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

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

In 2015 DCF contracted with the Children's Alliance to implement a new trauma-informed statewide training curriculum for foster and adoptive parents called: Trauma Informed Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP). TIPS-MAPP is fully implemented and is currently being delivered as the only statewide foster and adoptive pre-licensing training curriculum by both the Department and private Child Placing Agencies (CPAs). This ensures consistency in that all prospective parents receive the same training and carry the same expectations. Since December 2014, 130 DCF and private agency staff have been certified to train prospective foster and adoptive applicants in this curriculum. Additionally, there are two approved statewide trainers to deliver a, "train the trainer" approach in order to sustain the self-sufficiency of this initiative. Providers were also trained in cultural humility in Six Core Strategies (Violence prevention), and in permanency preparation work.

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

The Department recognizes the importance of workforce development opportunities and 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:

1. Using a results oriented approach to strategy development
2. Identification of performance measures, with a focus on outcomes
3. Using data to manage performance
4. Using performance data to analyze effectiveness of strategies and to inform strategy modification

GENERAL INFORMATION

Collaboration

The Department continues to recognize the value and importance of collaboration and consultation

with the community to improve outcomes for children, youth and families. Therefore, the Department has established and participates in a variety of opportunities to partner with key stakeholders.

The Department receives community input from a number of statewide and local advisory councils. At the statewide level, the State Advisory Council (SAC) is a 17-member body appointed by the Governor, with representations from all six DCF Regional Advisory Councils, to advise the Commissioner on all matters pertaining to services for children and families. The membership includes persons represented a variety of sectors and professions, including attorneys, a physician, psychiatrist and community providers. The SAC also has parents who are members.

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

Each year, the SAC convenes a joint day-long retreat with the RACs. This meeting is attended by the Department's senior leadership, including the Commissioners and her entire executive team. This year, the SAC focused on supporting better coordination and communication across CT' child and family serving advisory bodies (e.g., CBHAC, Behavioral Health Oversight Committee, Youth Advisory Board, etc.), especially as it pertains to supporting positive outcomes for adolescents.

At the 2016 retreat, presentations were provided by the Chairs of various CT advisory bodies to hear about the work in which they are engaging and to offer strategies regarding how each could better partner with one another. The Department also discussed its CONNECT grant, which is seeking to support greater coordination and data sharing across advisory groups and State agencies. Last, as has occurred for the past couple of SAC retreats, youth were invited to attend and were given formal speaking spots on panels throughout the day.

The Department also receives significant input from a statewide Children's Behavioral Health Advisory Council (CBHAC), local Regional Advisory Councils (RACs) affiliated with each of our six regions, advisory councils at each of our facilities and Youth Advisory Boards (YAB). In addition the department

works with the Children's Behavioral Health Plan Implementation Advisory Board, which meets quarterly with subcommittee meetings in between. The focus is on advising the agency and the states on the efforts to advance the recommendations set forth in the 2014 plan submission outlined in Public Act 13-178. In addition, the department has quarterly meetings between agency Program Leads, providers and regional partners to review and analyze the array of service types.

DCF has been working very hard in helping and assisting youth aging out of the foster care system. Towards this goal DCF has been utilizing the expertise of the SAC and our partnership/ collaboration with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Developmental Service (DDS). These partnerships include a holistic approach to support the youth's transition and engage the youth's own support network in the planning process. DMHAS/DDS Regional Office staff meet with DCF local Area Office and Central Office staff to review and track youth transitioning from DCF to DMHAS/DDS; the purpose of these meeting is to identify who is transitioning, the transition plan and timing and any barriers that need to be addressed systemically or on an individual basis.

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

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

DCF Interface with DMHAS and DDS

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

DMHAS offers a specialized Young Adult Services program (YAS) for 18-25 year olds aging out of the DCF system who have significant psychiatric disabilities and who will need services and supports when they leave the children's system. DMHAS also has an array of adult mental health services, but most of the DCF-involved youth who meet the program criteria go directly to this specialized YAS program. DCF has referred an average of 298 youth to DMHAS YAS each year between 7/1/2006 through 6/30/2016. 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 118 youth to DMHAS each year between the ages of 18 and 21.

DDS works with individuals who have developmental disabilities and are likely to need support and services throughout their lifetime. DDS has an array of services and has been able to target resources not available to the general public specifically for youth aging out of DCF. As of May 2016, DCF has identified 204 children/adolescents who have been referred to and made eligible for DDS and who will eventually transition to adult services, typically at age 21. DCF and DDS maintain a "shared client list" which is updated regularly to assure that DCF involved youth are identified, referred and transitioned. DCF has been tracking transitions to DDS since SFY 2011, and an average of 70 youth per year have

transitioned to DDS through FY 2016.

DDS used to be the state agency overseeing a program for children and adults on the autism spectrum (ASD) without intellectual disabilities (ID). This program has been moved from DDS to the Department of Social Services (DSS) and DCF is now working with DSS around access to services for youth with ASD. The program has a limited number of slots with only 50 set aside for children. From the point when the program began, DCF transitioned 37 youth from the DCF Voluntary Program to the Autism Spectrum Division (a Medicaid Waiver supported program). However, due to several years of state budget cuts, the transfers were put on hold. DCF continues to maintain a list of eligible youth in the hope that transfers will be possible at some point in the future. In the meantime, DCF has been able to refer some of these children to the ASD behavioral services for children with HUSKY A, C or D up to age 21. For families who are not HUSKY eligible but have private insurance, DCF works collaboratively with Connecticut's Office of the HealthCare Advocate to assure families are getting the most out of private insurance coverage for children with ASD.

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

1. Agency specific Memorandum of Agreements which formally define coordination and collaboration;
2. Statewide screening process utilizing standardized criteria to identify youth starting at age 15 who need referral to DMHAS or DDS (DCF has screened an average of 837 youth annually between FY 2007 and 2016);
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 (YAS) staff plus representatives from their local YAS Programs meet with DCF Area Office staff to discuss individuals who have been referred to DMHAS; they address issues that impact transition and identify resource needs so support 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
- DMHAS holds monthly meetings with the Albert J. Solnit Children's Center 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. Based on need there are also meetings with the Connecticut Juvenile Training School.
- The Office of Interagency Client Planning participates in a monthly meeting at the Department of Corrections facility that houses 18-21 year olds to assure those who are involved with DCF are identified if they need to be referred to DMHAS or DDS.
- Case-specific transition planning is done between the Social Worker at the DCF Area Office and the DMHAS or DDS Case Manager.

- To address administrative and systems issues that cannot otherwise be resolved at the local level, DCF convenes interagency meetings to provide a forum to discuss and address these issues
    - In addition to agency specific discussions, this year, a subset of the group above has been meeting (comprised of DCF, DMHAS, DDS, DSS and OPM) to discuss services and gaps for individuals with Autism Spectrum Disorders.

7. Staff of the DCF Office of Interagency Client Planning are 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.
8. Participation in a number of interagency committees/workgroups by the DCF Office of Interagency Client Planning
9. DCF has the capacity to develop child-specific agreements with DMHAS and DDS which allow access to services - which based on specific needs may not be available within DCF - earlier than usual. This allows a young adult to a move to a more permanent community setting when they are ready, prevents multiple moves, and can even avoid a youth prematurely signing out of DCF care.

10. Budget permitting, special transition initiatives between DCF and DDS for transfer of:
    - DCF Voluntary cases to the DDS Behavioral Services Program; and
    - Children on the autism spectrum to the DSS Autism Division Medicaid Waiver program.

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. Upon review, DCF and DMHAS recognized youth coming from both foster care and congregate care settings, were not as sufficiently prepared for community living.

DCF and DMHAS began a pilot project in one DCF Area Office (New Britain) around both better transition planning and improving life skills. The collaboration brought together DCF, DMHAS, community provider staff as well as youth who had already transitioned to DMHAS and could provide feedback on what did/did not work. To look at the area of life skills, DMHAS also included Occupational Therapists with special training in assessing and teaching skills to young adults with psychiatric disabilities. A specific assessment tool (Learning Inventory of Skills Training – LIST) was developed and piloted originally just in New Britain and is now being used by DCF statewide for all adolescents age 14 and over regardless of their DMHAS status. This made it possible to move forward with statewide implementation of LIST inclusion as a requirement in all DMHAS referrals and with annual updates provided to DMHAS.

Future Planning

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

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

1. *All DCF referrals to DMHAS include a LIST and there is now a requirement for an annual reassessment to the baseline LIST to allow for comparison of the two scores to determine if any progress has been made. The Office of Interagency Client Planning has begun to look at early data*

related to this expansion and will continue to review outcomes related to life skill development in the DMHAS population.

2. Continued tracking of the transition process and reporting on the use of the DMHAS Transition Action Plan (TAP) and providing feedback to DCF and DMHAS staff –
3. Update the Memorandum of Agreements to assure they reflect current practice –*The DCF/DDS MOA is in the process of being revised and will be completed in FY 17.*
4. Enhance transition from DCF to DDS through coordination of benefits transfer, particularly around Medicaid and SSI related issues; this has been identified as a barrier to timely and smooth transitions – *SSI completion is being tracked for both DMHAS and DDS and there is ongoing coordination with the DCF Revenue Enhancement around IV-E issues which may impact the timing of SSI applications. There has been considerable coordination with Regional Social Security Liaisons. The Office of Interagency Client Planning provides a quarterly report to each Liaison to assist in tracking and planning for youth going to DMHAS and DDS. This had been done for a longer period of time around DMHAS and was implemented with DDS this past year in response to delays in DDS transitions related to SSI.*
5. Develop practice guides for DCF staff around screening, eligibility, referral and transition to DMHAS and DDS – A *work group with representatives from among the Regional Resource Group staff in the DMHAS/DDS liaison roles was convened for input in the development of the document. A draft of the document is currently being prepared with the goal to have a draft completed by the end of FY 2017. As part of this process, a checklist for DDS transition was prepared, reviewed and disseminated to be used in the Region on a pilot basis.*
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
7. Identify 1-3 interagency pilot projects addressing special needs populations for youth who are at risk of "falling 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.–
8. Develop a specific plan for transition of youth to DMHAS and DDS in foster care settings; for DDS this includes a collaboration between the staff working with DDS licensed Community Care Homes and the DCF Foster Care staff to review licensing, rates, provider and family expectations and services offered in each model, develop a system to educate current foster care parents on

DDS CCH options and cross-train staff – *ongoing discussions with DMHAS and DDS have made this a greater priority and it is now considered an ongoing part of the work between the agencies. DDS continues to offer to meet directly with families around CCH development as well as the impact on the family for children who are adopted or where there is a transfer of guardianship. DDS is not offering the same services to these youth as those who age out at 21 from DCF, however, DDS has agreed to give "DCF age out status" to individuals who have an adoption subsidy over a certain amount, which is an indication that the youth has more intensive needs. Collaboration between DDS Regional staff, the Office of Interagency Client Planning, and the DCF Adoption Subsidy unit has increased.*

The CT Behavioral Health Partnership (CT BHP)

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

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

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

In Calendar Year 2016, almost 50,000 Medicaid enrolled children and youth (under age 18) utilized a behavioral health service and approximately 6,900 of these children were involved with DCF through

child welfare, juvenile justice or voluntary services. The 2016 CT BHP program targets for youth involved a continued focus on identifying youth with frequent and unnecessary behavioral health visits to the ED in order to propose crisis planning and diversionary interventions. Utilizing Medicaid claims data, reports continue to be available to DCF staff that identify DCF -involved youth who are frequent visitors to an Emergency Department (ED) due to a behavioral health concern so that crisis planning can be effectuated. Similarly, reports that identify DCF youth who are experiencing inpatient overstays or repeat hospitalizations are also available to assist in the identification of youth who might need assistance from a Regional DCF Integrated Service System or other DCF supported treatment planning activity to promote or maintain discharge. The CTBHP is also focusing on the emerging adult population specifically reviewing the process of transitioning youth from the child serving system to the adult serving system. Finalized reports will be available by the end of Calendar Year 2017.

The regional discussions that began following a statewide meeting between DCF senior administrators and clinical staff and hospital ED Administrators have continued. All six DCF regions meet with local hospitals and key stakeholders to facilitate increased communication and collaboration on a local level for DCF youth when seen in crisis in the Emergency Department.

ACCESS MH

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

Since program inception on June 16, 2014-March 31, 2017:

- 86% of pediatric and family care practices are enrolled
    - the program has served 3,188 unique youth and their families More male than female with 54%/46% split respectively

- 12-15% were noted to be DCF involved

- 15,622 consults provided statewide since inception (with 43% of the consults involving HUSKY youth)
- 95% of the initial calls from the PCP were answered within 30 minutes
- PCP satisfaction rate remains at 4.99 out of 5

CAFAF

Since 1995, DCF and The Connecticut Alliance of Foster and Adoptive Families (name changed from The Connection Association of Foster and Adoptive Parents – CAFAP – in 2016) have engaged in a partnership benefiting thousands of children and families. The Connecticut Alliance of Foster and Adoptive Families makes a difference in the lives of foster, adoptive and relative caregivers by providing support, training, and advocacy. They receive an average of 150 inquiries to the KidHero line a month. There are currently 1,850 DCF licensed families; CAFAF provides support to all DCF licensed families.

Beginning in 2014, CAFAF 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. CAFAF 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. CAFAF has begun sending monthly KidHero inquiry reports to every region and compiles this information on a quarterly and annual basis.

CAFAF has been very responsive to the increasing focus on placing children with kinship families and in maintaining those placements through the services of the CAFAF liaisons. Each DCF Office has a CAFAF 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 2017-2018 we expect to see the partnership with CAFAF continue to evolve. A continued area of focus is on CAFAF's development of online training opportunities for post-licensing trainings through a service called, "ProProfs". This system enables foster parents to complete post-licensing modules from any computer with Internet access and not have to travel to a training. The first online module (Cultural Competency) went live in April 2016. An additional module, Domestic Violence, is now also available

online in both English and Spanish. The ProProfs training system is able to aggregate module results and report to CAFAF and DCF what modules are being completed and where improvements in the system are needed. We expect this will aid in the increase of completion rates for post-licensing trainings. Over the course of the past year, CAFAF has also made enhancements to their exit survey given to families (core, relative and fictive kin) when they voluntarily end their licensure. The enhancements are intended to capture better additional elements related to permanency, training and support needs.

The Early Childhood Trauma Collaborative

The Early Childhood Trauma Collaborative (ECTC) is a 5-year initiative awarded to the Child Health and Development Institute (CHDI) by SAMHSA as part of the National Child Traumatic Stress Network to expand trauma-specific services for children age birth to seven in Connecticut. ECTC is a collaboration between CHDI, the Office of Early Childhood (OEC) the Department of Children and Families (DCF), 12 community mental health agencies, and the Consultation Center at Yale University (evaluator).

The mission of ECTC is to develop a more trauma-informed early childhood system of care to improve outcomes for young children suffering from exposure to trauma through enhanced early identification and improve access to trauma-focused evidence-based treatments (EBTS). This will be accomplished by disseminating or expanding access to four EBTs for young children and their families: Attachment, Self-Regulation and Competency (ARC); Child Parent Psychotherapy (CPP), Trauma Affect Regulation: Guide for Education and Therapy (TARGET: for caregivers), and Child and Family Traumatic Stress Intervention (CFTSI). ECTC will also provide training to a range of professionals who serve young children in order to improve their knowledge about childhood trauma and ability to identify and refer children to trauma-focused assessment or treatment when indicated.

The Department of Children and Families appointed a designee to serve as liaison to the ECTC including participating on the ECTC Advisory Group and working with ECTC providers implementing evidence-based practices at the local level to improve the identification and referral of young children in the child welfare system in need of these services and ensure their families can successfully access these services.

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) The Commissioner of DCF meets quarterly with the Chief Administrative Judge for Juvenile Matters to discuss and develop polices and protocols of mutual interest.
2) DCF staff are members of various statewide panels and committees that collaborate on addressing systemic problems that have an impact on child welfare. One of the most significant of these panels is the Juvenile Justice Policy Oversight Committee.
3) DCF staff participated in a series of trainings offered to attorneys by the Office of the Public Defender and the Superior Court for Juvenile.
4) DCF continued its ongoing collaboration with the Judicial Branch, Department of Mental Health and Addiction Services, Office of the Attorney General, Office of the Public Defender and the substance abuse provider community on the RSVP program. The program offers parents who abuse drugs and alcohol and who have lost custody of their children due to child abuse and neglect a recovery case manager, expedited access to treatment services and more intense juvenile court proceedings.

DCF- Headstart Partnership

For over 16 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. Head Start staff were given priority in the last DCF funded Infant Mental Health Series training and Headstart funds were used to support Reflective Supervision groups.

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. This population needs to be recognized as distinctive and in need of specific services tailored to its needs.

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 3,200 service providers through the work of an interdisciplinary, interagency rotating training team. In addition to offering a conference for administrators and supervisors, and an international conference, the Workgroup also created an Interview Assessment Guide to assist workers in identifying these families. The Workgroup has drafted recommendations regarding the use of plain language in communicating with all parents and developed a training on plain language.

The Workgroup's Annual meeting will take place in November 2017 and will focus on adult children of parents with cognitive limitations and related practice implications.

<u>Early Childhood Cabinet</u>

This year, the Early Childhood Cabinet, became the State Advisory Council (SAC) on Early Childhood Education and Care. The core responsibilities of the SAC are as follows:

- Conducting periodic statewide needs assessment on the quality and availability of high quality early care and education (ECE) programs;
- Identifying opportunities and barriers for collaboration and coordination among federally and state funded ECE programs and services;
- Establishing recommendations in the following key areas:
    - Developing a statewide, unified, data collection system
    - Creating or enhancing a statewide professional development system
    - Improvements in state early learning standards

- Increasing participation of children in ECE programs, including outreach to underrepresented and special populations
- Assessing the capacity and effectiveness of institutions of higher education to support career development of early childhood educators.

The Cabinet continues to be co-chaired by CT's Lieutenant Governor and the Commissioner of the Office of Early Childhood. Cabinet membership is diverse and represents both state and local agencies, early care educators and providers, and foundations. The Cabinet meets on a quarterly basis. The following represents a brief summary of the areas of focus for the Cabinet this past year:

1. The Office of Early Childhood (OEC) is conducting an analysis of the demand and capacity of pre-school and infant/toddler programs statewide. Preliminary findings indicate a shortage of regulated infant/toddler care statewide; most of the gaps are noted in the major cities of the state. Once the report is finalized, a series of webinars will be offered to share findings with key stakeholders;
2. The Office of Early Childhood continues their efforts to build a Quality, Recognition and Improvement System (THRIVE) within their early care education programs based on the Five Pillars of Quality, including:
    a. Health and Safety (group size, staff ratios, nutrition and sanitation)
    b. Learning and Environment (rating system, curriculum, NAEYC accreditation, Headstart/Early Learning and Development Standards)
    c. Workforce (Core knowledge and competencies, education level)
    d. Family Engagement (cultural responsiveness, whole child approach, community involvement)
    e. Leadership (role of Director/Administrator/Principal, staff policies, program management).
3. Every Student Succeeds Act – ESSA requires three long term goals that focus on steady and sustained growth toward critical targets that will ensure student success, specifically improving student achievement, increasing graduation rates, and promoting English language proficiency. The CT State Department of Education developed an implementation plan to solicit feedback from stakeholders, including Cabinet members around the requirements of this Act. Over 80 stakeholders participated in focus groups and 6500 survey responses were received. The plan includes many early childhood provisions, including collaboration between public schools and

community early care and education programs and a tiered approach to support underperforming schools.

4. The Cabinet authorized a subcommittee be established as a result of Project Launch, a 5 year grant awarded by SAMHSA. The grant requires the establishment of a statewide council designed to promote the health and wellness of children ages 0-8 with a primary focus on system integration. The Cabinet agreed to function as an advisory entity and formalize the work of the subcommittee.
5. Child Care Development Fund – The Office of Early Childhood conducted six informational sessions about the changes that will occur as a result of the CCDF reauthorization. Although the reauthorization will better serve children and families by focusing on quality and continuity of care, it impacts capacity as it increases length of stay in the program. As there is no additional funding connected to the reauthorization, fewer children will be served which has resulted in closed enrollment for specific populations. Over 1300 families are currently on the waitlist. These changes have a serious impact for early care and education providers as well as families and will be monitored closely by the OEC.

The areas cited above will continue to be an area of focus for the Cabinet this upcoming year.

<u>CT's Home Visiting Consortium</u>

The establishment of the Home Visiting Consortium was a result of legislation (PA 15-45) that was passed in 2015. The group has broad representation, including state and local agencies, Birth to Three Programs, and multiple Home Visiting Programs. It is charged with developing a plan for implementing the recommendations put forth in the 2014 Home Visiting Report submitted by the Office of Early Childhood.

Subcommittees were established to address the four priority areas. The following represents a brief summary of the work as follows:

1. Strengthen the Referral Infrastructure for Home Visiting Programs (include access to services and referral structure): The workgroup is exploring the possibility of creating a centralized intake process, focusing on creating a system in CT that effectively triages families, minimizes service delays, and creates efficiencies in transitioning families from one service to another. In order for this approach to be successful, the intake staff must fully understand the nature of the service array, recognizing the uniqueness and eligibility criteria for each program to ensure families are connected to the appropriate service based on their individual needs.

2. Develop a communication strategy to increase public awareness, knowledge and perception of home visiting programs. Work deferred as it is dependent on the recommendations/scope of work of the other subcommittees.
3. Workforce Development – establish a core set of competencies and coordinate training: Research conducted to identify the competencies developed by other states. Initial analysis suggests the need to identify multiple levels given the broad service array, educational requirements of staff etc.
4. Develop program standards that promote high quality programs and outcomes: Identifying quality indicators across all programs, specifically focusing on how programs promote child and family health; promote and support child/caregiver interactions and attachment; promote child development and school readiness; and reduce risk factors and promote protective factors. The workgroup will be identifying how these areas are measured by the array of tools that are implemented within each service type.

The Consortium continues to meet on a quarterly basis. Subcommittees will continue their work as described above.

Help Me Grow Advisory Committee

This committee was developed as a result of a merger with two distinct workgroups: The Help Me Grow Quality Improvement Workgroup and the Early Childhood Comprehensive Systems (ECCS). The ECCS was initially established as a result of a prior HRSA grant that ended in 2016 which provided resources related to developmental awareness, screening and detection, early intervention and service linkage. When CT was not selected to continue this work, the ECCS group disbanded. All ECCS members subsequently joined the HMG Advisory Committee. To maximize the skills and expertise of Committee members, the following workgroups were established, charged with developing messages around the importance of developmental screening, early identification and intervention for health care providers, early care and education providers, and families. Additionally, the committee is charged with increasing the integration of Help Me Grow and Birth to Three efforts, as well as coordinating efforts of the State Health Improvement Plan (SHIP) related to developmental screening. Given the nature and charge of this group, staff from Elm City Project LAUNCH have joined this committee to coordinate work related to developmental screening and assessment (one of the strategies of the SAMHSA grant) as well as collaborate on the public awareness campaign. Recently, the committee has been asked to function as an advisory group to the CONNECT grant, with a primary focus on early childhood. The work described above will continue this upcoming year.

CT Children's Behavioral Health Plan

Following the tragic events that occurred in Newtown Connecticut in December 14, 2012, the Connecticut General Assembly passed Public Act 13-178 which specifically directed DCF to produce a children's behavioral health/mental health plan for the state of Connecticut. The public act pushed Connecticut to focus fully on child and family mental health and well-being. As of late 2014 there were approximately 783,000 children under age 18 in Connecticut, constituting 23% of the state's population. Epidemiological studies suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment. However, many of these children are not able to access services. Public Act 13-178 is intended to address this and related children's mental health issues.

The public act required the behavioral health/mental health plan to be comprehensive and integrated and meet the behavioral and mental health needs of all children in the state, and to prevent or reduce the long-term negative impact for children of mental, emotional, and behavioral health issues.

The behavioral health/mental health plan developed out of this process resulted in seven broad thematic areas, each with specific goals and strategies for significantly improving Connecticut's children's behavioral health/mental health service system. The Plan includes a proposed timeline for implementation that focuses on the development of the infrastructure and the planning of the array of services that will comprise the System of Care. The seven broad themes identified in the plan are:

- System Organization, Financing and Accountability
- Health Promotion, Prevention and Early Identification
- Access to a Comprehensive Array of Services and Supports
- Pediatric Primary Care and Behavioral Health Care Integration
- Disparities in Access to Culturally Appropriate Care
- Family and Youth Engagement
- Workforce Development

DCF began in 2015 to implement the behavioral health/mental health plan, in partnership with eleven other state agencies, numerous private agencies and the children and families of Connecticut. A number of steps remain to be taken in achieving the goals of the plan, ensuring that Connecticut's children and families have full access to quality mental health care in support of achieving social,

emotional, and behavioral well-being. Since 2014, progress updates have been submitted annually to the CT Legislature.

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 (Office of Early Childhood) in the implementation of the Birth to Three System. During the meetings, Birth to Three shares quarterly reports (including budget and program information) to ICC members. The council provides opportunities for cross-system collaboration and partnership, informing members of the various committees/groups that have been established and related activities, highlighting local programs (including discussion around best practices, challenges and/or barriers to accessing or provision of services, as well as providing a forum for parents to share their personal experiences with the Birth to Three program. The ICC will continue to meet quarterly.

Overview of Supportive Housing for Families Five Year Federal Grant (ISHF)

The Connecticut Department of Children and Families (DCF) is in its final year of a five year grant to meet the needs of child welfare involved families who experience severe housing barriers. The grant was 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) 5-year initiative currently has 18 of the 50 family capacity still enrolled in the project. The program reached full capacity and is in the winding down phase. The project evaluation team consisting of the University of Connecticut and Chapin Hall are gathering preliminary data on participating families in the areas of the following:

1) Evidence Based Intervention Enrollment
2) Participation in Team meetings
3) Preservation or Reunification of the family
4) Children Outcome Measures (Ages and Stages Questionnaire, Child Behavior Checklist, Child Trauma Screens)

5) Parent and Household Measures (Simple Screening Instrument for Alcohol and Other Drugs, Brief Symptom Inventory screen, North Carolina Family Assessment Tool, Brief Trauma Questionnaire, Parent Stress Index, etc.)
6) Vocational/Employment/Educational services for Parents

There are promising results in many areas so far and especially in preservation, vocation, and employment outcomes. The final report is scheduled for completion in the summer of 2018 after all families have been discharged and follow up measures have been completed.

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

1. Establish and utilize data-sharing agreements between state agencies
2. Literature review and staff survey on strengths and weaknesses of Scatter-site verse single-site permanent housing models.
3. Continued work on Engagement and Cost studies.
4. Completion of final analysis and report.

Other major activities and accomplishments this year are as follows:

Three Branch Institute/Project Advisory Board

The Project Advisory Board, called the *Connecticut Collaborative on Housing and Child Welfare,* functioned as one of three working groups of the Three Branch Institute. While the Three Branch Institute has completed its mission with identifying the priority needs of children, several groups have continued the important work of the Three Branch Institute and will remain established such as the *Connecticut Collaborative on Housing and Child Welfare* (CCHCW) and its workgroups.

Connecticut Collaborative on Housing and Child Welfare (CCHCW) Spring Meeting

The CCHCW spring meeting was hosted by Community Action Agency in New Haven, CT on April 25, 2017. The event- The Road to Hope, a candid conversation about the pathway to family stability featured speakers Matthew Desmond, Ph.D., author of *Evicted,* and Juan Salgado, President and CEO of Instituto del Progreso Latino in Chicago. Members of the CCHCW attended and heard findings from the American Housing Survey, how stable housing is essential to workforce opportunities, proposed housing policy reform across the country. The next CCHCW workgroup meeting is planned for November 2017.

Families with Children (CCHCW Workgroup)

From November 2016 to the present, the Families with Children workgroup under CCHCW and the Partnership for Strong Communities has continued to meet monthly to refine the group's work plan and ensure these efforts align with the group's intergenerational target outcomes for both parents and children. As part of the state's mission to end family homelessness by 2020, we aim to learn as much as possible about the needs of homeless families in order for them to sustain their housing. The group has discussed the use of assessment tools for identifying the needs of families experiencing homelessness and ways of integrating early childhood development supports into the services offered to families with young children experiencing homelessness.

Connecticut's office of Early Childhood presented a video on the Early Care Coordination/Head Start Partnership with Homeless Shelters that Connecticut participated in along with several other states. From this activity the group proposed a pilot between 211 (Statewide Help Line) Child Development Info (CDI) Line and the Southeastern Coordinated Access Network (CAN) to test a systematic approach to ensuring that development concerns are addressed and that families have the tools to monitor their children's development. It was presented to the Southeastern CAN that families would be provided with the Ages and Stages Questionnaire (ASQ) during their interview. If concerns are identified, care coordination services are available through 211 CDI to connect them to appropriate services. This pilot is planned to begin in the spring of 2017 with the hopes that other CANs across the state will adopt this practice to help identify the developmental needs of young children as early as possible.

The Families with Children Workgroup recognizes this work involves many systems and often there is overlap. Our workgroup has committed to working collaboratively with other work groups to ensure that we are not duplicating efforts.

Workgroup chairs met with the Homeless Youth and Young Adult workgroup chairs to discuss how to address the needs of young parents. From this discussion, a combined subgroup will be formed to increase employment resource opportunities, reduce childcare barriers, and promote achievement of higher education. Our workgroup has shared our work plan with the Re-tooling the Crisis Response System and the Affordable Housing work groups to solicit their feedback and input as we embark on strategies that are strongly correlated to their work. When necessary, the groups will collaborate and jointly complete activities that will help us reach our goals.

With the ending chronic homelessness Zero 2016 campaign successfully wrapping up, the Partnership for Strong Communities (largest state housing advocacy group that facilitates the Opening Doors CT strategy that aligns with the federal policy to end Family Homelessness by 2020) are ramping up. The United States Interagency Council on Homelessness (USICH) recently released a framework and benchmarks for ending family homelessness with some helpful guidance and challenging goals. Overall, Connecticut has many strengths in that many of the elements of the framework are in place or in progress. The benchmarks, as currently written, represent an expansion of the population of families that will be targeted for housing, new requirements for housing, or providing shelter to all families experiencing homelessness. CT has adopted this framework to guide our work.

The Systems Integration and Sustainability (CCHCW Workgroup)

The Workgroup is revisiting their prospective areas of focus to determine whether this workgroup should be reconfigured or absorbed by another statewide data group already underway.

Policy and Legislative Advocacy Workgroup (CCHCW Workgroup)

The workgroup continues to meet and expand efforts to communicate the work of the Collaborative via the bi-annual newsletters and attendance and participation at local, state and national conferences and advocacy events related to Families and Youth Homelessness. Members of this workgroup are actively supporting work of the Families with Children Workgroup as they network and present at events and conferences.

Collaborate with Youth and Other Programs – Start and CCEH

Since November 2011, DCF has maintained a Homeless Youth Program entitled "Start" to prevent or end homelessness for young adults struggling to maintain safe and stable housing. The two- year model provides young adults the opportunity to gain employment and/or vocational or higher education while living in their community. They are offered case management services, linkages to services including mental health, substance abuse, and medical, along with an opportunity to re-connect with family, friends and build a new network of support and resources to maintain their success and continued growth into adulthood.

In January 2016, Melville Charitable Trust approached DCF after hearing positive feedback from youth, providers, and the community on the successful outcomes of the Start program. Previously, the

National Network for Youth, the National Alliance to End Homelessness Practice Knowledge Project, Funders Together to End Homelessness, U.S. Interagency Council on Homelessness and with the support of the Raikes Foundation and the Melville Charitable Trust held in-depth discussions around implementing rapid rehousing models for youth. It was found that rapid re-housing works well for even highly vulnerable youth although different from adults. Services need to be more intensive and longer lasting and may cost more in the beginning but have huge cost savings for systems in the future. Rigorously designed evaluation research of these programs would advance what we know about what works and what doesn't work for youth and the aspects of the models that make them effective. Therefore, the Melville Charitable Trust and the Institute for Community Research (ICR) proposed to conduct rigorously designed mixed-method evaluation research of the Start Program. The goals of the evaluation research are to: 1) Document the impact of the rapid re-housing program on young adults' lives over the program period and one year post, and identify the key factors that drive these outcomes; 2) Demonstrate the cost-effectiveness of the program; and 3) Assess the transferability of the program to other communities and states in the US.

Since August, ICR and the Youth Action Hub have been working with The Connection, DCF and the Melville Charitable Trust to design a scientifically rigorous evaluation of the Start program. The design of the evaluation currently under development is interested in understanding how the Start model impacts the following five areas of young people's lives:

1) Housing stability,
2) Social support network
3) Emotional and physical health
4) Education/employment status
5) Earned income/financial stability.

The study design will use both quantitative and qualitative methods (survey and in-depth interviews). The entire sample of each cohort group will receive the baseline and two follow-up surveys over a year. Case managers and outreach workers at The Connection will administer surveys with participants in their program and on their waiting list. A subsample of participants from each cohort and the comparison group will be selected for a baseline and 12-month follow-up interview. The Youth Action Hub staff will

conduct all in-depth interviews with participants who will be located throughout the state (e.g., Hartford, Bridgeport, New Haven, Norwich, New London, Waterbury, Meriden, and Middletown).

DCF also continues to allocate $50,000 annually to the CT Coalition to End Homelessness (CCEH to conduct the HUD's national Homeless Youth Count in 2015 and again in 2017. The Count allows for DCF and the Department of Housing (DOH) to gather data on the length and number of episodes of youth homelessness, social networks, family relationships, and reunification with family. In 2016, funds were utilized to educate, strengthen community awareness on youth homeless as part of their preventative efforts.

2. Assessment of Performance – CFSR, Systemic Factors, and Case Review System

The CFSR Round 3 Data Profile (updated version provided June 1, 2017) provided data on three of the seven national indicators, Placement Stability, Maltreatment in Care, and Recurrence of Maltreatment. Risk-standardized results for Placement Stability indicated that CT has performed statistically better than national performance with this measure for all reported submissions (from 13B14A through 16A16B). Risk-standardized results for both of the other two measures showed that our performance has been statistically worse than national performance, though our most recent observed performance on Recurrence of Maltreatment reported in the profile does meet the national standard (<=9.1%). The remaining four national indicators related to permanency were unable to be calculated by the Children's Bureau due to a single data quality problem (exceeded the 10% limit) with missing Discharge Reasons for eight of the 15 AFCARS submissions included in the measurement period. This was the only data quality problem that exceeded thresholds for any of the submissions. It is also important to note that the most recent submission (16B) had no issues with this, or any other, data quality check so the data issues appear to have been resolved as of this writing.

The automated Results-Oriented Management (ROM) system is what the agency utilizes to manage important aspects of child welfare practice, and monitor the effects of systems/practice changes on agency performance over time. This system contains reports for these indicators built to federal specifications, but instead of being based on static submissions to AFCARS and NCANDS they are based on SACWIS (LINK) data updated on a daily basis. The results for the measures based on these reports are as follows:

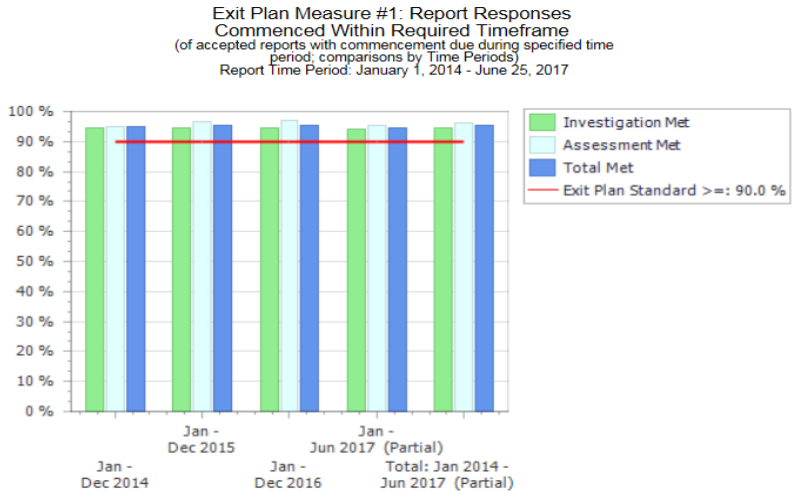
FEDERAL MEASURE	CY11	CY12	CY13	CY14	CY15	CY16	TREND
Recurrence of Maltreatment (<=9.1%)	9.7	9.1	9.2	10.1	8.7	10.2	
Maltreatment in Foster Care (<=8.5 victims/100k days)	5.0	5.3	5.5	6.6	6.4	6.5	
Placement Stability (<=4.1 moves/1k days)	3.3	3.0	2.8	2.6	3.1	3.6	
Permanency in 12 Months (>=40.5%)	39.5	37.7	34.2	30.9	26.7	25.5	
Permanency in 12 Months for Children In Care 12-23 Months (>=-43.6%)	43.2	43.1	44.0	39.3	45.2	42.9	
Permanency in 12 Months for Children In Care >=24 Months (>=30.3%)	22.4	23.7	27.0	25.8	31.7	28.8	
Re-Entry to Foster Care (<=8.3%)	13.1	12.0	15.2	15.6	15.1	15.0	

The results for Recurrence of Maltreatment and Placement Stability appear to be confirmatory of those reported in the Data Profile, given the differences in time periods and data sources. Further, Stability of Foster Care Placement (Item 4) of the CFSR was the item on which our review showed the best results (86%). However, the results for Maltreatment in Foster Care are quite different as reported by ROM when compared to the Data Profile. The ROM report shows that CT has consistently met the national standard on this measure, while the Data Profile does not. Further exploration of the relevant datasets will be required in order to interpret the differences.

The ROM reports regarding the permanency measures provide an indication of our performance in this area, where the Data Profile was unable to do so, and unfortunately present a portrait of mixed performance in these areas. We have been very close to meeting the measures, and have met them in a few periods, for achievement of permanency in 12 months for children in care both 12-23 and >=24 months. While the trend for those in care 12-23 months has been back and forth between meeting and not meeting the measure, there is an overall improving trend for those in care >=24 months. Unfortunately, performance for the base measure of achievement of permanency in 12 months has been steadily declining so that in CY16 our performance was 15 percentage points below the standard. At the same time, our rates for Re-Entry have been just under twice the level that they should be, though there has been slight but steady improvement over the past two year period.

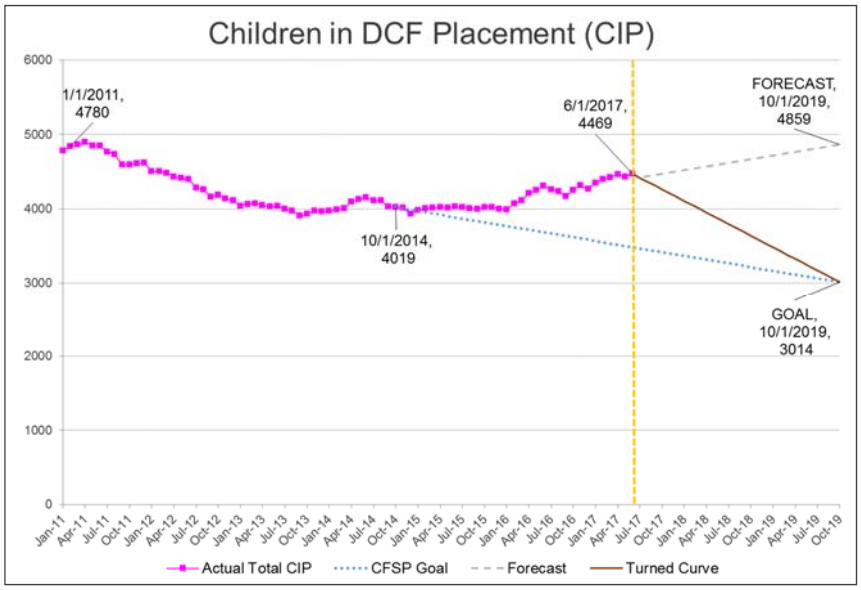
The below sets forth the Department's current performance on Safety, Permanency and Well-Being Items:

- **Item 1**
  - CFSR Result: n=41, 59% Strength, 41% ANI
  - ROM EP#1 and EP#2 – CY14 – CY16 – screenshot ROM Report annual aggregation

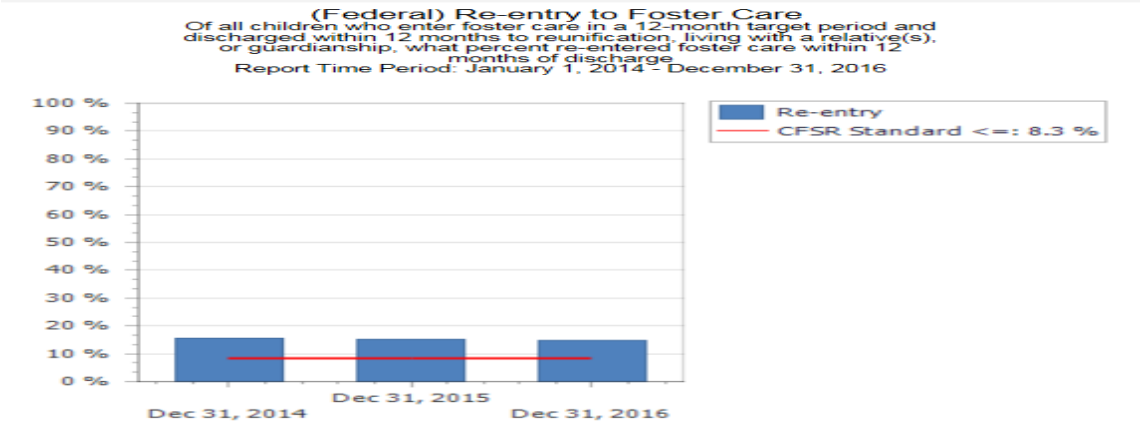


Report Period	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016		Jan - Jun 2017 (Partial)		Total: Jan 2014 - Jun 2017 (Partial)	
- Total Investigation	17956	100.0%	16693	100.0%	18155	100.0%	9563	100.0%	62367	100.0%
Investigation Met	17005	94.7%	15812	94.7%	17168	94.6%	8997	94.1%	58982	94.6%
Investigation Not Met	951	5.3%	881	5.3%	987	5.4%	566	5.9%	3385	5.4%
- Total Assessments	12061	100.0%	12810	100.0%	12825	100.0%	6647	100.0%	44343	100.0%
Assessment Met	11476	95.1%	12374	96.6%	12437	97.0%	6329	95.2%	42616	96.1%
Assessment Not Met	585	4.9%	436	3.4%	388	3.0%	318	4.8%	1727	3.9%
- Total	30017	100.0%	29503	100.0%	30980	100.0%	16210	100.0%	106710	100.0%
- Total Met	28481	94.9%	28186	95.5%	29605	95.6%	15326	94.5%	101598	95.2%
- Total Not Met	1536	5.1%	1317	4.5%	1375	4.4%	884	5.5%	5112	4.8%

- **Item 2**
  - CFSP Objective:
    - 1.1. # of children in foster care will be reduced by 25% through continued implementation of CFCFTM meetings;

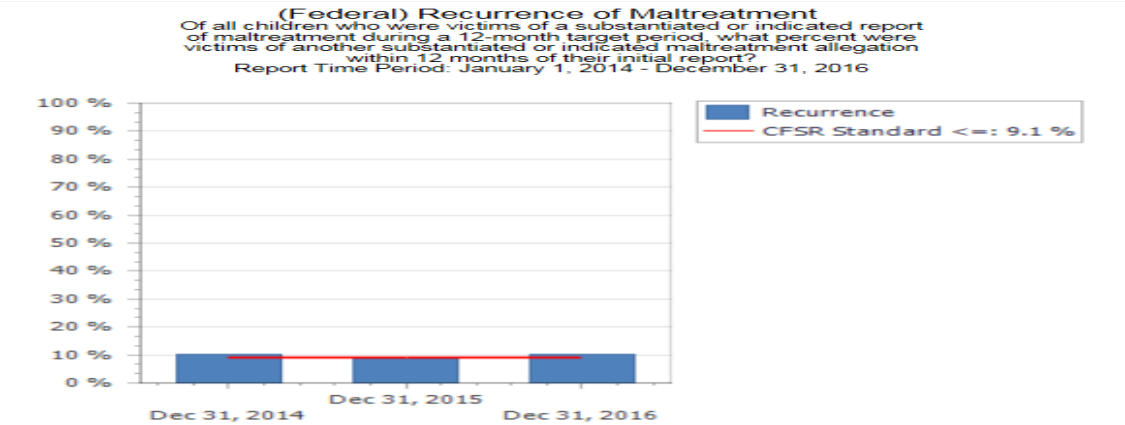


  - CFSR Result: n=21, 57% Strength, 43% ANI
  - ROM Federal Re-Entry to FC – CY14 – CY16 – screenshot ROM Report annual aggregation



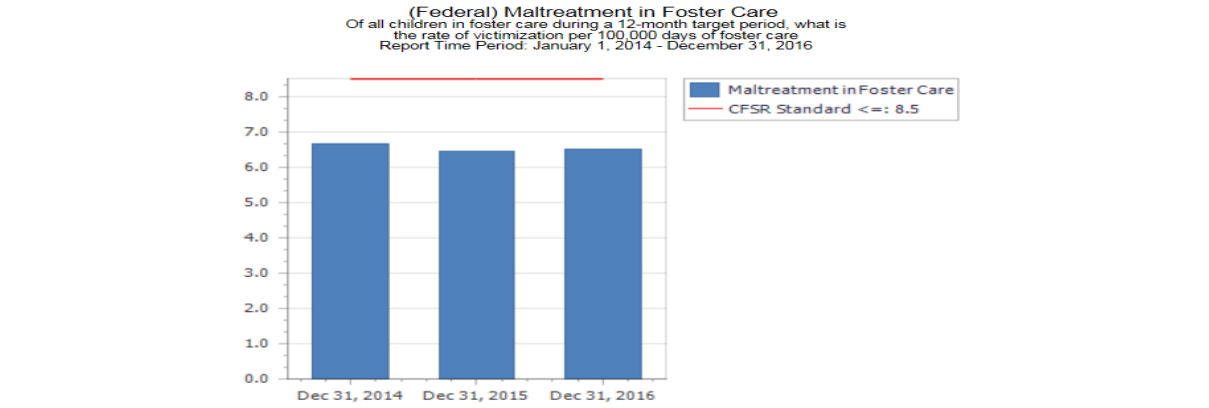
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
Total	524	100.0%	504	100.0%	455	100.0%
Maintained Permanency	442	84.4%	428	84.9%	387	85.1%
Re-entry	82	15.6%	76	15.1%	68	14.9%
Entered Care During	Jan - Dec 2012		Jan - Dec 2013		Jan - Dec 2014	

- ROM Federal Recurrence of Maltreatment – CY14 – CY16 – screenshot ROM Report annual aggregation



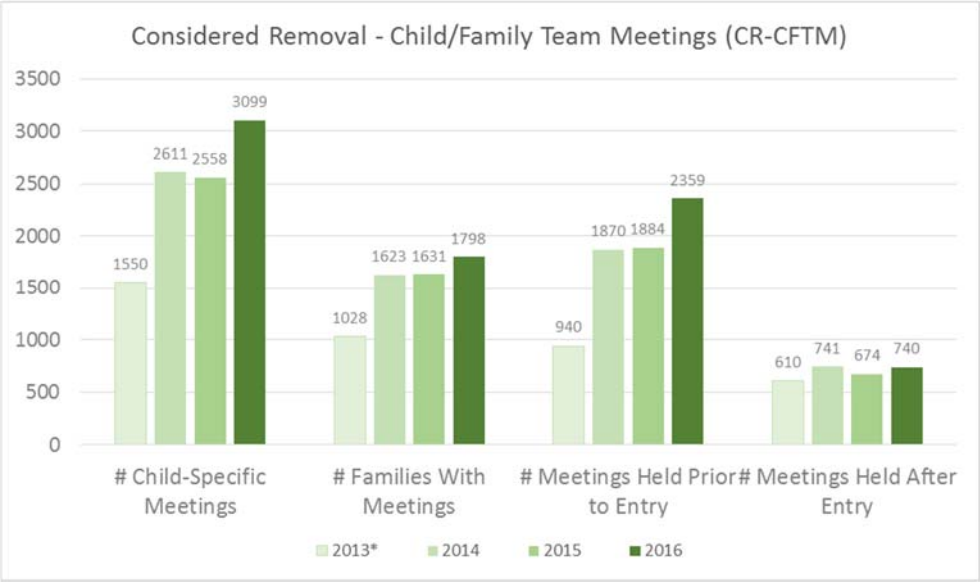
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
Safe	6566	89.9%	6719	91.3%	6620	89.8%
Recurrence	741	10.1%	638	8.7%	755	10.2%
Total Child Victims	7307	100.0%	7357	100.0%	7375	100.0%
Inital maltreatment during	Jan - Dec 2013		Jan - Dec 2014		Jan - Dec 2015	

- ROM Federal Maltreatment in Foster Care – CY14 – CY16 – screenshot ROM Report annual aggregation

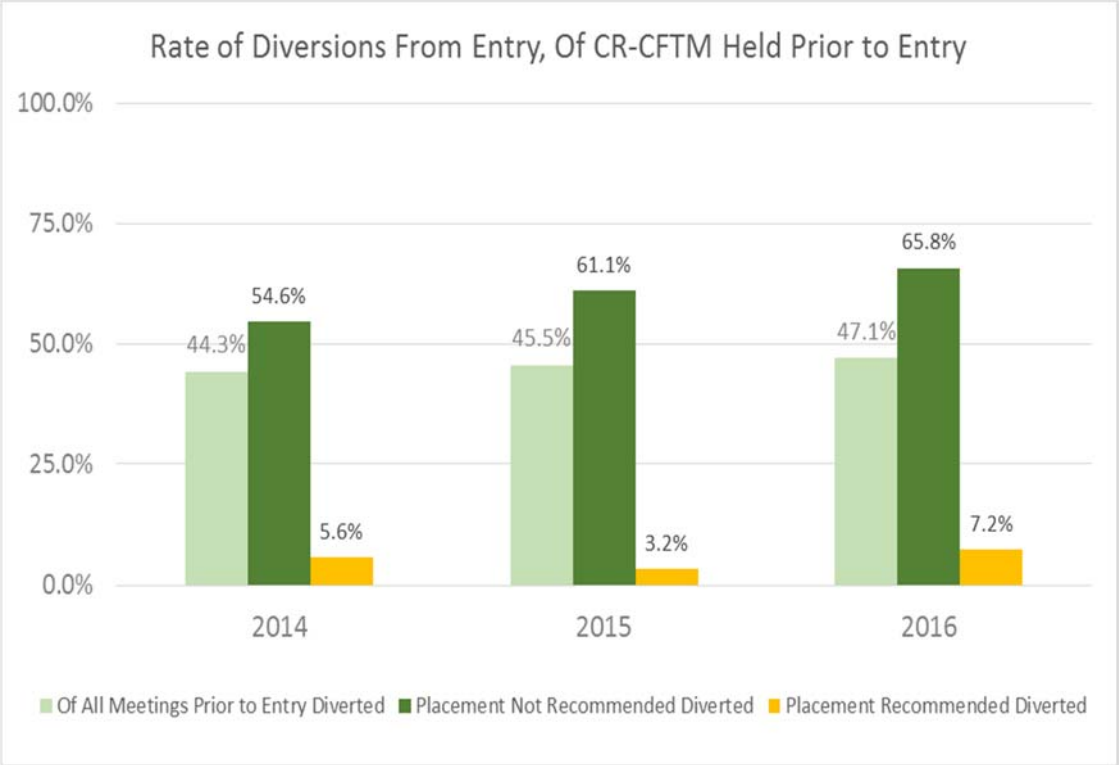


Report Period End	Dec 31, 2014				Dec 31, 2015				Dec 31, 2016			
	Count	Reports	Days	Rate	Count	Reports	Days	Rate	Count	Reports	Days	Rate
Maltreatment in Foster Care	5504	90	1353634	6.6	5618	85	1320716	6.4	5870	90	1383701	6.5
Rolling 12 Month Period	Jan - Dec 2014				Jan - Dec 2015				Jan - Dec 2016			

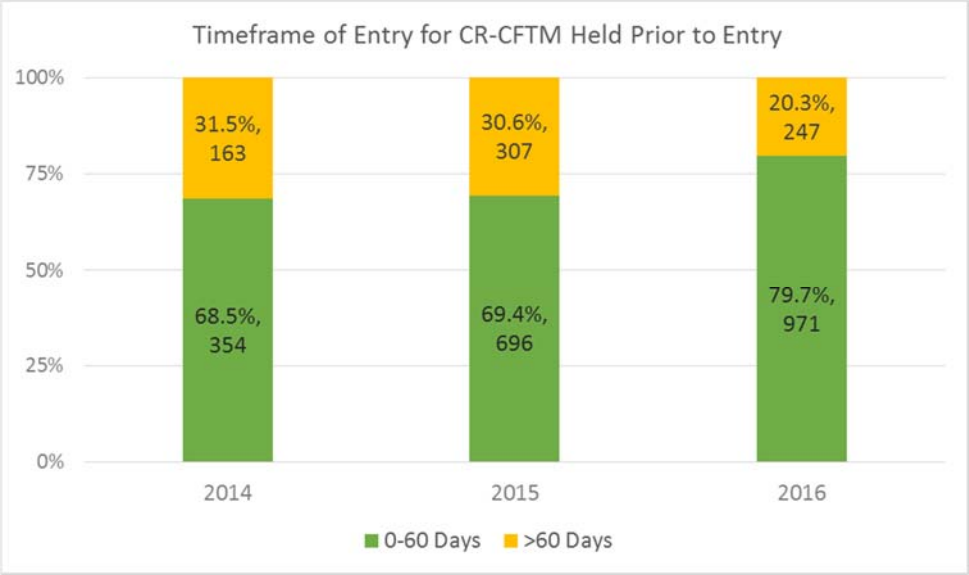
- CRCFTM Data – CY14 – CY16
  - # Child Specific Team Meetings
  - #/% Meetings Held Prior



  - #/% Children who Entered Care
  - #/% Children that did not Enter Care



- #/% Children who Entered Care within 60 days



- NOTE: the following had been in this section, but better fits under Item 10 Placement with Relatives so can be found there now… Of entries, #/% children placed with relatives/kin

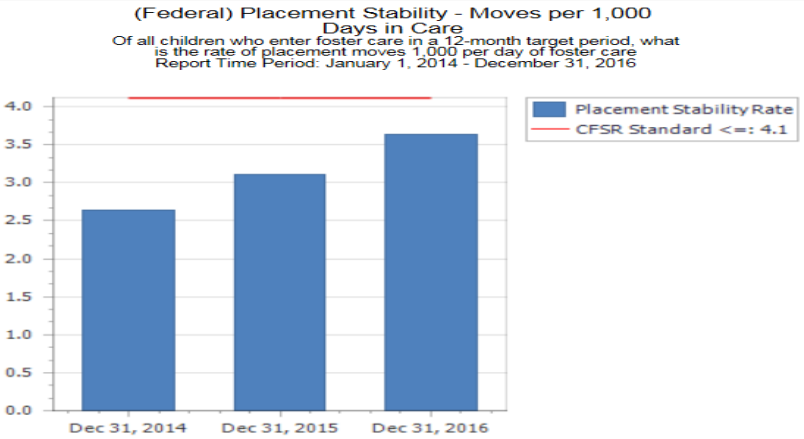
- **Item 3**
  - CFSR Result: n=82, 51% Strength, 49% ANI
  - ACRI Case practice elements – Strength % - CY15 -16 quarterly aggregation
    - Risk & Safety – Child in Placement

Sl.No	Measure	Statewide								
		Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015	Quarter 1, 2016	Quarter 2, 2016	Quarter 3, 2016	Quarter 4, 2016	Quarter 1, 2017
		Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength
		%	%	%	%	%	%	%	%	%
10	Risk & Safety - Child in Placement	93%	92%	90%	91%	92%	92%	91%	88%	89%

- Timely Accurate SDM – Parents
- Timely Accurate SDM – Child

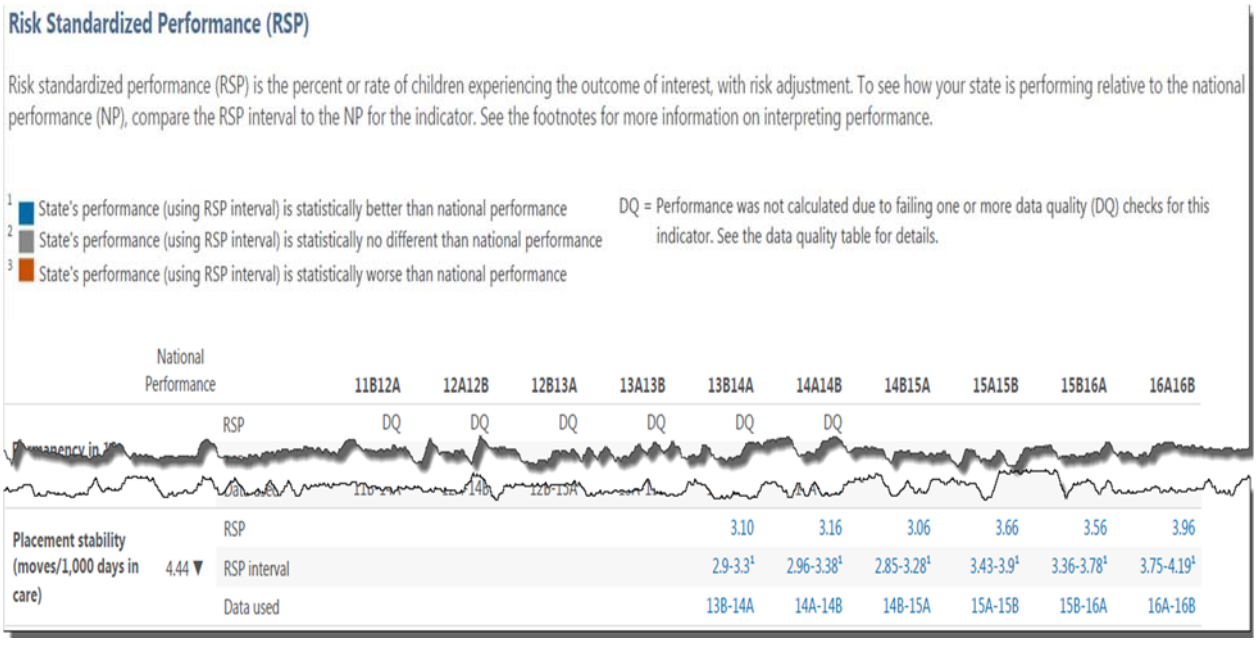
Sl.No	Measure	Statewide								
		Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015	Quarter 1, 2016	Quarter 2, 2016	Quarter 3, 2016	Quarter 4, 2016	Quarter 1, 2017
		Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength
		%	%	%	%	%	%	%	%	%
22	Timely Accurate SDM- Parents	79%	77%	75%	76%	77%	79%	77%	75%	74%
23	Timely Accurate SDM- Child	87%	87%	79%	83%	77%	80%	82%	72%	74%

- **Item 4**
  - CFSR Result: n=42, 86% Strength, 14% ANI
  - ROM Federal Placement Stability - CY14 – CY16 – screenshot ROM Report annual aggregation



Report Period End	Dec 31, 2014				Dec 31, 2015				Dec 31, 2016			
	Count	Moves	Days	Rate	Count	Moves	Days	Rate	Count	Moves	Days	Rate
Placement Stability Rate	1884	845	319764	2.6	1941	965	310792	3.1	2226	1333	366988	3.6
Rolling 12 Month Period	Jan - Dec 2014				Jan - Dec 2015				Jan - Dec 2016			

Updated National Data Profile data indicator results here as well



- **Item 5**
  - CFSP Objective:
    - 2.2. Permanency Teaming will be implemented to improve the likelihood of permanency for all children and to reduce the use of APPLA by 50%

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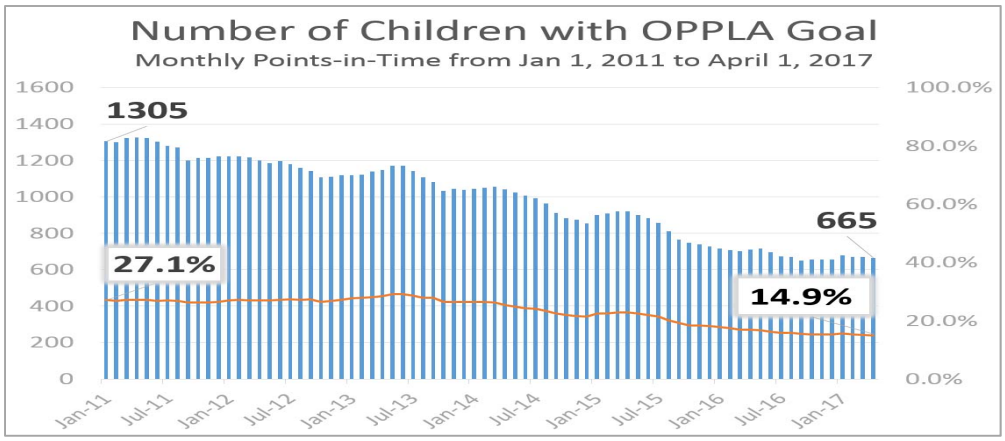
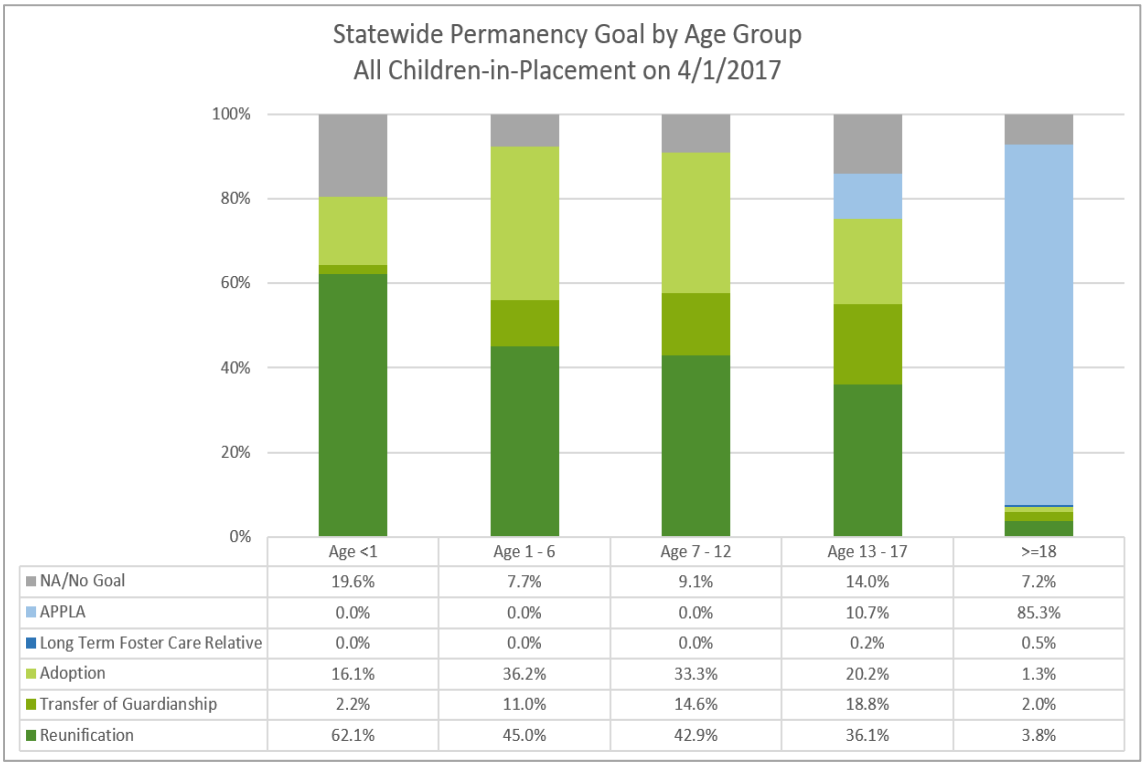
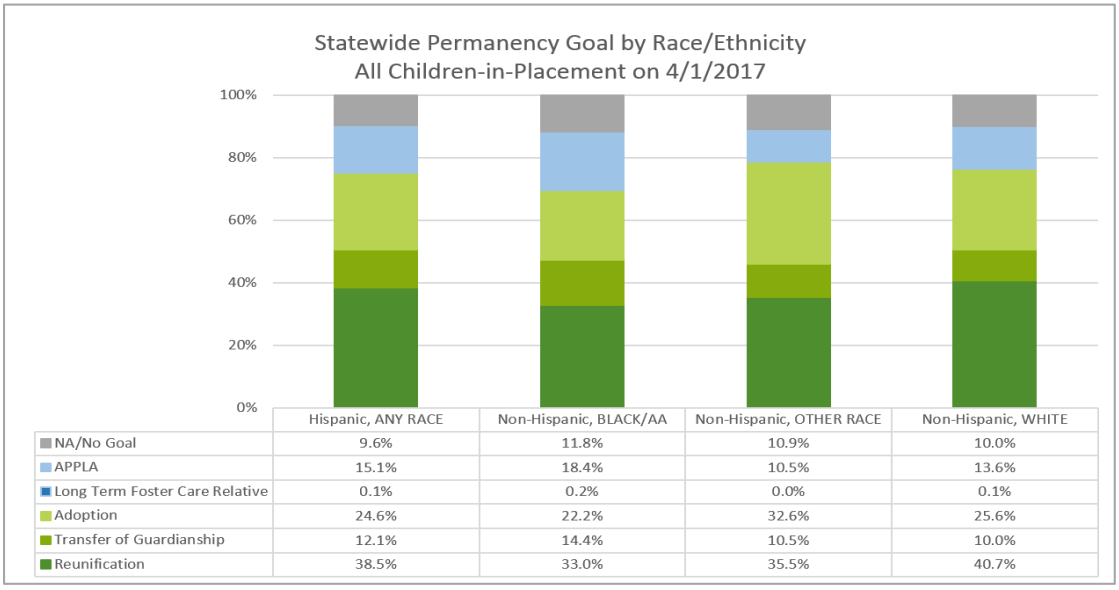


- **Other Related Data**



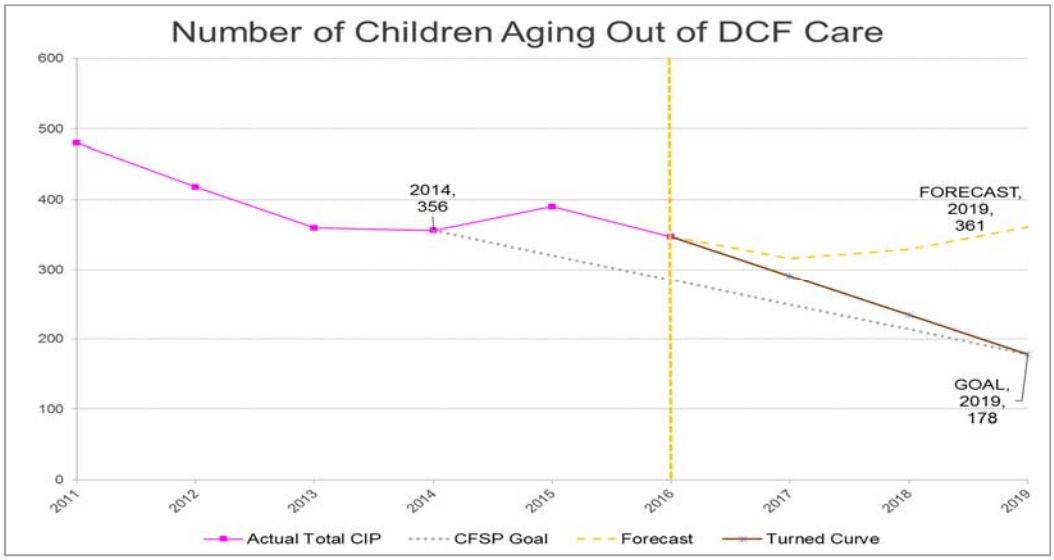
	Age <1	Age 1 - 6	Age 7 - 12	Age 13 - 17	>=18
NA/No Goal	19.6%	7.7%	9.1%	14.0%	7.2%
APPLA	0.0%	0.0%	0.0%	10.7%	85.3%
Long Term Foster Care Relative	0.0%	0.0%	0.0%	0.2%	0.5%
Adoption	16.1%	36.2%	33.3%	20.2%	1.3%
Transfer of Guardianship	2.2%	11.0%	14.6%	18.8%	2.0%
Reunification	62.1%	45.0%	42.9%	36.1%	3.8%



	Hispanic, ANY RACE	Non-Hispanic, BLACK/AA	Non-Hispanic, OTHER RACE	Non-Hispanic, WHITE
NA/No Goal	9.6%	11.8%	10.9%	10.0%
APPLA	15.1%	18.4%	10.5%	13.6%
Long Term Foster Care Relative	0.1%	0.2%	0.0%	0.1%
Adoption	24.6%	22.2%	32.6%	25.6%
Transfer of Guardianship	12.1%	14.4%	10.5%	10.0%
Reunification	38.5%	33.0%	35.5%	40.7%

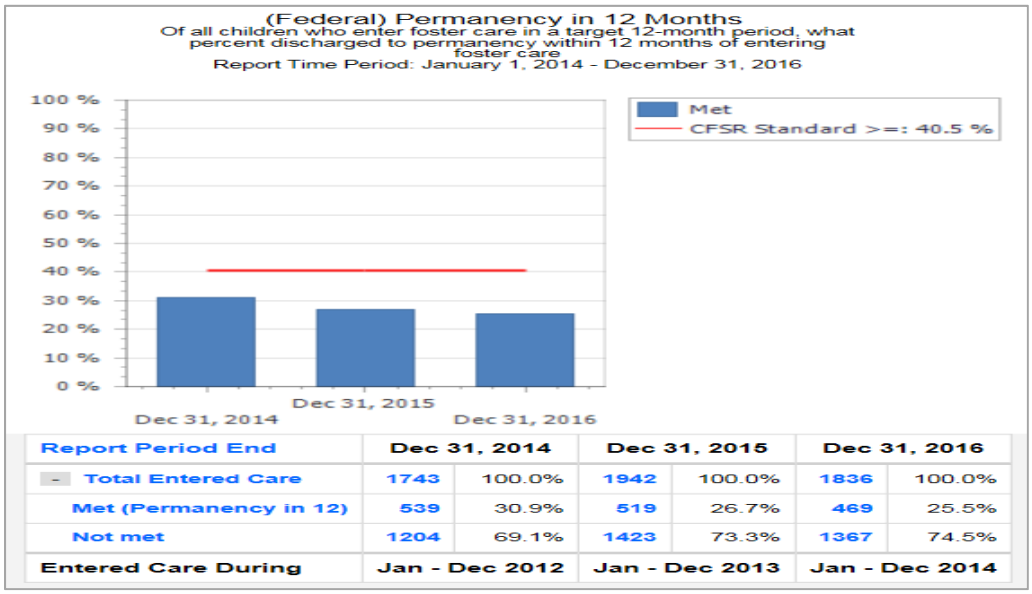
- CFSR Result: n=41, 78% Strength, 22% ANI

- **Item 6**
  - CFSP Objective
    Number of youth aging out of care without legal or relational permanency will be reduced by 50%.



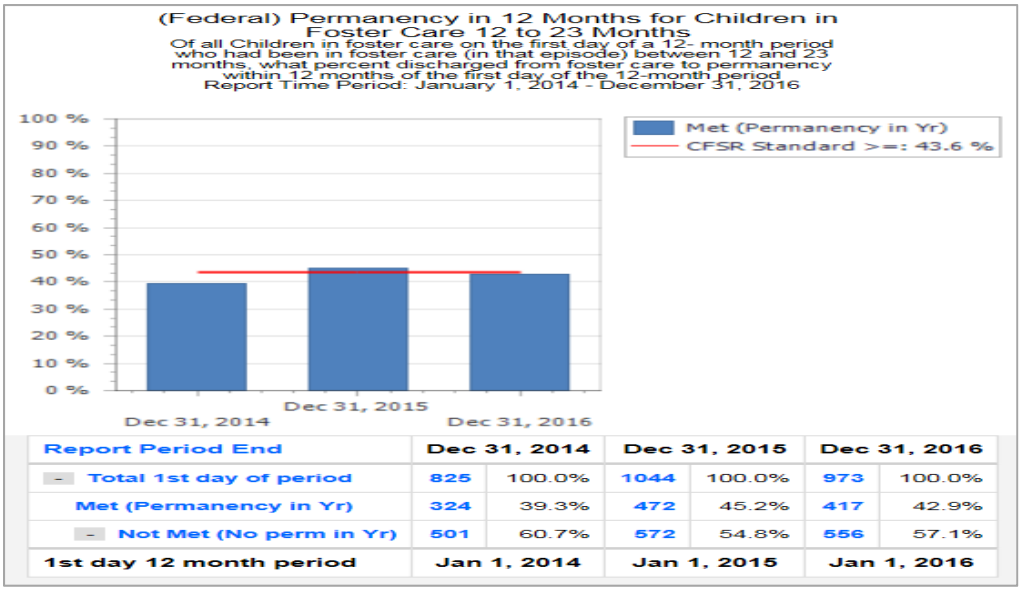
  - CFSR Result: n=42, 31% Strength, 69% ANI
  - CFSR National Data Indicator Results: All three relevant permanency measures were unable to be calculated due to a data quality issue with a single data element, discharge reason, for the measurement periods required for each measure. It should be noted that this data quality problem has already been resolved in the subsequent submission of FFY16B AFCARS data.

- ROM Federal Permanency in 12 Months



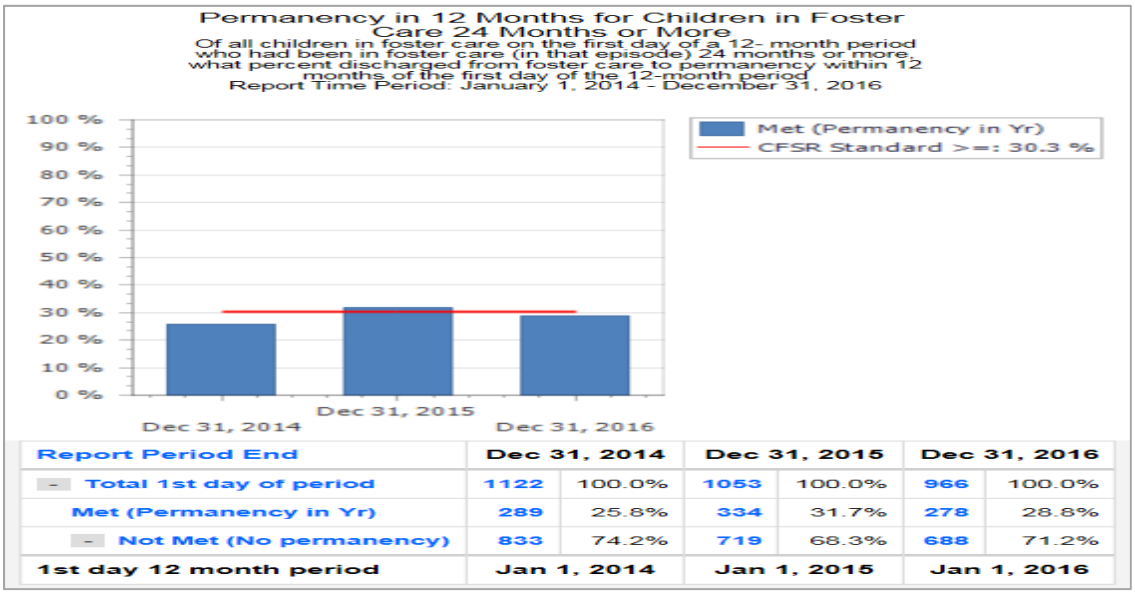
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
- Total Entered Care	1743	100.0%	1942	100.0%	1836	100.0%
Met (Permanency in 12)	539	30.9%	519	26.7%	469	25.5%
Not met	1204	69.1%	1423	73.3%	1367	74.5%
Entered Care During	Jan - Dec 2012		Jan - Dec 2013		Jan - Dec 2014	

- ROM Federal Permanency in 12 Months for CIP 12-23 Months



Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
- Total 1st day of period	825	100.0%	1044	100.0%	973	100.0%
Met (Permanency in Yr)	324	39.3%	472	45.2%	417	42.9%
- Not Met (No perm in Yr)	501	60.7%	572	54.8%	556	57.1%
1st day 12 month period	Jan 1, 2014		Jan 1, 2015		Jan 1, 2016	

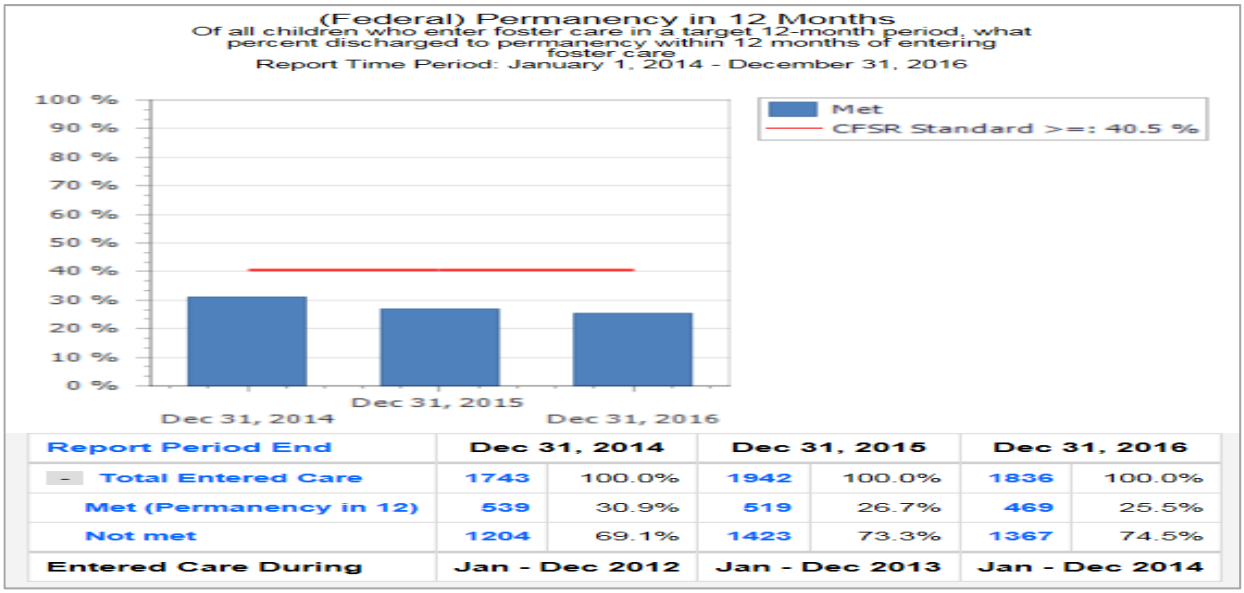
- ROM Federal Permanency in 12 Months for CIP >=24 Months



Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
- Total 1st day of period	1122	100.0%	1053	100.0%	966	100.0%
Met (Permanency in Yr)	289	25.8%	334	31.7%	278	28.8%
- Not Met (No permanency)	833	74.2%	719	68.3%	688	71.2%
1st day 12 month period	Jan 1, 2014		Jan 1, 2015		Jan 1, 2016	

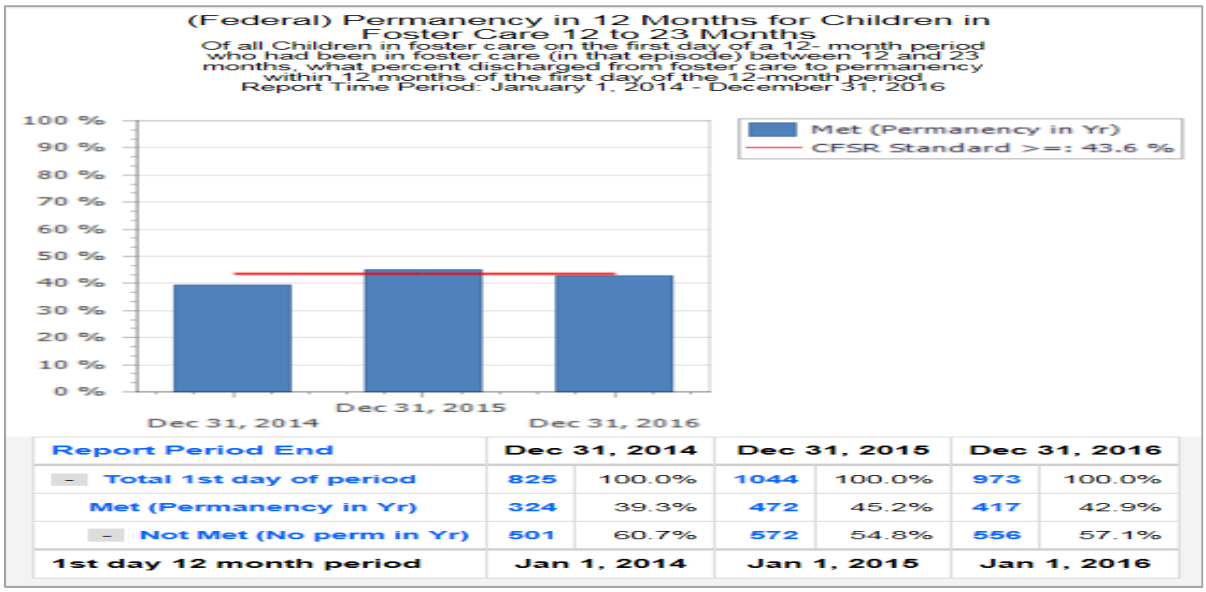
- CFSR Result: n=42, 31% Strength, 69% ANI

- ROM Federal Permanency in 12 Months



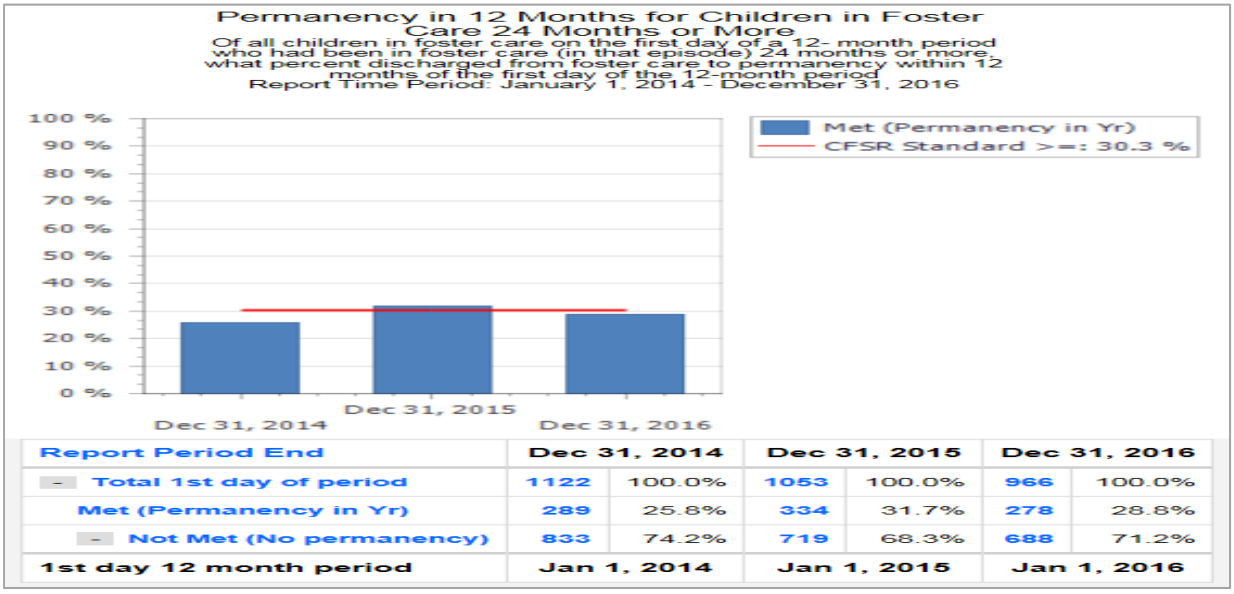
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
- Total Entered Care	1743	100.0%	1942	100.0%	1836	100.0%
Met (Permanency in 12)	539	30.9%	519	26.7%	469	25.5%
Not met	1204	69.1%	1423	73.3%	1367	74.5%
Entered Care During	Jan - Dec 2012		Jan - Dec 2013		Jan - Dec 2014	

- ROM Federal Permanency in 12 Months for CIP 12-23 Months



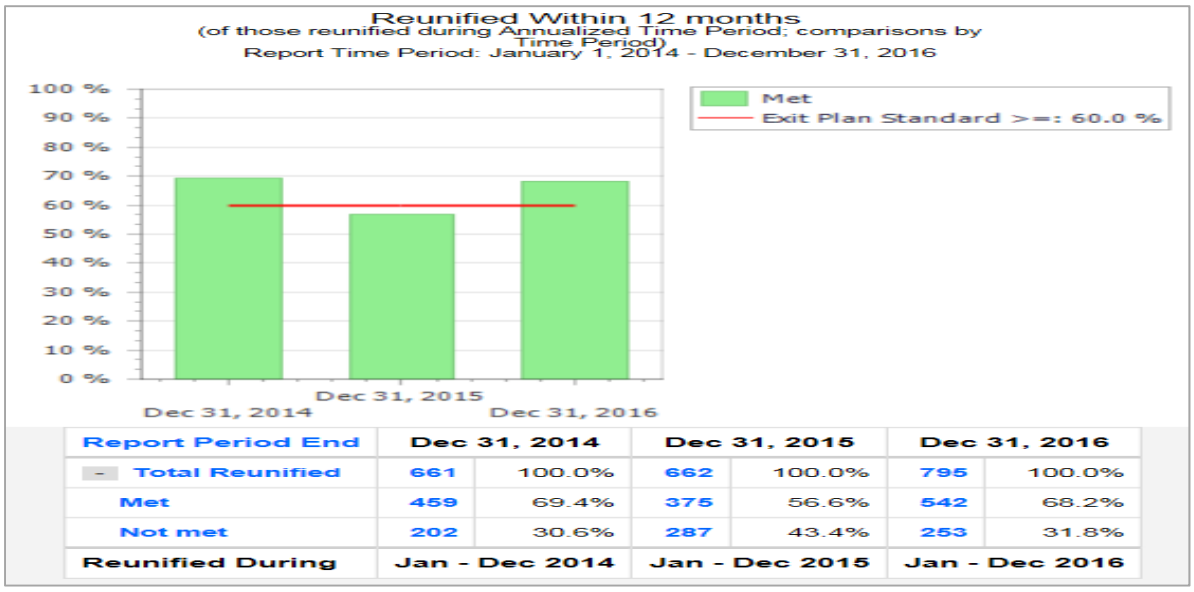
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
Total 1st day of period	825	100.0%	1044	100.0%	973	100.0%
Met (Permanency in Yr)	324	39.3%	472	45.2%	417	42.9%
Not Met (No perm in Yr)	501	60.7%	572	54.8%	556	57.1%
1st day 12 month period	Jan 1, 2014		Jan 1, 2015		Jan 1, 2016	

- ROM Federal Permanency in 12 Months for CIP >=24 Months



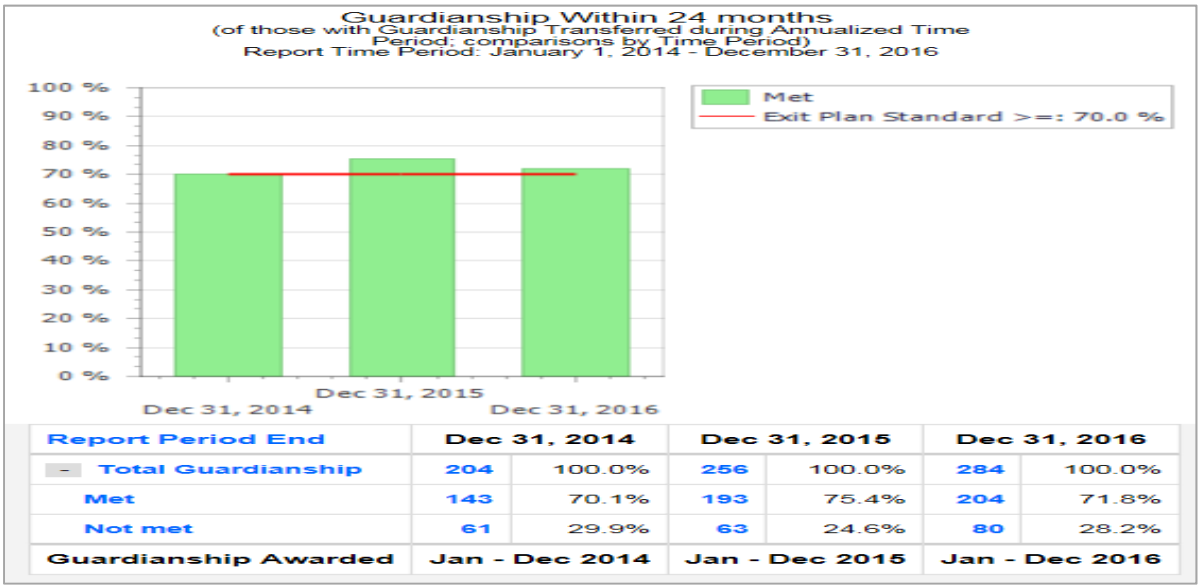
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
Total 1st day of period	1122	100.0%	1053	100.0%	966	100.0%
Met (Permanency in Yr)	289	25.8%	334	31.7%	278	28.8%
Not Met (No permanency)	833	74.2%	719	68.3%	688	71.2%
1st day 12 month period	Jan 1, 2014		Jan 1, 2015		Jan 1, 2016	

- ROM EP #7 Reunification in 12 Months



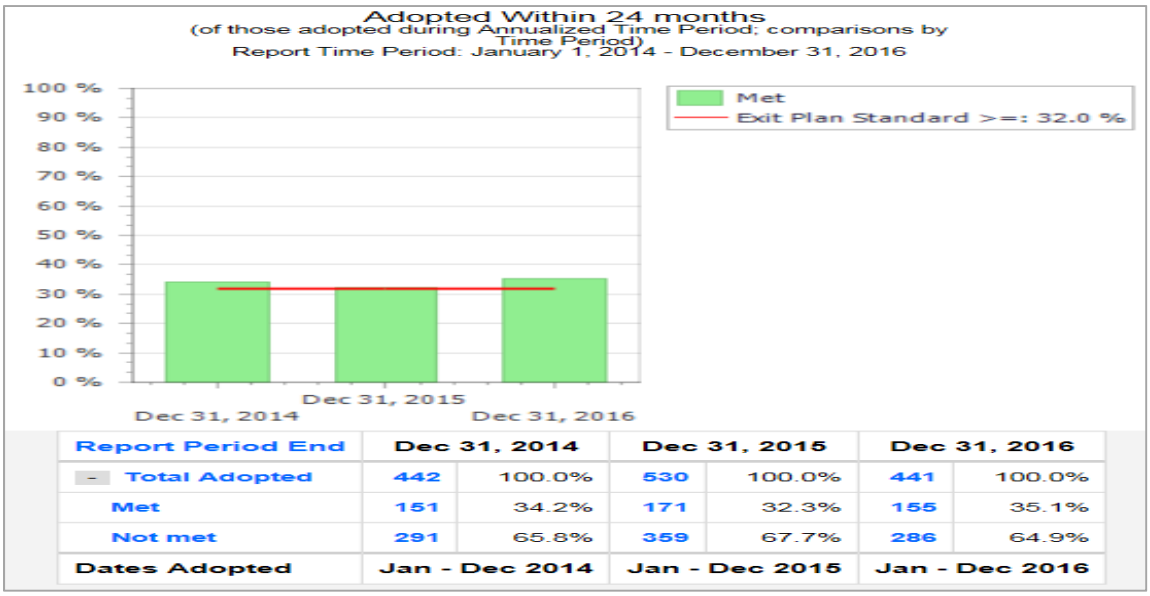
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
- Total Reunified	661	100.0%	662	100.0%	795	100.0%
Met	459	69.4%	375	56.6%	542	68.2%
Not met	202	30.6%	287	43.4%	253	31.8%
Reunified During	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016	

- ROM EP #9 TOG in 24 Months



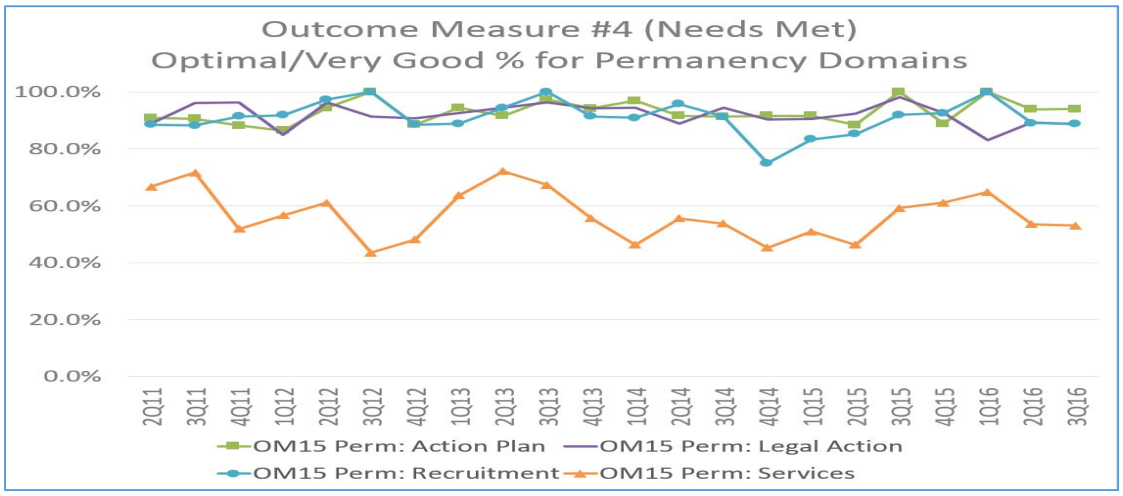
Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
- Total Guardianship	204	100.0%	256	100.0%	284	100.0%
Met	143	70.1%	193	75.4%	204	71.8%
Not met	61	29.9%	63	24.6%	80	28.2%
Guardianship Awarded	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016	

- ROM EP #8 Adoption in 24 Months

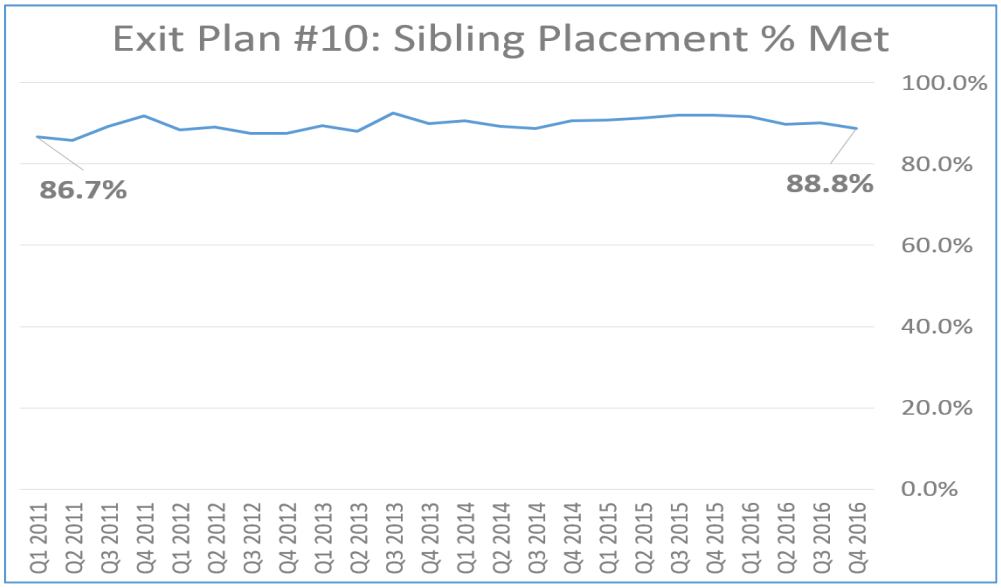


Report Period End	Dec 31, 2014		Dec 31, 2015		Dec 31, 2016	
– Total Adopted	442	100.0%	530	100.0%	441	100.0%
Met	151	34.2%	171	32.3%	155	35.1%
Not met	291	65.8%	359	67.7%	286	64.9%
Dates Adopted	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016	

- Other Related Data]



- **Item 7**
    - CFSR Result: n=21, 76% Strength, 24% ANI
    - CIP Dashboard Since 2011 - % CIP In Kin Placement Jan '11 – June '17
        - **21.0**% in Kinship Care on Jan 1 2011 (17.3% in Relative only)
        - **40.6**% in Kinship Care on June 1 2017 (33.6% in Relative only)
    - EP #10 CY15 – CY16 – quarterly performance



- **Item 8**
    - CFSR Result: n=28, 75% Strength, 25% ANI
    - 2016 Child Visitation Study Results

Siblings: The study included 148 unique children, which yielded 299 sibling pairs. Of the 299 sibling pairs, the frequency of visitation met or exceeded the expectation for 148 (49.5%) of the sibling pairs. This is an increase from the 2015 report results in which the expectation was met for 41.4% of the sibling pairs. The expectation was met for 84 (56.8%) target children and at least one of their siblings which is an increase from 2015 where the expectation was met for 49.4% of the target children. Documentation regarding the factors considered in making visitation determinations was located in the child's plan of treatment (which the Department refers to as the "Case Plan") for 198 (66.2%) pairs which was an increase from 2015 where information was found in the case plan for 57.2% of the sibling pairs. For 58 (19.4%) of the pairs, the information was located within supervisory conference notes, case narratives or were obtained directly from the assigned social worker or supervisor. Although the expectation was

less than weekly for 72 (24.1%) of the pairs, there was Information in the Case Plan regarding the factors used to determine the frequency for 50 (69.4%) of these sibling pairs. Another 19 (26.4%) sibling pairs had information located in other areas of the case record or was obtained via interview.

There were a number of identified barriers to meeting the visitation expectations. The most often identified barrier for the sibling pairs for whom DCF did not meet the visitation expectation was "Child Refusal" (32, 21.2%). This included cases in which either the target child and/or the sibling refused to visit. Following was "Parent Refusal/Unavailable" (31, 20.5%). This consisted of cases in which the parents of the siblings of the target children either refused to allow visitation or did not attend scheduled visits that included the siblings. For the majority (69, 45.7%) of the pairs, the "Unknown/UTD" barrier was chosen. This included cases in which there wasn't sufficient information regarding the barriers but also where visitation was allowed to be scheduled and facilitated by the caretakers, such as foster parents, guardians, adoptive parents or the target child. In some instances, there were references in the documentation that visits occurred, but because they may be facilitated by someone other than DCF direct service staff, there isn't information about the frequency, duration or assessments of these visits. Similar information is lacking in cases in which the target child is an adolescent and/or visiting with adult siblings. Of the 151 sibling pairs that did not meet the expected frequency, 42 (27.8%) included an adult sibling. In the absence of any known safety concerns, youth are often encouraged to manage scheduling their own visits in an effort to ensure a normative experience for them, but it is more difficult to obtain comprehensive and accurate reporting on results from them. The 2015 report provided anecdotal information regarding the influence that the target child's legal status had on meeting expectation and that once the parental rights are terminated on a child, they have less contact with their siblings. This 2016 report demonstrated this point in that 52.1% of the target children whose parental rights had not been terminated met the visitation expectation compared to 33.3% of those whose rights were terminated.

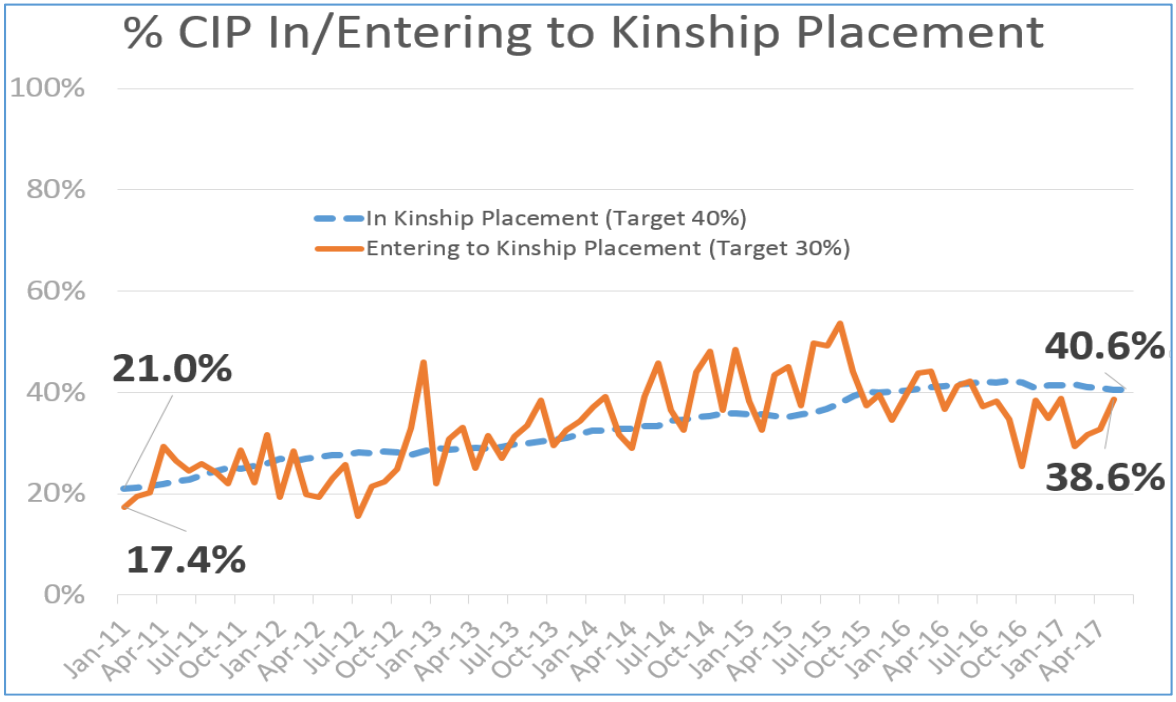
Parents: The compliance determination for visitation with parents was based on 118 children of the 148 children who populated the sample. This yielded 201 unique child/parent pairs. Thirty of the children were not included in the measure because they did not have any parents for whom visitation would have been expected during the period under review. The expected frequency of visitation was met for 112 (55.7%) parent/child pairs which is an increase from 51.2% in the 2015 report. Cases in which there was an expected frequency determined by the department, the compliance was based on whether or not the typical pattern of the visitation exceeded or met that expectation.

Reviewers identified barriers to meeting the visitation expectation for the 89 (44.2%) parent/child pairs for which the measure was not met. The most often identified barrier was "Parent Refusal/Unavailable", which was present for 26 (29.2%) of the pairs. This was followed by "Child Refuses" for 20 (22.5%) of the pairs. For 30 (33.7%) of the cases, a barrier to visitation was not identified in the case review and labeled as "Unknown/UTD." The "Unknown/UTD" category included cases in which the visitation was scheduled by the youth, caretakers or third party and there wasn't sufficient information in the record regarding those visits to determine the frequency of the visitation that occurred. For the remaining cases in the "Other" category, barriers included transportation, child illness, parents' whereabouts unknown, clinical reasons and cease of visitation by the court or attorney.

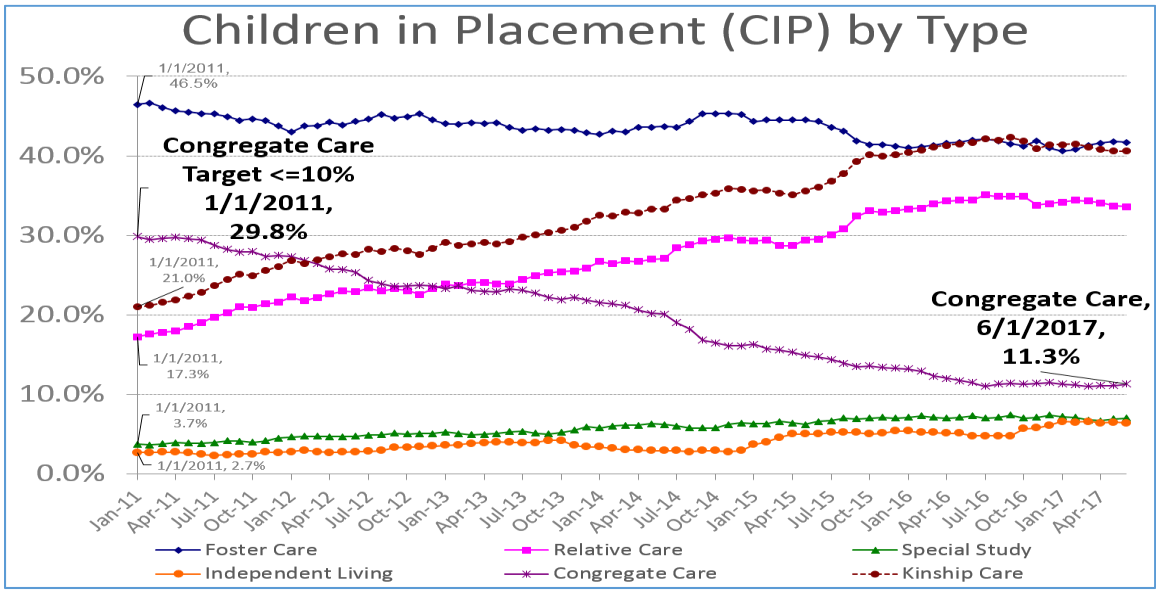
There was a clear visitation expectation identified in the case record for 172 (85.6%) child/parent pairs. There was documentation found in the Case Plan regarding the frequency for 138 (80.2%) of these pairs. For the remaining cases, visitation documentation was located in the running narratives or obtained via interview.

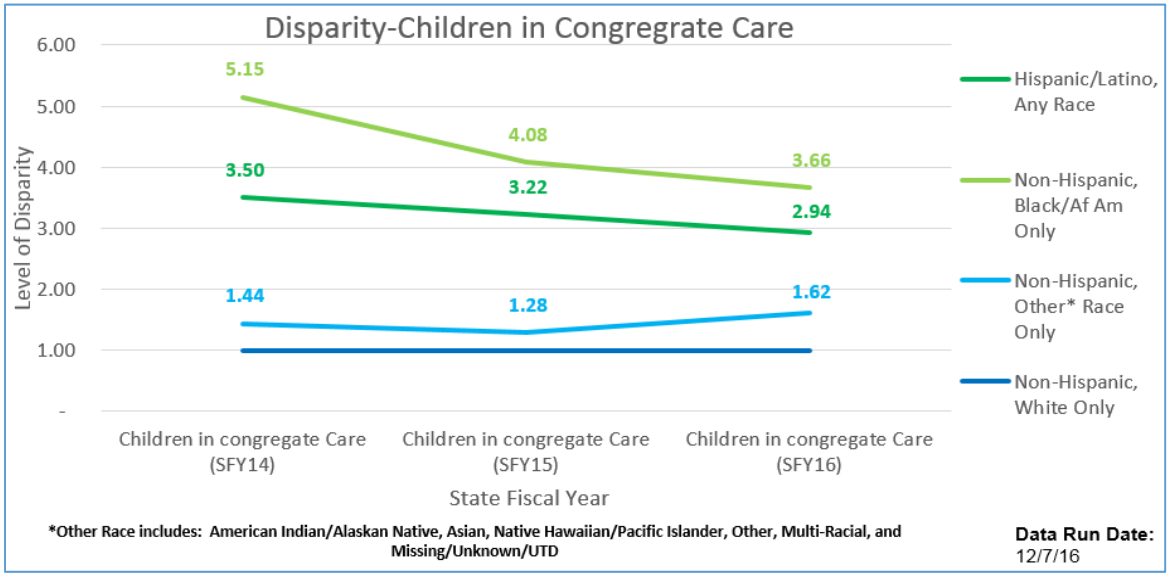
- **Item 9**
    - CFSR Result: n=42, 50% Strength, 50% ANI

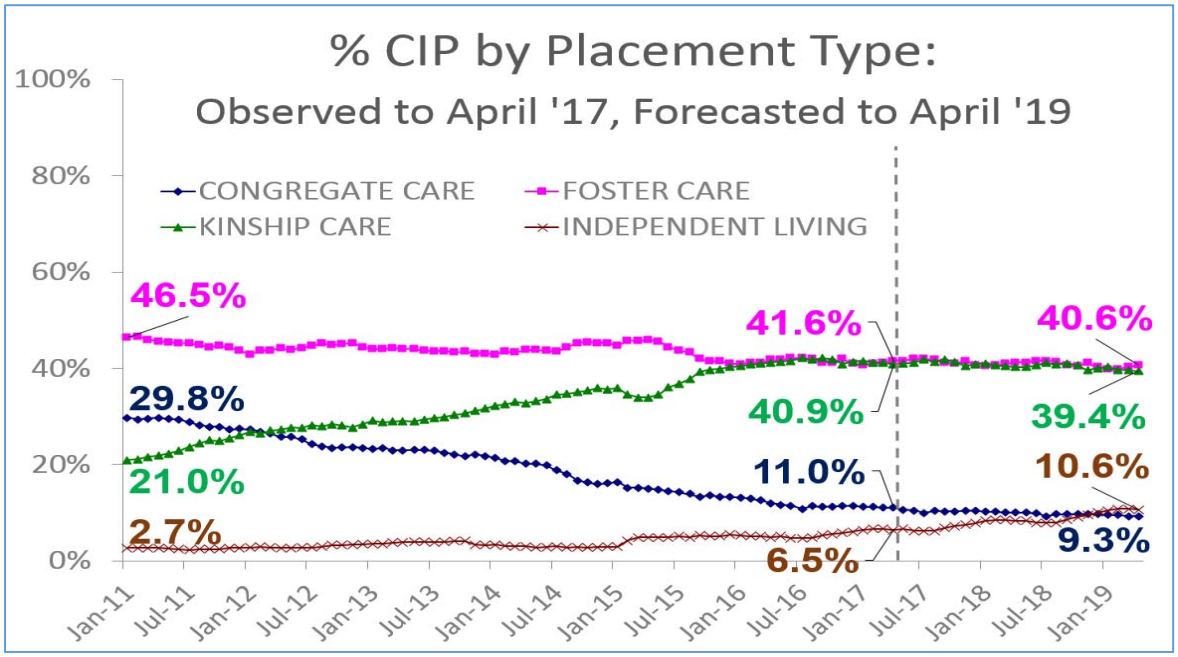
- **Item 10**
    - CFSP Objective:
        - 1.3. 40% of all initial placements and 30% of overall placements will be with relatives and kin (show target point as of 6/15 compared to observed line from CIP Dashboard PIT/Initial Placement %)



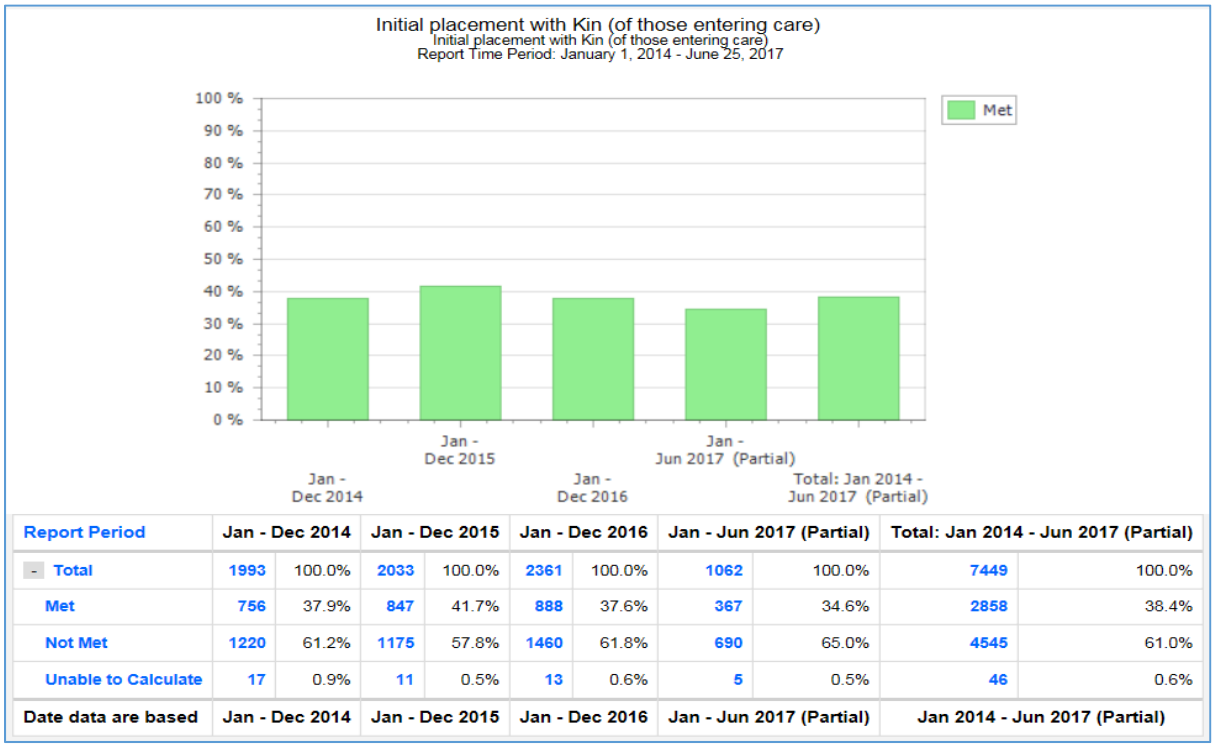
- 3.1. Number of children in Congregate Care settings will be no more than 10% of total CIP (show CIP dashboard PIT by Placement Type with target lines based on stated goals/dates)




Disparity-Children in Congregate Care
6.00
5.00
4.00
3.00
2.00
1.00
-
Level of Disparity
5.15
4.08
3.66
3.50
3.22
2.94
1.44
1.28
1.62
Children in congregate Care (SFY14)
Children in congregate Care (SFY15)
Children in congregate Care (SFY16)
State Fiscal Year
Hispanic/Latino, Any Race
Non-Hispanic, Black/Af Am Only
Non-Hispanic, Other* Race Only
Non-Hispanic, White Only
*Other Race includes: American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Other, Multi-Racial, and Missing/Unknown/UTD
Data Run Date: 12/7/16

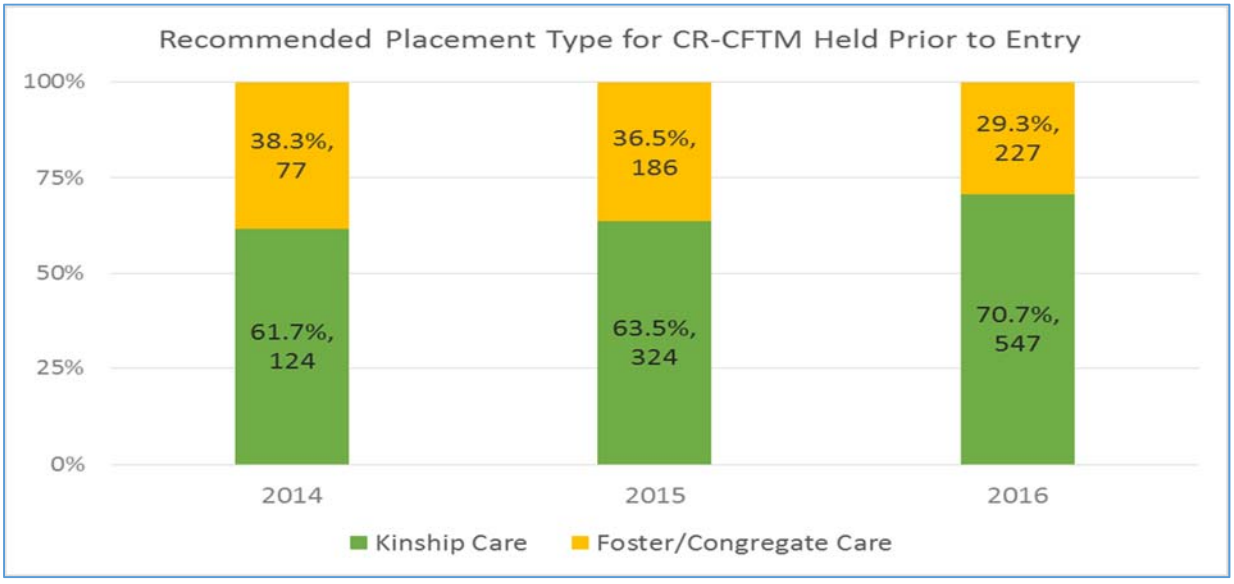

% CIP by Placement Type:
Observed to April '17, Forecasted to April '19
100%
80%
60%
40%
20%
0%
CONGREGATE CARE
FOSTER CARE
KINSHIP CARE
INDEPENDENT LIVING
46.5%
29.8%
21.0%
2.7%
41.6%
40.9%
11.0%
6.5%
40.6%
39.4%
10.6%
9.3%
Jan-11
Jul-11
Jan-12
Jul-12
Jan-13
Jul-13
Jan-14
Jul-14
Jan-15
Jul-15
Jan-16
Jul-16
Jan-17
Jul-17
Jan-18
Jul-18
Jan-19

- CFSR Result: n=42, 62% Strength, 38% ANI
- ROM Initial Placement with Kin CY14 – CY16 – screenshot ROM Report annual aggregation

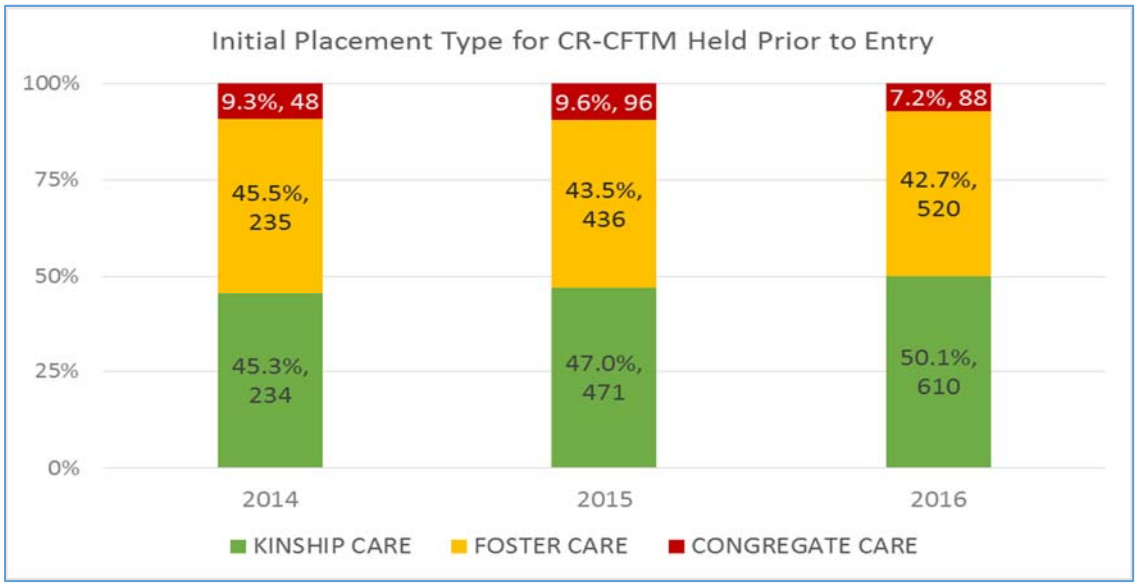


Report Period	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016		Jan - Jun 2017 (Partial)		Total: Jan 2014 - Jun 2017 (Partial)	
- Total	1993	100.0%	2033	100.0%	2361	100.0%	1062	100.0%	7449	100.0%
Met	756	37.9%	847	41.7%	888	37.6%	367	34.6%	2858	38.4%
Not Met	1220	61.2%	1175	57.8%	1460	61.8%	690	65.0%	4545	61.0%
Unable to Calculate	17	0.9%	11	0.5%	13	0.6%	5	0.5%	46	0.6%
Date data are based	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016		Jan - Jun 2017 (Partial)		Jan 2014 - Jun 2017 (Partial)	

- CR-CFTM Data:
  - % Recommended Placement with Relatives (of those with placement recommendations) – annual aggregation CY15 – 16



- Of entries, #/% children placed with relatives/kin



- **Item 11**
  - CFSR Result: n=24, 67% Strength, 33% ANI
  - ACRI Case Practice Elements
    - Continuity of Relationship – Child w/Parents
    - Continuity of Relationship – Child w/Mothers
    - Continuity of Relationship – Child w/Fathers

Sl.No	Measure	Statewide								
		Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015	Quarter 1, 2016	Quarter 2, 2016	Quarter 3, 2016	Quarter 4, 2016	Quarter 1, 2017
		Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength
		%	%	%	%	%	%	%	%	%
12	Continuity of Relationship - Child w/ Parents	91%	90%	89%	93%	92%	93%	92%	90%	90%
13	Continuity of Relationship - Child w/ Fathers	87%	89%	87%	90%	90%	90%	91%	88%	88%
14	Continuity of Relationship - Child w/ Mothers	94%	91%	91%	95%	94%	95%	93%	93%	93%

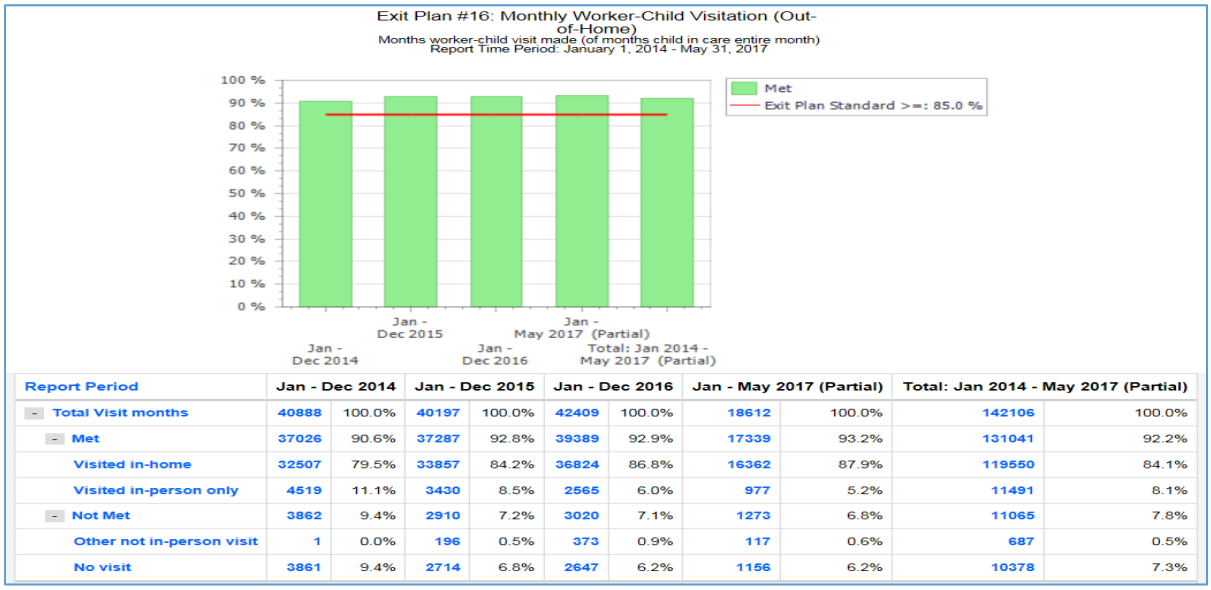
- **Item 12**
  - CFSR Results for 12 (Overall) : n=82, 27% Strength, 73% ANI
    - 12A: n=82, 59% Strength, 41% ANI
    - 12B: n=73, 27% Strength, 73% ANI
    - 12C: n=41, 61% Strength, 39% ANI
  - EP #15 Needs Met – CY15 – CY16 Quarterly Aggregation

- **Item 13- REFER TO SYSTEMIC FACTOR SECTIONS ON CASE REVIEW**

- CFSR Result: n=81, 41% Strength, 59% ANI

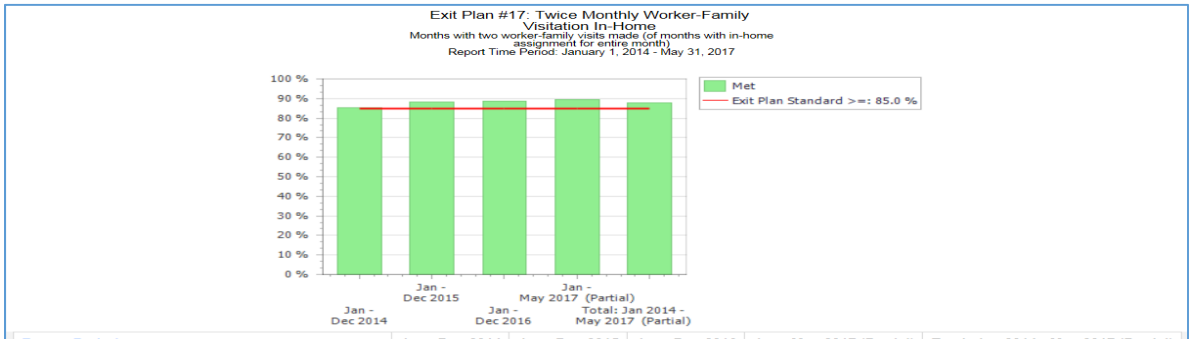
- **Item 14/15**

  - CFSR Result Item 14: n=82, 55% Strength, 45% ANI
  - CFSR Result Item 15: n=72, 33% Strength, 67% ANI
  - ROM EP# 16 - CY14 – CY16 – screenshot ROM Report annual aggregation



Report Period	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016		Jan - May 2017 (Partial)		Total: Jan 2014 - May 2017 (Partial)	
Total Visit months	40888	100.0%	40197	100.0%	42409	100.0%	18612	100.0%	142106	100.0%
Met	37026	90.6%	37287	92.8%	39389	92.9%	17339	93.2%	131041	92.2%
Visited in-home	32507	79.5%	33857	84.2%	36824	86.8%	16362	87.9%	119550	84.1%
Visited in-person only	4519	11.1%	3430	8.5%	2565	6.0%	977	5.2%	11491	8.1%
Not Met	3862	9.4%	2910	7.2%	3020	7.1%	1273	6.8%	11065	7.8%
Other not in-person visit	1	0.0%	196	0.5%	373	0.9%	117	0.6%	687	0.5%
No visit	3861	9.4%	2714	6.8%	2647	6.2%	1156	6.2%	10378	7.3%

  - ROM EP# 17 - CY14 – CY16 – screenshot ROM Report annual aggregation



Report Period	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016		Jan - May 2017 (Partial)		Total: Jan 2014 - May 2017 (Partial)	
Total	30948	100.0%	30934	100.0%	34799	100.0%	15166	100.0%	111847	100.0%
Met	26385	85.3%	27340	88.4%	30802	88.5%	13581	89.5%	98108	87.7%
Not Met	4563	14.7%	3594	11.6%	3997	11.5%	1585	10.5%	13739	12.3%
No visit since case in-home assignment	250	0.8%	139	0.4%	183	0.5%	72	0.5%	644	0.6%
Only 1 visit documented this month	2962	9.6%	2393	7.7%	2645	7.6%	1066	7.0%	9066	8.1%
No visit since last calendar month	615	2.0%	501	1.6%	531	1.5%	181	1.2%	1828	1.6%
No more than 1 visit in last calendar month	376	1.2%	258	0.8%	296	0.9%	120	0.8%	1050	0.9%
No more than 1 visit in 2 or more calendar months	360	1.2%	303	1.0%	342	1.0%	146	1.0%	1151	1.0%

  - ACRI Case Practice Elements – CY15 – CY16
    - Visitation with Child and Parents
    - Frequency of Visits – Parents

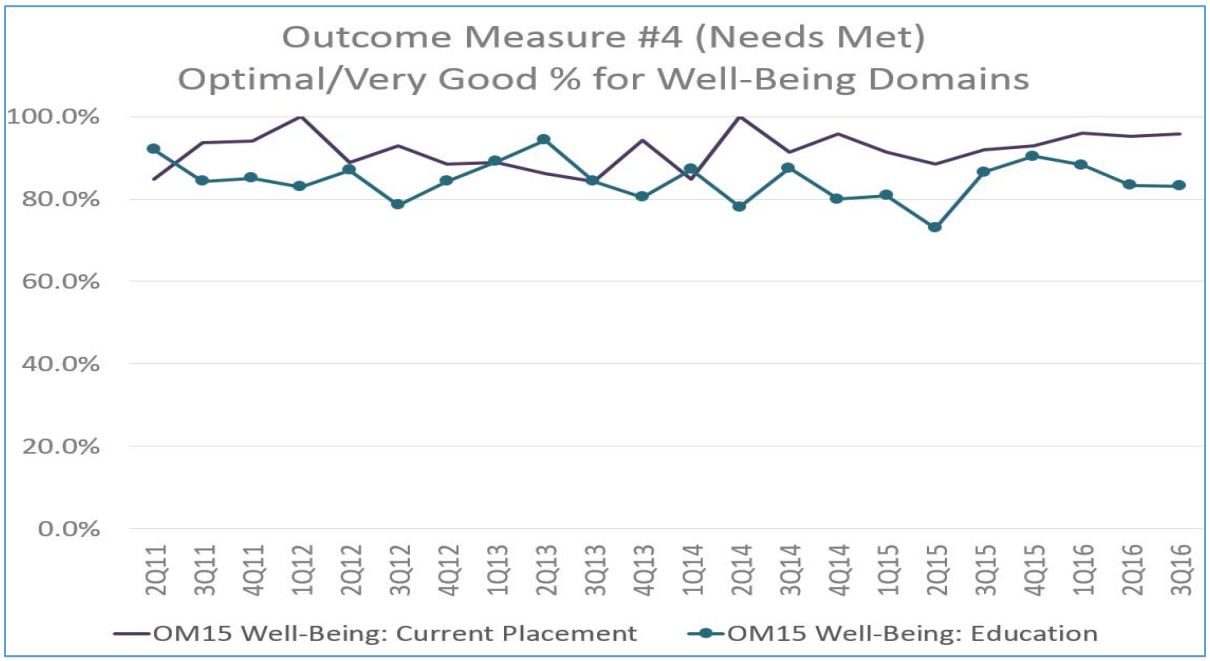
- Frequency of Visits – Father
- Frequency of Visits – Mother
- Quality of Visits – Parents
- Quality of Visits – Father
- Quality of Visits – Mother
- Frequency of Visits – Child
- Quality of Visits – Child

Sl.No	Measure	Statewide								
		Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015	Quarter 1, 2016	Quarter 2, 2016	Quarter 3, 2016	Quarter 4, 2016	Quarter 1, 2017
		Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength
		%	%	%	%	%	%	%	%	%
1	Visitation with Child and Parents	67%	61%	60%	64%	68%	69%	65%	58%	61%
2	Frequency of visits - Parents	68%	60%	60%	65%	70%	69%	67%	59%	61%
3	Frequency of visits - Father	62%	54%	54%	59%	65%	62%	61%	51%	53%
4	Frequency of visits - Mother	72%	65%	64%	70%	74%	74%	71%	66%	68%
5	Quality of visits - Parents	68%	62%	63%	67%	73%	73%	71%	64%	67%
6	Quality of visits - Father	64%	56%	58%	60%	68%	67%	65%	56%	60%
7	Quality of visits - Mother	72%	67%	68%	73%	76%	78%	75%	70%	73%
8	Frequency of visits - Child	76%	71%	76%	78%	81%	83%	83%	77%	80%
9	Quality of visits - Child	76%	72%	77%	80%	82%	85%	84%	77%	82%

- **Item 16**
  - CFSR Result: n=53, 85% Strength, 15% ANI
  - ACRI Case Practice Elements – CY15 – CY16
    - Educational/development needs – Child
    - Educational/development needs assessed – Child
    - Educational/development needs addressed – Child

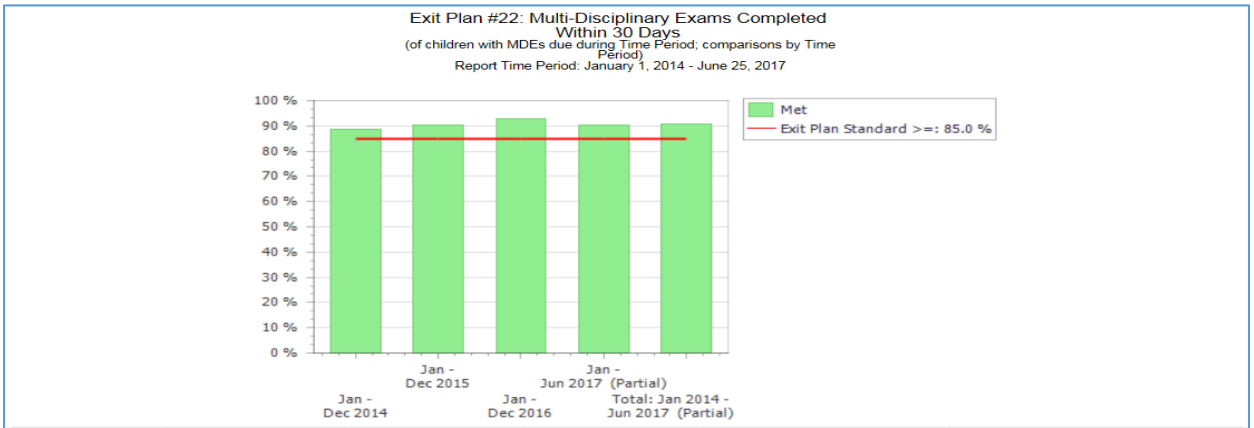
Sl.No	Measure	Statewide								
		Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015	Quarter 1, 2016	Quarter 2, 2016	Quarter 3, 2016	Quarter 4, 2016	Quarter 1, 2017
		Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength
		%	%	%	%	%	%	%	%	%
26	Educational/development needs - Child	93%	93%	94%	94%	94%	95%	93%	94%	93%
32	Education/development needs assessed - Child	95%	95%	96%	96%	95%	97%	94%	95%	94%
33	Education/development needs addressed - Child	95%	94%	95%	95%	94%	96%	94%	94%	95%

- Exit Plan #15 Needs Met – Educational Domain



- **Item 17/18**

  - CFSR Result Item 17: n=58, 62% Strength, 38% ANI
  - CFSR Result Item 18: n=49, 45% Strength, 55% ANI
  - ROM EP#22 MDE - CY15 – CY16 annual aggregations



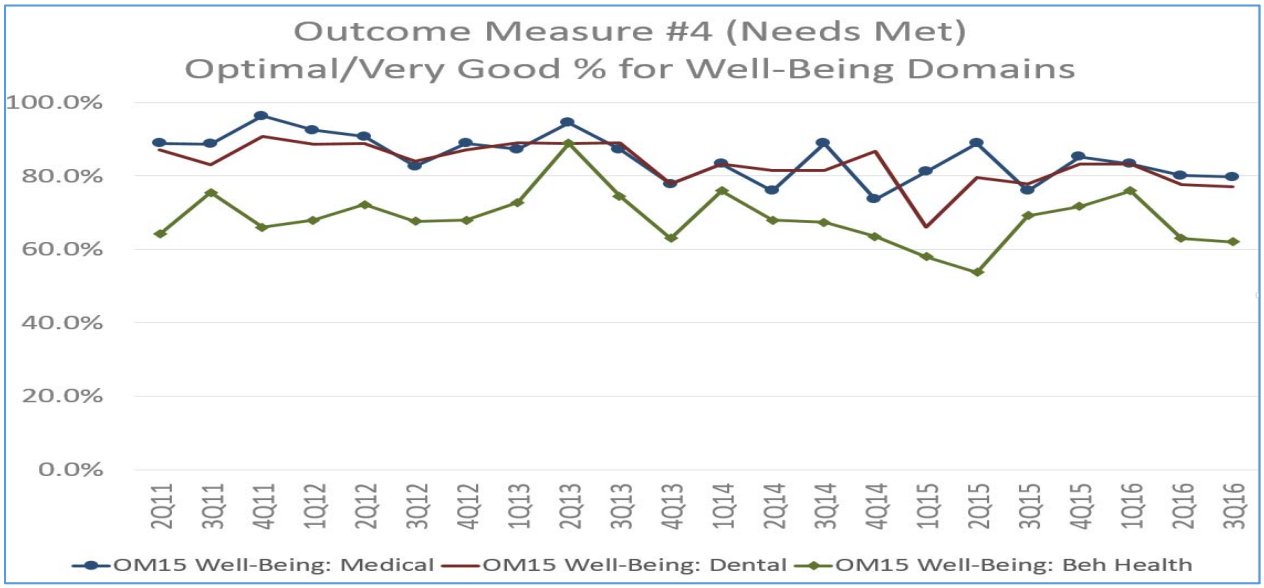
Report Period	Jan - Dec 2014		Jan - Dec 2015		Jan - Dec 2016		Jan - Jun 2017 (Partial)		Total: Jan 2014 - Jun 2017 (Partial)	
- Total	1162	100.0%	1279	100.0%	1436	100.0%	700	100.0%	4577	100.0%
Met	1029	88.6%	1158	90.5%	1333	92.8%	631	90.1%	4151	90.7%
Not met	133	11.4%	121	9.5%	103	7.2%	69	9.9%	426	9.3%
Child removed in	Dec 2013 - Nov 2014		Dec 2014 - Nov 2015		Dec 2015 - Nov 2016		Dec 2016 - May 2017 (Partial)		Dec 2013 - May 2017 (Partial)	

  - ACRI Case Practice Elements – CY15 – CY16
    - Physical Healthcare needs – Child
    - SA/Social Support/MH needs – Child

- Physical Healthcare needs assessed – Child
- Physical Healthcare needs addressed – Child
- Dental Healthcare needs assessed – Child
- Dental Healthcare needs addressed – Child
- Vision needs addressed – Child

Sl.No	Measure	Statewide								
		Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015	Quarter 1, 2016	Quarter 2, 2016	Quarter 3, 2016	Quarter 4, 2016	Quarter 1, 2017
		Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength	Strength
		%	%	%	%	%	%	%	%	%
24	Physical health care - Child	86%	82%	83%	85%	84%	86%	81%	82%	82%
25	SA/Social Support/MH - Child	90%	84%	84%	88%	88%	91%	88%	86%	86%
27	Physical health care needs assessed - Child	96%	96%	95%	96%	95%	97%	93%	94%	94%
28	Physical health care needs addressed - Child	93%	92%	92%	93%	93%	93%	91%	91%	91%
29	Dental health care needs assessed - Child	94%	91%	92%	94%	92%	94%	91%	91%	92%
30	Dental health care needs addressed - Child	92%	89%	91%	91%	91%	92%	89%	90%	91%
31	Vision needs - Child	95%	94%	95%	94%	94%	95%	92%	93%	95%

o Exit Plan #15 Needs Met – Domains for Medical, Dental and Behavioral Health

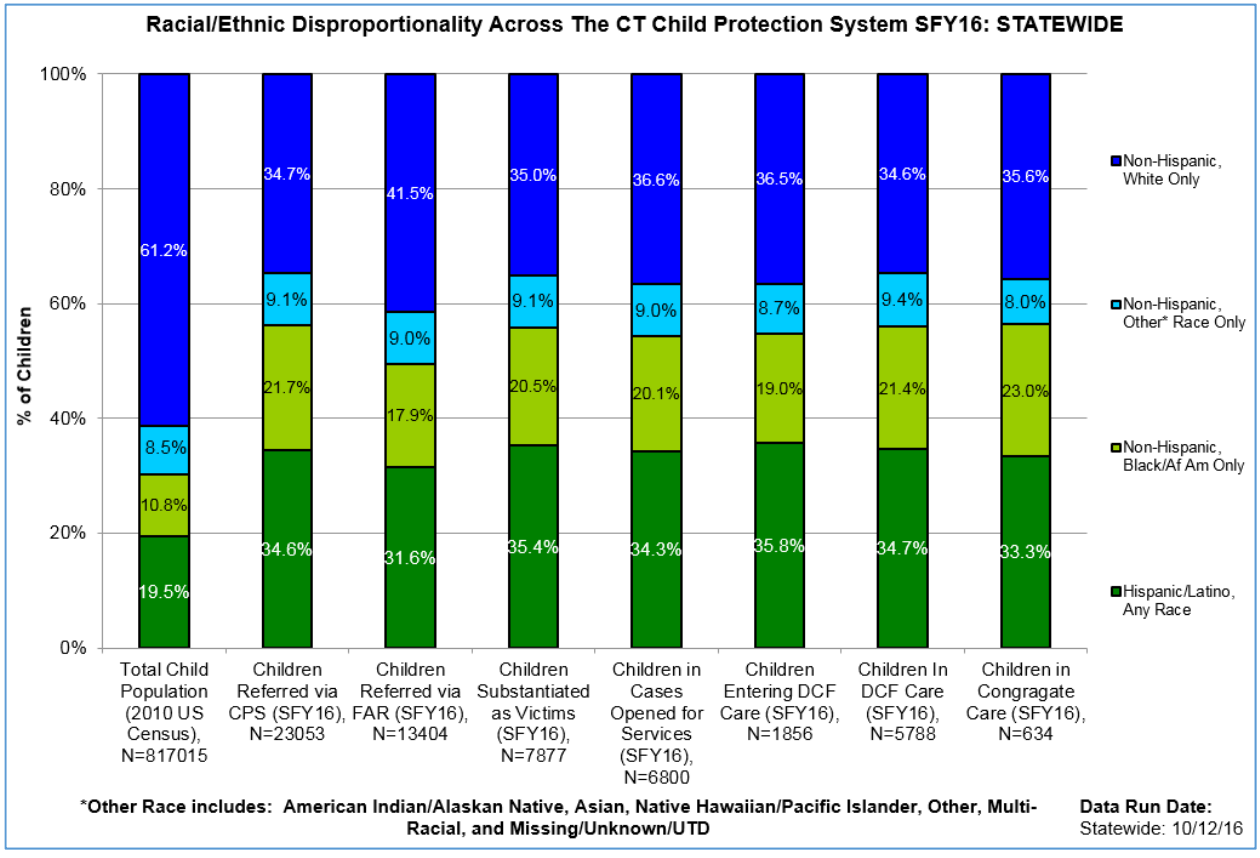


- **Item 19**
    - CFSR Result: **ANI**
    - AFCARS Data Quality Checks (most recent)

AFCARS Data Quality Checks

	Limit	MFC	Perm	PS	09B	10A	10B	11A	11B	12A	12B	13A	13B	14A	14B	15A	15B	16A	16B
AFCARS IDs don't match from one period to next	> 40%	•	•	•	23.5%	22.7%	22.2%	21.9%	21.9%	18.0%	21.2%	19.0%	25.9%	17.1%	18.0%	18.7%	19.4%	17.7%	
Age at discharge greater than 21	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.1%	0.0%	0.4%	0.2%	0.1%	0.0%	0.4%	0.0%
Age at entry is greater than 21	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Date of birth after date of entry	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Date of birth after date of exit	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dropped records	> 10%	•	•	•	0.2%	0.4%	0.5%	2.4%	4.2%	3.8%	4.6%	3.7%	9.2%	4.6%	5.0%	6.2%	6.3%	5.5%	
Enters and exits care the same day	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	1.8%	1.1%	2.0%	1.8%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Exit date is prior to removal date	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	2.1%	0.8%	1.2%	1.9%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
In foster care more than 21 yrs	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing date of birth	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing date of latest removal	> 5%	•	•	•	0.0%	0.0%	0.0%	0.0%	2.4%	2.2%	2.4%	2.1%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing discharge reason (exit date exists)	> 10%		•		1.4%	2.7%	2.6%	3.8%	7.8%	11.8%	9.7%	11.8%	13.8%	23.1%	23.2%	27.0%	29.5%	26.9%	0.0%
Missing number of placement settings	> 5%			•	1.0%	0.9%	0.8%	0.5%	3.3%	4.5%	4.0%	4.6%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of children on 1st removal	> 95%	•	•	•	77.8%	77.3%	77.3%	77.4%	80.1%	80.4%	80.7%	80.7%	80.8%	81.7%	81.5%	82.5%	83.6%	83.9%	84.6%

- SFY16 Disproportionality Pathway (Statewide) Chart



- Placement/Permanency Report – Chart IX

Race Gender		Age_Grp2					
		<1	1-5	6-12	13-17	>=18	TOTAL
Am.Ind/Al.Native	Female		1		1		2
	Male				2		2
	TOTAL	0	1	0	3	0	4
Asian	Female		3	1	4	4	12
	Male			1	4	2	7
	TOTAL	0	3	2	8	6	19
Black	Female	36	145	113	128	107	529
	Male	34	147	134	143	81	539
	TOTAL	70	292	247	271	188	1068
Multi-Race	Female	19	108	54	43	35	259
	Male	15	106	71	39	18	249
	TOTAL	34	214	125	82	53	508
Nat.Haw./Pac.Isl.	Female				1	1	2
	TOTAL	0	0	0	1	1	2
Unknown	Female	7	1	1	1	1	11
	Male	7	6	3	2		18
	TOTAL	14	7	4	3	1	29
White	Female	87	411	319	307	177	1301
	Male	91	428	337	297	152	1305
	TOTAL	178	839	656	604	329	2606
TOTAL		296	1356	1034	972	578	4236

- Placement/Permanency Report – Chart XII (ideally condensed to drop breakout of TPR Filed or not, and to show only <2 and >=2 Months LOS)

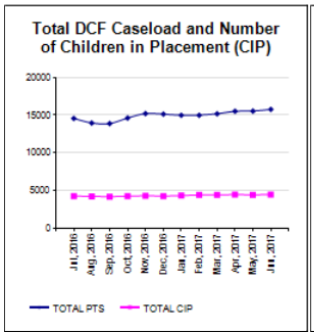
	LOS (Months)		
Current Case Plan Goal	<2 Months	>=2 Months	Grand Total
#			
Reunification	102	1536	1638
Transfer of Guardianship	2	487	489
Adoption		566	566
Long Term Foster Care Relative		2	2
OPPLA		85	85
(blank)	189	32	221
%			
Reunification	3.4%	51.2%	54.6%
Transfer of Guardianship	0.1%	16.2%	16.3%
Adoption	0.0%	18.9%	18.9%
Long Term Foster Care Relative	0.0%	0.1%	0.1%
OPPLA	0.0%	2.8%	2.8%
(blank)	6.3%	1.1%	7.4%
Total #	**293**	**2708**	**3001**
Total %	**9.8%**	**90.2%**	**100.0%**

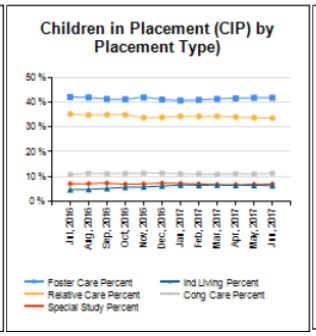
- Placement/Permanency Report – Pivot detail to provide Legal Status breakout for the Pre-TPR kids.

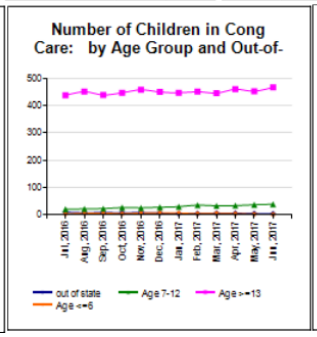
Current Case Plan Goal	#
96 Hour Hold	5
Commitment Abuse/Neglect/Uncared For	2358
Commitment Dual	21
Commitment FWSN	2
Commitment Mental Health	1
DCF Custody Voluntary Services	3
Not Committed	47
Order Of Temporary Custody	557
Probate Court Custody	3
Probate Court Guardianship	1
Protective Supervision	3
Grand Total	**3001**

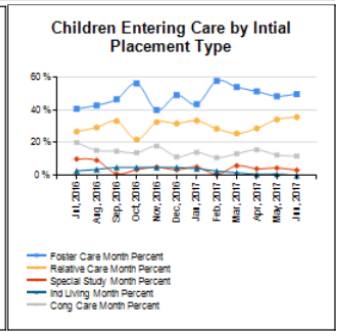
- CIP Dashboard – screenshot most recent 12 month view including table and charts

CIP DASHBOARD			% of Total Children-in-Placement (CIP)					# in Congregate Care Subgroups				# and % of Children Entering Placement During Time Period					
			Family Foster Care						Age Group				Kinship Care				
Observation Date	Total Caseload Points	Total CIP	Foster Care	Relative Care	Special Study	Independent Living	Congregate Care	Out of State	>=13	7-12	<6	Entries During Period	Relative Care	Special Study	Foster Care	Congregate Care	Independent Living
07/01/2016	14,566	4,252	42.0 %	35.2 %	7.1 %	4.8 %	10.9 %	10	437	21	4	180	26.7 %	10.0 %	40.6 %	20.0 %	2.8 %
08/01/2016	13,961	4,221	41.8 %	34.8 %	7.2 %	4.9 %	11.3 %	8	450	22	6	216	29.2 %	9.3 %	42.6 %	15.3 %	3.7 %
09/01/2016	13,886	4,177	41.3 %	34.9 %	7.4 %	5.2 %	11.2 %	8	438	23	7	203	33.0 %	1.0 %	46.3 %	14.8 %	4.9 %
10/01/2016	14,620	4,242	41.2 %	34.9 %	7.0 %	5.7 %	11.3 %	8	446	27	5	225	21.8 %	3.6 %	56.0 %	13.8 %	4.9 %
11/01/2016	15,209	4,305	41.9 %	33.8 %	7.1 %	5.8 %	11.4 %	8	457	26	7	179	32.4 %	5.0 %	39.7 %	17.9 %	5.0 %
12/01/2016	15,133	4,253	41.1 %	34.0 %	7.4 %	6.2 %	11.4 %	7	449	28	8	203	31.5 %	3.4 %	48.8 %	11.3 %	4.9 %
01/01/2017	14,986	4,329	40.7 %	34.3 %	7.3 %	6.6 %	11.2 %	5	446	30	7	213	33.3 %	5.2 %	43.2 %	14.1 %	4.2 %
02/01/2017	14,987	4,402	40.9 %	34.3 %	7.1 %	6.5 %	11.2 %	5	450	36	5	148	28.4 %	0.7 %	57.4 %	10.8 %	2.7 %
03/01/2017	15,173	4,413	41.3 %	34.3 %	6.8 %	6.6 %	11.0 %	6	445	33	6	235	25.5 %	6.0 %	53.6 %	13.2 %	1.7 %
04/01/2017	15,522	4,456	41.6 %	34.0 %	6.7 %	6.5 %	11.2 %	6	459	34	5	147	28.6 %	4.1 %	51.0 %	15.6 %	0.7 %
05/01/2017	15,542	4,434	41.8 %	33.8 %	6.9 %	6.5 %	11.1 %	5	452	37	3	241	34.0 %	4.6 %	48.1 %	12.4 %	0.8 %
06/01/2017	15,768	4,469	41.7 %	33.6 %	7.0 %	6.4 %	11.3 %	4	466	39	2	93	35.5 %	3.2 %	49.5 %	11.8 %	0.0 %
% Change from 7/1/2016 to Latest	8.3%	5.1%	4.4%	0.3%	3.0%	39.2%	9.7%	-60.0%	6.6%	85.7%	-50.0%	-48.3%	-31.3%	-83.3%	-37.0%	-69.4%	-100.0%









- Congregate Care Dashboard (CC/OPPLA) – most recent month's view (data as of 6/1/17)

	Summary							
	CC CIP		CC CIP IN OOSP		CC CIP With OPPLA Count		All CIP With OPPLA Goal	
Region	#	%	#	%	#	%	#	%
Region 1	45	9.5%	0	0.0%	5	11.1%	74	15.6%
Bridgeport	41	14.2%	0	0.0%	4	9.8%	52	18.0%
Norwalk/Stamford	4	2.2%	0	0.0%	1	25.0%	22	11.9%
Region 2	73	11.6%	0	0.0%	12	16.4%	129	20.5%
Milford	36	11.6%	0	0.0%	8	22.2%	51	16.4%
New Haven	37	11.6%	0	0.0%	4	10.8%	78	24.5%
Region 3	114	12.8%	3	2.6%	25	21.9%	115	12.9%
Middletown	16	13.3%	0	0.0%	3	18.8%	26	21.7%
Norwich	62	13.4%	2	3.2%	14	22.6%	56	12.1%
Willimantic	36	11.7%	1	2.8%	8	22.2%	33	10.7%
Region 4	117	13.1%	1	0.9%	34	29.1%	139	15.6%
Hartford	71	13.5%	1	1.4%	26	36.6%	93	17.7%
Manchester	46	12.5%	0	0.0%	8	17.4%	46	12.5%
Region 5	75	7.7%	0	0.0%	9	12.0%	104	10.7%
Danbury	5	2.4%	0	0.0%	1	20.0%	9	4.3%
Torrington	13	8.2%	0	0.0%	0	0.0%	15	9.4%
Waterbury	57	9.4%	0	0.0%	8	14.0%	80	13.2%
Region 6	75	12.6%	0	0.0%	24	32.0%	109	18.3%
Meriden	15	8.4%	0	0.0%	3	20.0%	37	20.8%
New Britain	60	14.3%	0	0.0%	21	35.0%	72	17.2%
Grand Total	507	11.3%	4	0.8%	109	21.5%	670	15.0%

- Permanency Goal Distribution
  - Trend in #/% of Children with OPPLA Goal – SEE ITEM #5
  - PIT CIP by Permanency Goal and Age – SEE ITEM #5
  - PIT CIP by Permanency Goal and Race/Ethnicity – SEE ITEM #5

- Judicial Data
  - Time to Filing Termination of Parental Rights Petition (of those filed in latest FY)

Time to Filing Termination of Parental Rights Petition

Explanation:
Where reunification has not been achieved, Average (median) time from filing of the original petition to filing of the petition to terminate parental rights. This is a Court Performance measure that is calculated for or State Court Improvement Grant.

Cohort: All TPR petitions filed during FY16

FY16						
# TPR filed	# within 15 months	# within 24 months	Average	Median	% Within 15 months	% Within 24 months
600	331	493	17	13	55%	82%

  - Time to Filing of Parental Rights Petition from Removal Date (of those filed in latest FY)

Time to Filing of Parental Rights Petition from Removal Date

Explanation:
Average and median time **in months** from removal date to filing of the petition to terminate parental rights. This is based on the removal date of the child (date of 96-hour hold, OTC or Commitment order) to the date the termination of parental rights petition was filed.

Cohort: All TPR petitions filed during FY16

FY16						
# TPR filed	# within 15 months	# within 24 months	Average	Median	% Within 15 months	% Within 24 months
600	376	528	17	13	62%	88%

- Time from Abuse/Neglect/Uncared For Petition Filing to TPR Granted (of TPR petitions disposed latest FY)

Time to Termination of Parental Rights

Explanation:
The number of days from filing of the neglect/uncared for/abused petition to the time the termination of parental rights is granted. Both the median and the average have been calculated. This is a Court Performance measure that is calculated for or State Court Improvement Grant.

Cohort: All TPR petitions disposed during FY16

FY16					
# Disps	Average	Median	Within 12 months	Within 24 months	Within 36 Months
493	756	675	10%	60%	88%

- **Item 20**
  - CFSR Result: ANI
  - ACRI Case Practice Element - Timely Case Plan – CY15 – CY16 quarterly aggregation

In Round 3 of the CFSR, Connecticut received an ANI on this item based on information from the statewide assessment and stakeholder interviews. Data continues to confirm that case plans are typically developed timely, which was also echoed in stakeholder focus groups during the CFSR. In CY 2016, there were over 13,400 ACR meetings held. This number includes ACRs for all children in placement, regardless of age, a portion of in-home cases, and all families with at least one child in care.

Measure	Statewide 2016			
	Strength		ANI	
	#	%	#	%
Timely Case Plan	12972	96%	539	4%

These reviews continue to occur every six (6) months. The ACR Case Practice Report indicates whether or not case plans have been submitted timely, which for the agency, is three (3) days prior to the ACR meeting. Data on agency performance for this item remains consistent, and in fact for 2017, the timeliness has gone up by one

percentage point from 95% at the time of the CFSR Statewide Assessment submission, to 96% for CY 2016.

The Department also has an "Exception Report" which identifies children in placement (CIP) for whom there is not a current case plan in LINK within 180 days. According to the CIP Dashboard report for 6/2/17, there were 4,449 CIP and of those, seventeen (0.4%) appeared on this report as having no current case plan within 180 days of either the most recent case plan or entry into care . This report is utilized by Area Offices to identify any children in care for whom a case plan has not be created in the system in a timely manner. As part of the CFSR Statewide Assessment, ACR Social Work Supervisors participating in the focus group confirmed that it is very rare for them to encounter an instance in which a child in placement does not have a case plan in accordance with required timeframes.

Age	No Updated Case Plan
1	2
2	1
3	3
4	1
5	1
7	2
12	2
14	1
15	1
16	2
17	1
Total	**17**

Despite the fact that case plans are typically developed timely, there was not data to indicate parental engagement is consistently occurring. The CFSR final report data reflects that for Item 13, Child and Family Involvement in Case Planning, 41% of the applicable cases were rated as a strength (49% of foster care cases). While engagement of children and mothers in case planning was below an acceptable rate, 52% and 58% respectively, the Department's greatest challenge is engagement with fathers in case planning (28%).

In an effort to maintain focus on and improve the agency's performance as related to parent and child engagement in case planning, several strategies have been implemented since the CFSR and have been incorporated into the PIP.

In recognition of the struggles specific to non-custodial parent engagement, typically fathers, a short-term workgroup convened to review the data, policies and current practices and will now look to develop a fatherhood and non-custodial parent practice guide. This workgroup has also identified policies and practices where current guidance is not clear and at times, may be perceived as in conflict with other policies. As a result, there will also be changes made to existing policy to clarify expectations with regard to engagement in case planning and visitation, particularly with non-custodial parents, so that the practice and expectations are in alignment with those required by the CFSR.

Since 2015, the Department did not have data that was easily aggregated related to engagement of children and parents in case planning. In May 2017, a question was added to the ACRI, the document completed by case reviewers, to specifically capture whether or not, through their review, it was determined that a parent and/or child was engaged in case planning. Not only has the question been added to the tool, but there is a data report accessible to all staff statewide that reflects current performance on this measure. This data is reviewed on an ongoing basis at all levels and is reviewed in quarterly performance meetings between regional office leadership and the agency's senior leadership team.

Measure	Statewide 2017
Engagement	78%

Additional QA/CQI activities include regional office qualitative reviews of in-home visitation, a minimum of four (4) per office, per month. This review and associated tool include questions and assessments specific to parent and child(ren) engagement in case planning. These reviews began in January 2017, following the conclusion of round 3 of the CFSR in October. This specific activity includes a coaching component so that area office staff (supervisors and managers) are conducting case reviews, debriefing the results, and discussing areas for improvement as well as strengths in practice.

As previously indicated, data reports are readily available to all agency staff through the Performance Reporting Portal located on the agency's SharePoint site and are used statewide in performance reviews and reporting.

It is expected that through the implementation of the PIP strategies and activities, improvement in engagement in case planning will be demonstrated and evidenced through the agency data as well as through the PIP case reviews.

Item 21: Periodic Reviews

The agency received an overall rating of strength for Item 21 based on information from the statewide assessment and stakeholder interviews. Periodic administrative reviews were found to have occurred timely in most cases and the agency has an effective process for manually identifying cases that are not automatically scheduled for a review so as to ensure periodic reviews are held timely. Reviews are conducted within sixty (60) days of a child's entry into care and every one hundred eighty (180) days thereafter. As a child enters care and the entry is documented in LINK, there are triggers to alert the

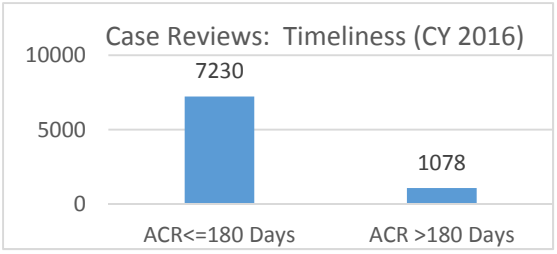
ACR Office Assistant and the CPS staff that an ACR meeting needs to be scheduled within 60 days of entry into care, and a case plan written and submitted in advance of that meeting. Similarly, following the first ACR, the system is designed to automatically calculate the due date for the next review, 180 days from the last ACR, and automated notifications are sent beginning at the 120th day.

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

In addition to conducting periodic reviews within required timeframes, the Department's Office of Administrative Case Review (OACR) provides data related to the timeliness of these reviews, presence of a current case plan, and engagement of parents.

In preparation for the ACR meeting, the OACR SWS conducts a comprehensive case review of the electronic record, which includes reading the case narratives for the entire period under review (PUR), In reviewing the narratives and through discussion at the review meeting, the OACR SWS facilitates a comprehensive discussion amongst meeting participants in order to assess: case status, child's safety in placement, the continuing necessity for and appropriateness of placement, the extent of compliance with the case plan and the extent of progress toward mitigating the need for out-of-home care. The ACR supervisor also leads the group in a discussion related to the child's permanency and timeframes for the achievement of permanency. Following the review meeting, the ACR supervisor documents his/her assessment in the Administrative Case Review Instrument (ACRI) which then gets electronically distributed to the social worker and his/her chain of command. The ACRI is also feeds the Department's Case Practice Report, a report that provides the agency valuable information with regard to case practice and outcomes for children and families.

The agency's case review system has been designed to ensure that a periodic review for each child occurs at least once every six (6) months through the Administrative Case Review (ACR) process. The agency has a report to assess the attainment in reviewing cases at least every 180 days. For CY 2016, the data shows that 87% of the ACRs for children in care (<18 years old) were held within 180 days and 98.9% of these reviews were held within 210 days from the last review, within 30 days of the due date. This represents an improvement from the last APSR submission where 78.8% of the reviews at that time were within the 180 days. In 2016, of those reviews held beyond 180 days, 36.2% went beyond by only 1-5 days, and 54.9% went over by 1-10 days.



# Days Beyond 180	Total Beyond 180 Days	% of >180 Days by # days
0-5	390	36.2%
6-10	202	18.7%
11-30	386	35.8%
>30	100	9.3%
Grand Total	**1078**	100.0%

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

Data from a Foster Care Survey conducted by the Department in 2015 offered the following findings with respect to how foster parents and youth respectively viewed aspects of the ACR process. The results from youth reflect some areas of concern, particularly with respect to their perception of the value of the ACR. Based upon this feedback, the OACR leadership team is developing a plan to outreach to youth to further assess this issue and formulate strategies to enhance the benefit of the ACR for youth. The Office for Research and Evaluation is currently conducting a follow-up survey; that data is not yet available.

Item 22: Permanency Hearings

The agency received an overall rating of Strength for Item 22 as it was determined that the case review system is functioning statewide to ensure that each child has a permanency hearing in a qualified court or administrative body that occurs no later than twelve (12) months from the date the child entered foster care and no less frequently than every twelve (12) months thereafter.

	Yes	No	Grand Total
Hearing with in 12 Months	4181	372	4553
Hearing with in 12 Months	91.8%	8.2%	100.0%

ACR Social Work Supervisors, as part of their case review for children in care, assess the timeliness of permanency hearings to ensure that a hearing occurs no later than twelve (12) months from the date the child entered foster care and no less frequently than every twelve (12) months thereafter. A review of the ACR data for this element, as related to case reviews conducted during CY 2016, reflects that in nearly 92% of the reviews, permanency hearings were found to have occurred within twelve months from the date of entry into foster care and 87.9% occurred no less frequently than every twelve (12) months thereafter.

	Yes	No	Grand Total
ThereAfter 12 months	4049	557	4606
ThereAfter 12 months	87.9%	12.1%	100.0%

The court also provides the agency with data for "time to subsequent permanency hearing" which is a Court Performance measure that is calculated for the State Court Improvement Grant. For the children who exited care in FY16, the percentage of permanency plan dispositions that were held within 365 days of the prior permanency plan disposition was 92%.

FY15/16				
# PP	# Within 365 Days	Average	Median	%Within 365 days
2143	1973	307	312	92%

Item 23: Termination of Parental Rights

The ACR process also assesses for the filing of termination of parental rights (TPR) in accordance with required provisions. As part of the ACR meeting preparation and case review, the ACR Social Work Supervisor is responsible for reviewing the placement information for the child and documents the findings on the Administrative Case Review Instrument (ACRI). The ACRI has specific questions related to the time in care and specifically, the filing of TPR for those children in care >=15 cumulative months in the last 22 months. During Round 3 of the CFSR, the agency received an overall rating of Area Needing Improvement for this item as data reflected TPR petitions were infrequently filed for children in care fifteen (15) of the most recent twenty-two (22) months and only a small portion of those cases had a compelling reason documented.

During the ACR focus group, the ACR supervisors indicated that compelling reasons are often discussed at the meeting, or found in their record review, however, social work staff do not consistently document the compelling reason in the identified field for this in the electronic record. Efforts to improve the agency's performance on Item 23 will need to include retraining with front line

social workers and supervisors as to both the importance of this documentation and the specific location in the electronic record for where they should be documenting compelling reasons.

The agency's administrative case review instrument (ACRI) includes specific questions to assess how well the agency is functioning related to timely filing of TPR motions in accordance with the Adoption and Safe Families Act (ASFA). As the PIP development is underway, the agency will be expanding the data dashboards to include a permanency dashboard. While the agency has data specific to the timely filing of TPR, these reports are underutilized and not as easily navigated as the other data dashboards that have been developed. Strategies will be explored to ensure permanency data reports are posted in a prominent location and are utilized by area office leadership.

Pending: The May 4, 2017 Exit Plan Monthly Plaintiff report reflects that nearly 65% of the children in care identified as "Pre-TPR" have been in care less than fifteen (15) months. About 35% of the "Pre-TPR" children have been in care fifteen or more months. The table to the right is data pulled from that Exit Plan Monthly Plaintiff Report.

Time in Care	Pre-TPR Children in Care	
<15 months	1946	64.8%
>=15 months	1057	35.2%
Total	**3003**	**100%**

TPR Filed?	Permanency Goal	#	%
YES	Adoption	164	15%
	Reunification	26	2%
	APPLA	7	1%
	TOG REL SUB	7	1%
	TOG NREL SUB	5	0%
	TOG: Sub	3	0%
	TOG NREL NONSUB	2	0%
	TOG REL NONSUB	2	0%
	TOTAL	216	20%
NO	Reunification	308	29%
	TOG REL SUB	186	18%
	Adoption	172	16%
	APPLA	64	6%
	TOG NREL SUB	52	5%
	TOG: Sub	38	4%
	TOG REL NONSUB	13	1%
	TOG NREL NONSUB	6	1%
	(Blank)	3	0%
	LTFC Relative	2	0%
	TOG:Non-Sub	1	0%
	TOTAL	845	80%
TOTAL		1,061	100%

The data in the Exit Plan Monthly Plaintiff report also reflects that for approximately 80% of the "Pre-"TPR" children under 18 who have been in care for fifteen (15) or more months, TPR has not been filed. Additionally, when looking at the ages of the children in care 15 or more months, it is important to note that about 40% of these children are between the ages of 13-17. In reviewing the data, specifically for those children in care fifteen or more months where no TPR petition has been filed, the documentation reflects that for only 20% of these children is there a documented reason for not filing TPR. For approximately 80% of the 845 children, there is no documented reason in the data field

CIP >=15 Months + TPR not Filed, by Age Range		
Child Age Range	Total	%
1-5	279	33%
6-12	231	27%
13-17	335	40%
Grand Total	**845**	100%

to indicate why the agency has not filed for TPR. Based on ACR Supervisors' feedback in the focus group for Round 3 of the CFSR, it appears the issue may be very much connected to a lack of documentation of compelling reasons in the electronic record because the ACR Supervisors maintain that in their reviews, most often there is a compelling reason that TPR has not been filed and this is discussed during the ACR meeting.

As the agency seeks to improve permanency outcomes, strategies will need to be developed to improve documentation of compelling reasons when these in fact exist, but there will also need to be specific strategies for addressing those older children in care, specifically those between 13-17, who have been in care beyond fifteen (15) months and TPR has not been filed. These strategies and activities will be incorporated into the agency's PIP, which is still in development.

"Time to filing a Termination of Parental Rights Petition from Removal Date" is a Court Performance measure that is calculated for the State Court Improvement Grant. The following table was provided by the court for the cohort that includes all TPR petitions filed during FY16. The data is based on the removal date of the child (date of 96 Hour Hold, Order of Temporary Custody or Commitment order) to the date the Termination of Parental Rights Petition was filed.

2015-2016						
# TPR filed	# within 15 months	# within 24 months	Average	Median	% Within 15 months	% Within 24 months
600	331	493	17	13	55%	82%

Item 24: Notice of Hearings and Reviews to Caregivers

The agency received an overall rating of Area Needing Improvement for Item 24 based on data that reflected that the current process for providing notice of court hearings and administrative reviews is not consistently effective in providing notices to foster parents across the state. Stakeholders in the CFSR focus group indicated that caregivers are not always noticed on court hearings and participation in court is dependent on the judge, which at time results in a denied opportunity to be heard.

Although notification to caregivers is built into the ACR scheduling process and a report can be produced as requested, there is no management report that has been put into production so that this data is available on an ongoing basis or at specific points in time. The agency will explore developing a

report to track timely notification in real-time so that issues with regard to timeliness can be addressed on an ongoing basis and in those areas/offices most challenged with timeframes.

The agency expectation is that caregivers are notified of the ACR no later than twenty-one (21) days prior to the meeting. ACRI data for CY 2016 reflects that 70.2% of the notification letters to foster parents were generated twenty-one (21) or more days prior to the ACR being held and 74% were generated within 11 days of the ACR. This represents a significant improvement as compared to last year's APSR. The letters are generated by the ACR OA as part of the scheduling process, but this relies on the area office social worker having updated address information as well as having identified all of the necessary participants. Once the social worker has completed this, s/he checks of a box in LINK to indicate "all necessary participants have been identified". The OA can then proceed with generating the notification letters. While the data reflects when letters are generated, there is no data point that specifically captures whether or not caregivers are successfully notified. It is an expectation that social workers communicate important meeting dates, including court dates and case review dates, to caregivers as they get scheduled.

	Notification of ACR in <=21 Days		
Case Particpant	**NO**	**YES**	**Grand Total**
Foster Parent	29.8%	70.2%	100.0%
Grand Total	**29.8%**	**70.2%**	**100.0%**

In a foster parent satisfaction survey conducted in 2015, 79.1% of foster parents surveyed indicated they are consistently notified of scheduled court hearings and a higher percentage (87.9%) also reported having an opportunity to be heard in a review or court hearing. The Office for Research and Evaluation will again be surveying foster parents and this data will be used to further inform the agency's PIP and associated activities.

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

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

during the hearing. That may help identify hearings where foster parents have participated. This will continue to be explored as the PIP is developed.

During the next year, OACR will focus on transitioning aspects of the case review process to the OSRI as the case review tool for a portion of its case reviews and will continue to partner with the Office for Research and Evaluation to maintain the QA process that has been in place during both the pilot and official CFSR.

Item 25: See section titled "10. Quality Assurance System**"**
Item 26: Initial Training – See section titled "5. Program Support**"**
Item 27: Ongoing Training + Item 28: Foster Parents Training – See also Section F. Updates to Targeted Plans

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

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

As a means to support training for foster parent, the Department has a contract with the Connecticut Association of Foster and Adoptive Families (CAFAF) that includes a range of support, education, training, and advocacy services to foster families, adoptive families and relative caregivers intended to address and meet their needs, encourage and facilitate ongoing education and skill development, and

allow foster children to live in safe and stable home settings.

For families licensed by private agencies (e.g., Therapeutic Foster care), their training is tracked by their parent agencies. The Department engages in periodic random reviews during quality assurance site visits to assess each providers systems and will make recommendations for improvements.
In 2015 DCF contracted with the Children's Alliance to implement a new trauma-informed statewide training curriculum for foster and adoptive parents called: Trauma Informed Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP). TIPS-MAPP is fully implemented and is currently being delivered as the only statewide foster and adoptive pre-licensing training curriculum by both the Department and private Child Placing Agencies (CPAs). This ensures consistency in that all prospective parents receive the same training and carry the same expectations. Since December 2014, 130 DCF and private agency staff have been certified to train prospective foster and adoptive applicants in this curriculum. Additionally, there are two approved statewide trainers to deliver a, "train the trainer" approach in order to sustain the self-sufficiency of this initiative. Providers were also trained in cultural humility in Six Core Strategies (Violence prevention), and in permanency preparation work.

Next, staff at congregate care facilities are monitored by the Department's Licensing Unit for completion of mandatory training (e.g., CPR, first aid, ESI, mandated reporting). The DCF Office of Children and Youth in Placement (OChYP) ensures that all Therapeutic Group Homes meet their annual staff training plan requirements and monitors residential treatment centers annual staff training.

Items 29 +30: 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 uses a flexible funding approach to support children and youth to remain in stable family placements. These "wraparound funds" may be spent for both in-home and out-of-home youth on a range of services and concrete supports. The table below summarizes the top ten service

requests and expenditures for SFY2016.

Top Ten Services Purchased: Wrap Funds	
SRVC-TYPE-DESC	**Total**
Transportation Other-Foster care CPS	$ 1,656,282
Miscellaneous-Foster Care-CPS	$ 1,405,095
Therapeutic Support Staff - Foster	$ 1,181,083
Supervised Visits - Foster Care	$ 1,172,330
Other Family Supports	$ 1,166,550
Miscellaneous-Adoption	$ 716,297
Therapeutic Support Staff In-Home	$ 684,014
Other Services USE	$ 637,917
Extended Credentialed Services-USE	$ 619,247
Camp-Foster Care	$ 522,811
Grand Total	**$ 9,761,625**

The Annualized Expenses for SFY 2016 were over $14.2 million. Each Region has a caseload budget allocation. These range from about $2.3 million to $3.6 million. These funds can be used to purchase a variety of services (including clinical and treatment) that support children's and families individualized cultural and linguistic needs. This allows the Regions to use these dollars in the ways that best meet the needs of their families and their catchment. The distribution of expenditure by office is in the table below.

Office Name	Total Expenditure
Bridgeport Office	$ 1,008,341
Careline	$ 5,212
Danbury Office	$ 976,485
General Administration	$ 1,001,181
Greater New Haven Office	$ 850,950
Hartford Office	$ 1,562,544
Manchester Office	$ 779,187
Meriden Office	$ 511,467
Middletown Office	$ 330,798
New Britain Office	$ 879,779
New Haven Metro Office	$ 1,097,130
Norwalk Office	$ 400,534
Norwich Office	$ 1,593,672
Torrington Office	$ 478,492
Waterbury Office	$ 1,782,428
Willimantic Office	$ 1,006,465
Grand Total	**$ 14,264,664**

Children and youth with complex service needs may require a package of services or need services for an extended time period. The Department created a planning and review process for these Unique Service Expenditures (USE). USE plans are developed in the regions with their Regional Resource Group's input and the expenditures are monitored in Central Office. The tables below report the number of youth on USE plans and the total USE expenditures, by area office.

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

Total $ spent on USE plans (estimated costs):

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

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

The funds reported in the table above are also included in the totals for SFY16. The side graphic is a screenshot of some of the services that are supported by wraparound funds.

Since 2011, the Department has secured $40.9 million in direct DCF Grant Awards (Federal and Private Philanthropy Funds). The Department has helped secure an additional $28.9 million in Partner Grant

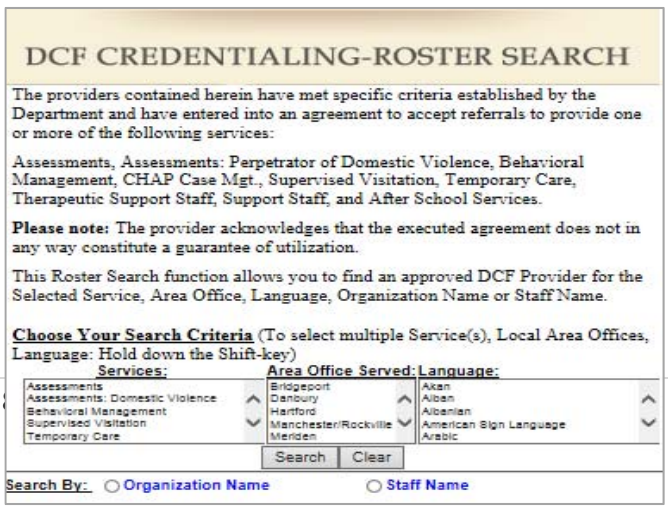
Awards, in which other state agencies or entities were the leads but DCF was a mandatory or key participant.

The Department, and its partners, have received a variety of grants to support service array expansion in vital areas such as substance use, mental health, IPV, housing and support for families caring for young children.

In fact, last month, DCF was awarded a SAMHSA grant of $3.1 million over 4 years for the Access, Screening and Engagement, Recovery Support, and Treatment (ASSERT) Project to enhance substance use services and recovery supports for adolescents and young adults statewide.

ASSERT will support the state's most vulnerable adolescents (12-17) and transitional age youth (18-21) who seek care through the publicly-funded substance use treatment and recovery support systems. Year 1 of the grant will target four Connecticut communities that have been impacted heavily by the opioid epidemic: Hartford (Region 4), Norwich/New London (Region 3), New Britain (Region 6) and Waterbury (Region 5). In years 2 through 4, ASSERT will expand to include Bridgeport (Region 1) and New Haven (Region 2).

Further, as noted above Department spends over $14 million a year in Wraparound/Flex dollars to support the individualized needs of the children and families whom it serves. These dollars allow the Regions to purchases needed services on a child and family level to address service gaps and to aid with the provision of culturally and linguistically competent care. In particular, DCF Credentialed Services array and process, which is funded using wrap dollars, supports provision of community-based care from local, culturally and linguistically competent service providers. The Credentialed Services portal has an option by which services can be searched by DCF Area Office and language (see screen shot below).



Item 31 + 32:

Please see the "Collaboration" section for an overview of the Department's various Community Partnerships.

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 most Statewide Provider Meeting was held on April 5, 2017. The meeting agenda was focused on an updates regarding the Juan F. Consent Decree, state budget and the Department's new tier classification system for service providers. Nearly 140 people representing 90 service providers were in attendance. During the question and answer period, provider agencies and Department staff engaged in a lengthy conversation about service gaps and what providers can do to address those gaps. The next meeting is scheduled for the Fall of 2017.

FAVOR had a statewide meeting this fiscal year to provide training and assist the Citizen Review Panels (CRPs) in defining the agenda for the year.

The Western CRP chose to focus on Voluntary Services. They met monthly throughout the year to get trainings, review how voluntary services is run in Connecticut and other states and to plan data collection efforts. They conducted 3 focus groups of families in the community and providers to explore how families learn about voluntary services and the perceptions about it.

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

Item 33:

The Regional foster care units continue to build and refine 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 Alliance of Foster and Adoptive Families (CAFAF) to develop and carry out recruitment and retention activities across the state. Key provisions from the CAFAF 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.

One improvement since the last report is that the Department is collecting data from CAFAF on a quarterly basis. The data includes number of inquiries by race and ethnicity, training participation, and elements related to foster parent satisfaction.

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 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.

- **Item 34**

All waiver requests pertaining to criminal and child protective service history require Commissioner review and approval. Such requests are thoroughly vetted by the Regional Offices prior to submission to the Commissioner. The waiver is generated through a collaboration between foster care staff and the ongoing services staff working with the child's case. The waiver must be reviewed and signed off on by the Program Managers of Foster Care and the Ongoing Services team. Then it is forwarded up the chain of command to the Regional Administrator, who is also required to review and approve the waiver request prior to submission to the Commissioner. Due to this comprehensive review and approval structure in the Regions, the waiver requests that get submitted to the Commissioner are

typically appropriate and sound in their rationale as they have already been viewed to be waivable by multiple levels of DCF staff.

Newly revised foster care policy (issued on June 1, 2017) reiterates that "No waiver shall be granted for non-compliance with a statutory requirement or a safety-related regulation". Foster care staff have been trained in this policy. Further, the Commissioner issued a memo on September 28, 2016 stating, "a waiver request must be submitted to the Commissioner prior to placement of a child into the home. If an emergency after -hours placement is authorized by the Regional Administrator, the formal waiver request must be submitted to the Commissioner on the next business day." Since the issuance of that memo, in situations where a Commissioner waiver is required, the Department has not actively placed children into a foster home without either an approved Commissioner waiver, or provisional emergency approval from a Regional Administrator.

- **Item 35**: See Section F. Updates to Targeted Plans
    - CAFAP Report section re: Post-Licensing Retention for most recent year/quarter available – **1Q CY17**

Post-Licensing Retention

- CAFAF Retention Specialist attempted to contact 126 families who were approaching renewal of their license for the first time. (An increase of 39 families after several quarters of decreased families in line to renew their license for the first time.) 31 families were reached and agreed to complete our survey (a 24.6% response rate).
- Of the 31 families that responded, 23 plan to renew their license, 5 were unsure and 3 families plan to close upon adoption.
- 27 reported having a positive relationship with their DCF support worker
- 28 reported feeling respected by DCF.

- FASU Quarterly Status Report for most recent year/quarter available

1st Qtr (Jan-Mar) 2017 STATUS REPORT

	LICENSED HOME DATA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
1	Number of Foster Homes Licensed During 1st Qtr	7	3	10	2	7	4
2	Number of Foster Homes Closed During 1st Qtr	38	5	4	6	7	12
3	Total Number of licensed Foster Homes as of Mar 2017	87	94	154	166	165	106
	ADOPTION DATA						
1	Number of Adoptive Homes Licensed During 1st Qtr	4	4	3	1	3	3
2	Number of Adoptive Homes Closed During 1st Qtr	6	7	3	6	2	0
3	Total Number of licensed Adoptive Homes as of Mar 2017	34	28	52	37	41	17
	FICTIVE KIN DATA						
1	Number of Fictive Kin Homes Licensed During 1st Qtr	3	8	8	6	1	7
2	Number of Fictive Kin Homes Closed During 1st Qtr	5	7	5	9	10	4
3	Total Number of Licensed Fictive Kin as of Mar 2017	25	31	50	45	40	22
	INDEPENDENT DATA						
1	Number of Independent Licensed During 1st Qtr	2	4	2	1	1	1
2	Number of Independent Closed During 1st Qtr	8	4	3	1	2	1
3	Total Number of licensed independents as of Mar 2017	7	4	11	11	15	6
	KINSHIP DATA						
1	Number of Kinship Homes Licensed During 1st Qtr	31	7	10	16	27	17
2	Number of Kinship Homes Closed During 1st Qtr	20	11	18	9	16	18
3	Total Number of licensed Kinship Homes as of Mar 1, 2017	75	101	154	207	162	114
4	Total Numbers of licensed Kinship Homes as of Mar 2017	79	99	145	212	167	113
	Total Number of New Homes Licensed	**47**	**26**	**33**	**26**	**39**	**32**
	Total Number of Closed Homes	**77**	**34**	**33**	**31**	**37**	**35**

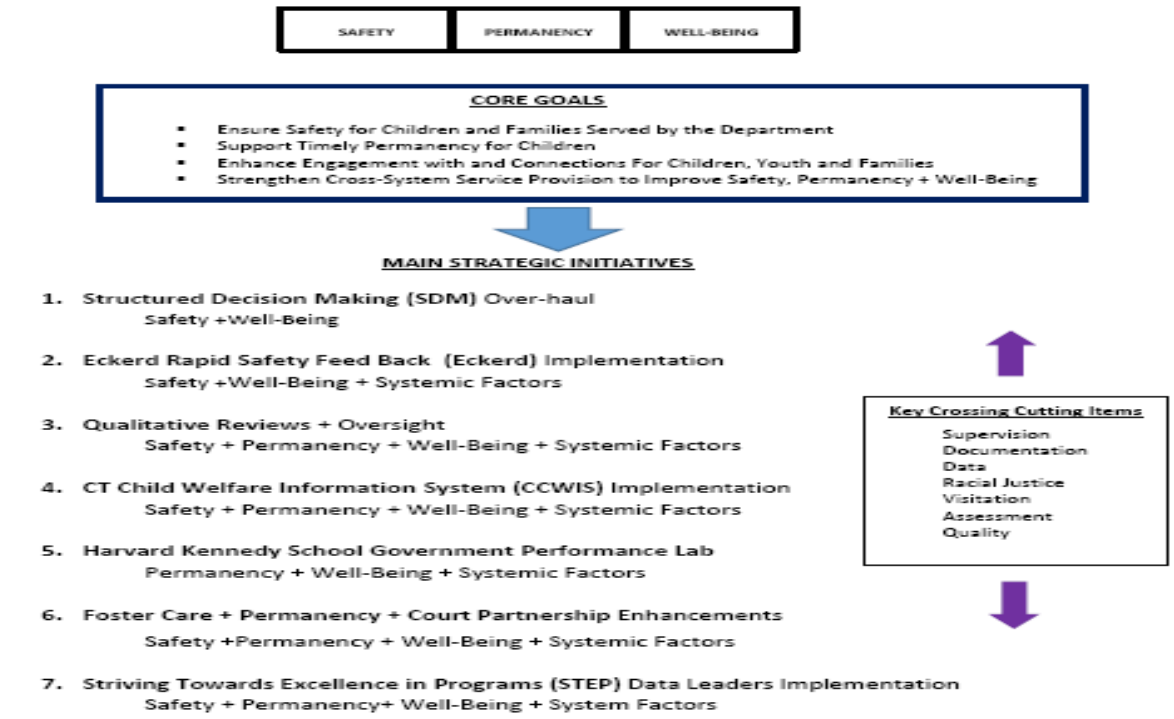
- **Item 36:**
  - CFSR Result: **ANI**
  - ICO Data for CY15 – CY17 (partial)

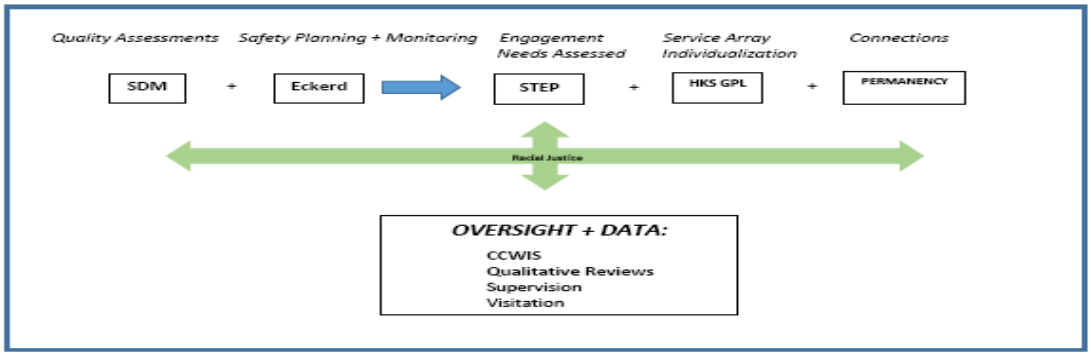
	CY2015	CY2016	CY2017 (Partial)
Requests for Inbound Children	427	498	309
Requests for Outbound Children	367	338	168
CT Children Placed Out-of-State			75
Average Time from Referral Submission to Placement (in months)			
Out-of-State Children Placed in CT			
Average Time from Referral Submission to Placement (in months)			
Licensed Independent Foster Homes			58
Newly Licensed Independent Foster Homes	69	51	18
Average Time to License (in months)			

3. Plan for Improvement and Progress Made to Improve Outcomes

Plan for Improvement

The Department has submitted its proposed PIP. That documents articulates the Department's current and proposed strategies to make improvements in key areas identified by the CFSR. Those have been provided in the "Strategic Plan and use of Results Based Accountability" section of this plan. The presented schemas represent the frameworks and foundational levers that will be used to support the desired improvements:





Implementation Supports

Progress Made to Improve Outcomes (see also Performance Assessment)

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 seven (7) communities of practice (COP). The 7 overarching committees include:

- **Office Directors**: charged with leading area office, special investigations unit, and Careline statewide change initiatives to ensure effective and consistent case practice.
- **Systems Directors**: charged with assisting in shaping and implementing major system-wide policy and practice initiatives while also providing a mutual learning environment among colleagues to support effective and consistent practice. The focus of this COP will be the implementation of Connecticut's Behavioral Health Plan.
- **Clinical Directors**: charged with assisting in shaping and implementing major system-wide policy and practice initiatives while also providing a mutual learning environment among colleagues to support effective and consistent practice. This COP's focus is system development.
- **Intake**: charged with planning statewide change initiatives to ensure effective and consistent intake practice in all regions.
- **Adolescent**: charged with providing guidance, input, feedback, recommendations and expertise to senior leadership by ensuring ongoing planning and development of comprehensive, individualized, and coordinated programs to meet the needs of youth in every facet of out of home care.
- **Juvenile Justice**: charged with providing guidance, input, feedback, recommendations and expertise to senior leadership by ensuring ongoing planning and development of comprehensive, individualized, and coordinated programs to meet the needs of youth with juvenile justice involvement.
- **Foster Care**: charged with recommending system improvements and coordinating the implementation of statewide change initiatives relative to the placement of children and youth in foster care.
- **Quality Improvement Council**: charged with reviewing and implementing projects to ensure standardized quality practice in all regions, facilities, and the central office as part of the DCF quality improvement plan.

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

In 2016, the Department continued to advance the implementation of key practice changes that were guided and informed by the Change Management process including:

- Child and Family Permanency Teaming
- Implementation of a new tools to enhance the assessments and provision of services for adolescents in care and adolescents involved with the Juvenile Justice System
- Implementation of a new foster care training curriculum
- Implementation of a tiered classification system for contracted service providers
- Development of assessment tools to evaluate the quality of the intake practice and in home visitation
- A number of new and revised policies and practice guides that reflect practice changes
    - A new Intimate Partner Violence Policy
    - A revised Immigration Policy
    - A revised Investigation Policy
    - A revised Foster Care Policy

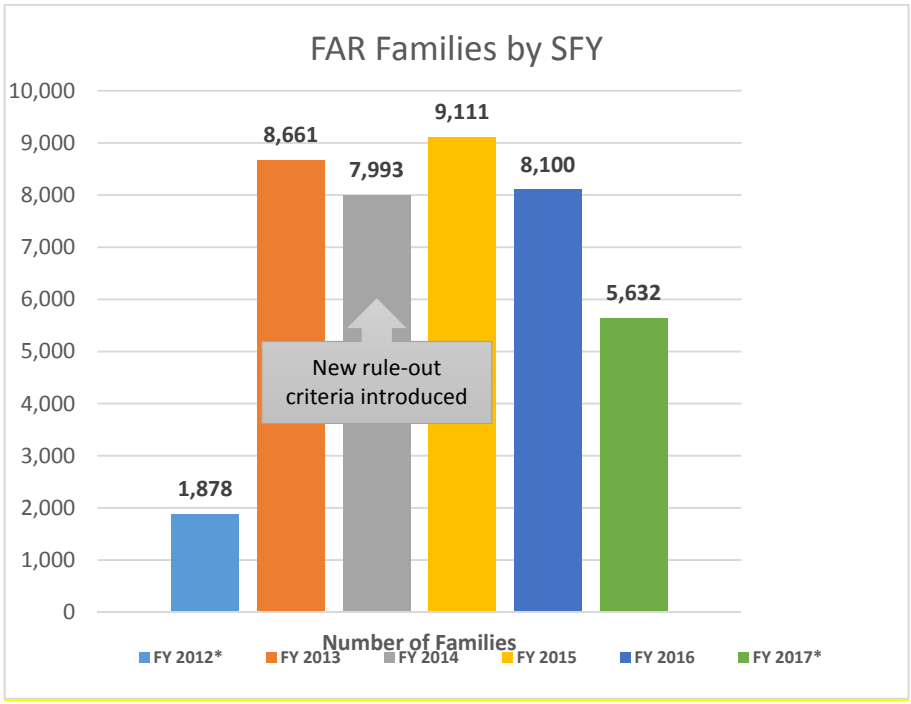
The Change Management Committee together with the Communities of Practice have been instrumental in offering critical feedback and recommendations relative to practice and system changes, informing the timing and staging of implementation and supporting sustainability of key initiatives and system reform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

Differential Response

On March 5, 2012, the Department of Children and Families launched its Differential Response System (DRS). UCONN School of Social Work continues to function as our Performance Improvement Center, analyzing our Family Assessment Response data and that of our contracted service, Community Support for Families Program. Representatives from the Careline and Area Office staff continue to meet monthly to address policy/practice issues relative to our intake practice. Recently, the MOA with UCONN was modified to include investigations data dating back to 2005 which will allow us the opportunity to evaluate our overall intake practice (inclusive of both tracks: Investigations and our Family Assessment Response (FAR). The analysis/evaluation is currently underway. Results of the analysis will be shared with senior leadership, regional and central office staff in the fall.

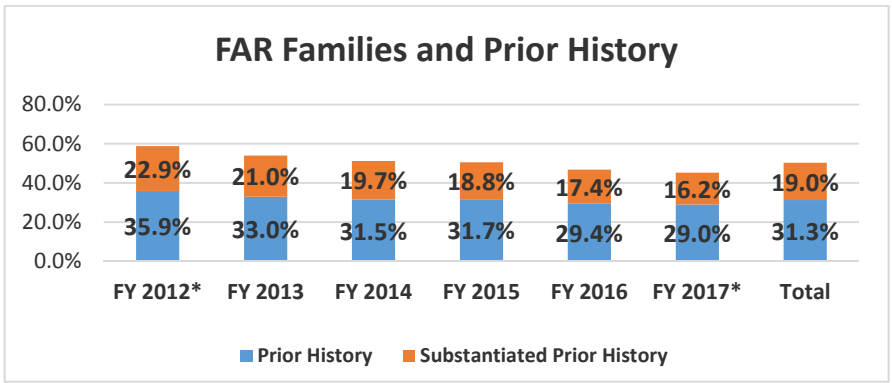
A review of 2016 data reveals that there were a total of 31,480 accepted reports of child abuse and neglect. Of the total number of accepted reports, 39.3% (12,384) were assigned to the FAR track, slightly lower than last year (43%).

The following chart represents unduplicated families who received a FAR since implementation (3/5/12) by SFY through 3/31/17. Although the Rule Out criteria changed in June 2014, reports designated as an investigation response continue to be the highest response type for accepted reports.



* Represents a partial Fiscal Year

The following chart represents families who have received a FAR by their prior history (including substantiated history). Data: 3/5/12-3/31/17.



31% of all FAR families had a prior CPS History.

19% of all FAR families had a prior substantiated report.

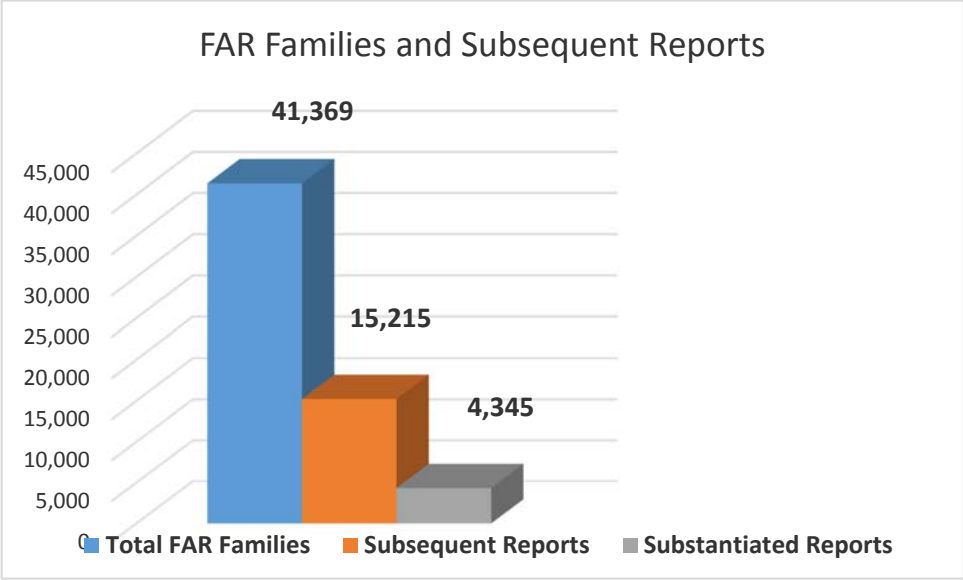
* Represents a partial Fiscal Year

FAR Families with Multiple Prior Reports by Fiscal Year

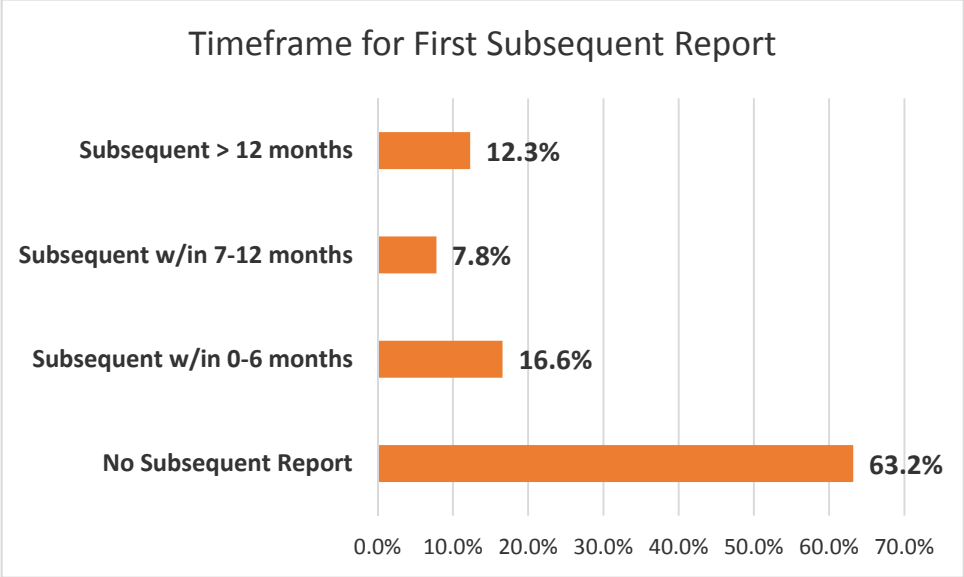
Fiscal Year+	No Prior	1 Prior	2 Priors	3 Priors	4 Priors	5+ Priors
FY 2012*	64.1%	10.9%	7.9%	5.1%	3.8%	8.4%
FY 2013	67.0%	10.4%	7.2%	4.8%	3.1%	7.6%
FY 2014	68.5%	11.1%	6.9%	4.7%	2.9%	5.8%
FY 2015	68.3%	12.3%	6.8%	4.1%	2.9%	5.6%
FY 2016	70.6%	12.0%	6.6%	3.5%	2.4%	4.9%
FY 2017*	71.0%	12.9%	6.0%	3.3%	2.3%	4.5%
Total	68.7%	11.6%	6.8%	4.2%	2.8%	5.9%

* Represents a partial Fiscal Year *Unduplicated Count – N=41,375 LINK Extract 3/3/12-3/31/17.*

The following chart represents FAR families who received a subsequent report. 26,154 families (63.2%) have not experienced a subsequent report, slightly lower than the previous year (67.4%). Of the 15,215 families (36.8%) who received a subsequent report, 10.5% were substantiated, slightly higher than the prior year (8.6%). Data: 3/5/12-03/31/17.



The following chart represents families who received a subsequent report and the timeframe in which a subsequent report was received. Of the families who receive a subsequent report, most occur within 6 months of case closing. Data: 3/5/12-12/31/17.



Included in our legislative CY 2016 report, UCONN conducted a Survival Analysis of our FAR data to determine what proportion of FAR families have not received a subsequent report in a given time period. This approach provides the least biased method for calculating subsequent or subsequent substantiated reports as it accounts for cases that may not have had enough time to experiences these outcomes.

Survival Analyses indicated the following for **Subsequent Reports**:

- 82% of FAR families have not received a subsequent report within **6 months** of their first FAR closing.
- 73% of FAR families have not received a subsequent report within 12 **months** of their first FAR closing.
- 61% of FAR families have not received a subsequent report within **two years** of their first FAR closing.

Survival Analyses indicated the following for **Subsequent Substantiated Reports**:

- 96% of FAR families have not received substantiated subsequent reports within **6 months** after their first FAR closing.
- 93% of FAR families have not received substantiated subsequent reports within **12 months** after their first FAR closing.
- 90% of FAR families have not received substantiated subsequent reports within **two years** after their first FAR closing.

Summary of Findings:

The majority of FAR families have not received a subsequent report within three years of their first FAR closing. Unadjusted survival analyses show some differences by race/ethnicity; however, when controlling for other factors, 12-month survival analyses indicate that the following risk factors increase the likelihood of a subsequent report:

- Age of victim is under five
- Higher risk category level
- Region (Additional Research is planned to understand regional differences. Given the vast differences in populations and community profiles, region is likely a proxy for factors inherent in the population)
- Single parent families
- Homelessness
- Four or more children involved in CAN incident

Most FAR Families did not have a substantiated subsequent report. Unadjusted survival analyses show some differences by race/ethnicity; however, adjusted 12-month survival analyses indicate that other risk factors play a more substantive role in predicting the outcome of substantiated subsequent reports than race/ethnicity:

- Age of victim is under five
- Higher risk category level
- Region (Additional Research is planned to understand regional differences. Given the vast differences in populations and community profiles, region is likely a proxy for factors inherent in the population)
- Homelessness
- Child with complex medical needs
- Primary caregiver has alcohol/drug problems

FAR Data continues to be routinely shared with central and regional office staff as well as senior leadership to help identify trends and inform practice and policy changes.

The University of Connecticut's (UCONN) School of Social Work continues to function as the

Performance Improvement Center (PIC) for the Community Support for Families (CSF) Program. Much of their initial focus was on improving the quality of data entered by CSF staff into the Provider Information Exchange (PIE). Both PIE and LINK data extracts continue to be sent to UCONN on a quarterly basis. Last year, the Department worked with providers and DCF staff to refine the Scope of Service, develop Performance Measures for the program within the RBA framework, and develop Data Dashboards for the program for each region. The NCFAS-G was added to the CSF Program to provide a more consistent approach to assessing families, informing service delivery, and evaluation.

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 voices are heard throughout every stage of the child welfare process. The implementation of Child and Family Team Meetings (CR-CFTM) 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.

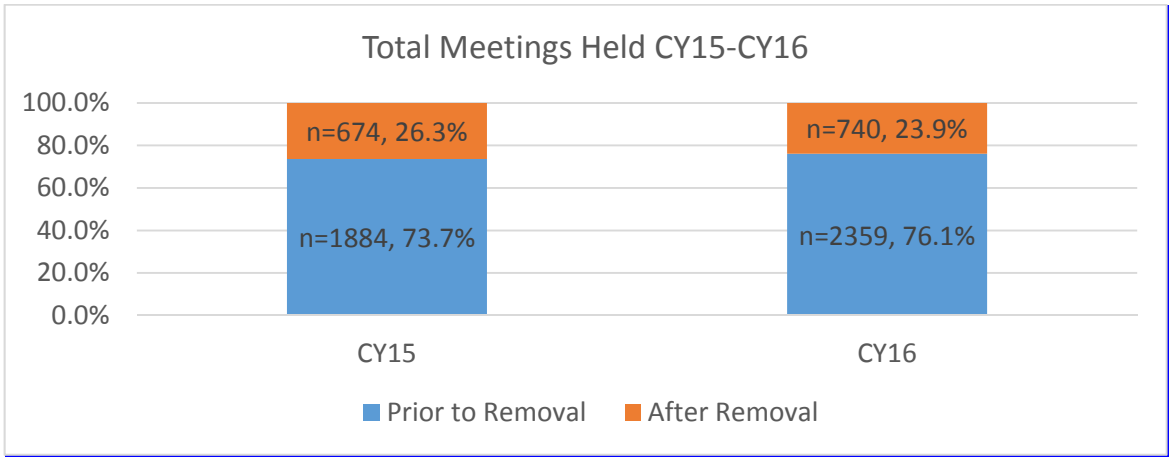
On February 11, 2013, the Department implemented CR-CFTM statewide. Monthly consultation days with the CR-CFTM Facilitators and Casey were held for one year post implementation for coaching, training, and case consultation.

In calendar year 2017, the department;

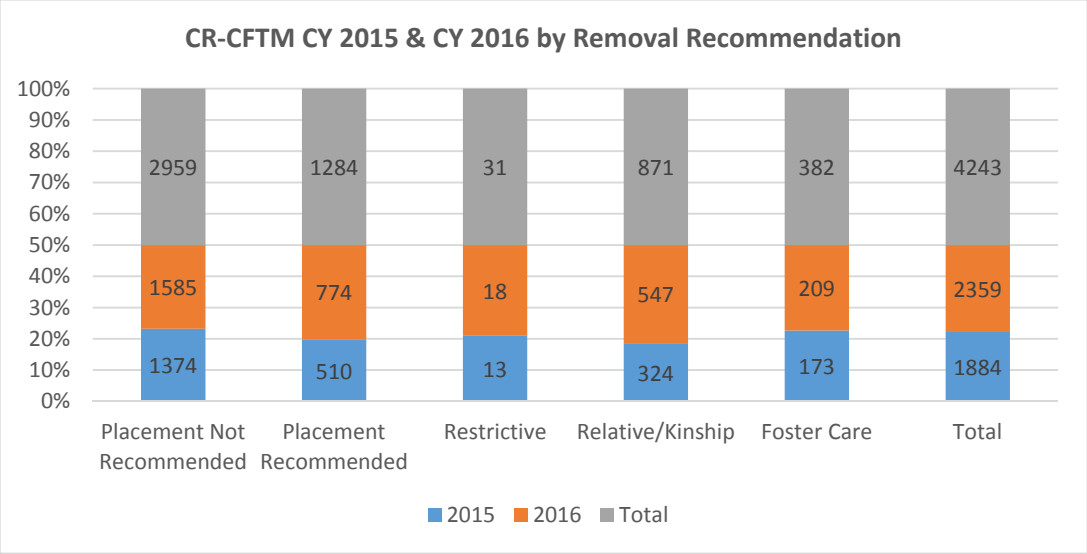
- Updated the CR-CFTM LINK Guide to increase consistency in data entry by the Considered Removal Facilitators.

- 19 DCF staff participated in a 3 day training of the CR-CFTM model. This included both new Facilitators and regional office staff that perform as Backups when needed. Back up guidance was modified to ensure they continue to hone and enhance their skills.
- The department held a 3 day LEAN Event of the CR-CFTM process as they prepare for the new CCWIS project. The event utilized the knowledge and resources of Considered Removal Facilitators from multiple regions, Central office staff, and Information Systems. The lean process helped demonstrate that the Department is maintaining model fidelity across the state. It did reveal some of the regional differences that exist primarily related to notifications and the various logs that have been created to monitor and track various outcomes of the meeting. It also highlighted the struggles/challenges with documentation in our current LINK system. Efforts are underway to enhance existing reports. The IS/CCWIS team has agreed to attend quarterly meetings to have an ongoing dialogue with Facilitators around issues/concerns and together come up with options to address many of them. Notifications and many of the internal processes that have been established will be automated in the new system.
- Regular quarterly meetings were held with all the CR-CFTM Facilitators to review our CR-CFTM practice.

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

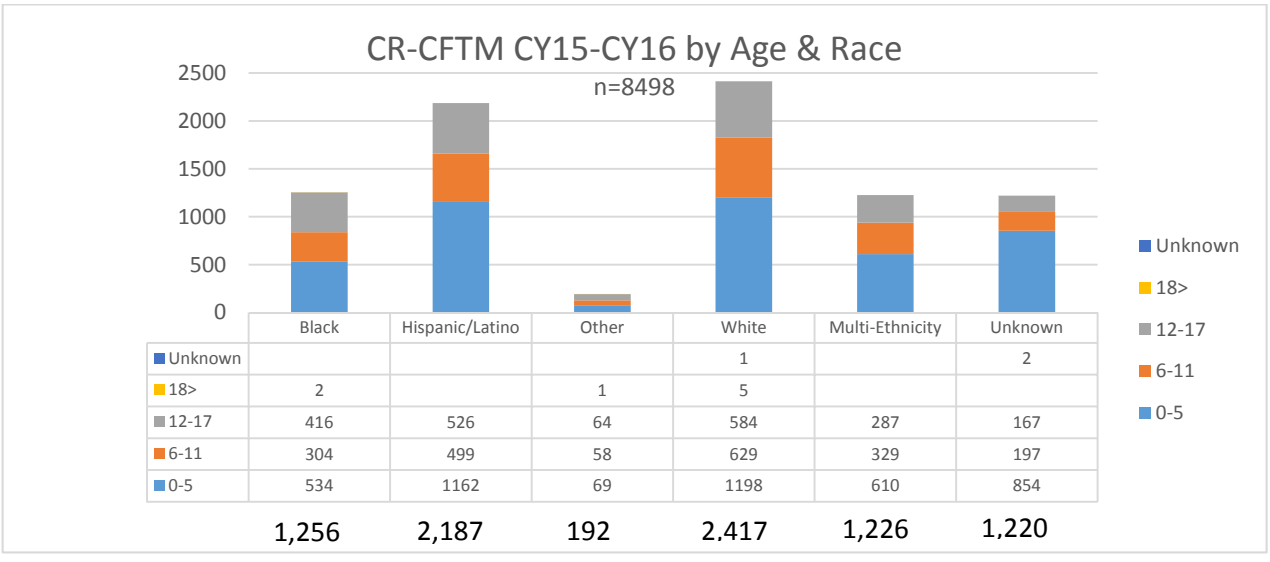


This chart above represents CR-CFTM data for calendar years 2015 and 2016.
In 2016, a total of 3099 CR-CFTMs were held, an increase of 541 from the prior year.
Over 75% of meetings were held prior to the child's removal, an increase over last year. Area Offices are making concerted efforts to conduct these meetings prior to the child's removal.



The chart above represents CR meetings held prior to removal for calendar years 2015 and 2016 as to whether the children were recommended for removal. In 2016, of the meetings held prior, 33% of children were recommended for removal, compared to 27% last year. Of the children recommended for removal, 71% of children were recommended for placement with a relative/kinship caregiver in 2016, compared to 64% in 2015.

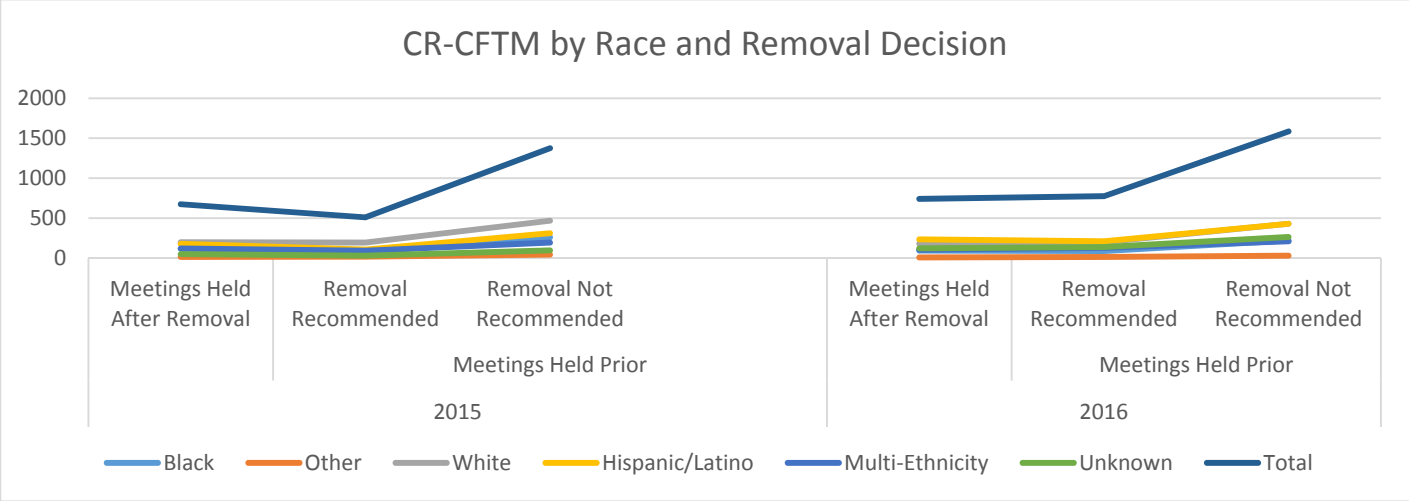
The chart below represents CR-CFTM by Age and Race for CYs 2015 and 2016. White children continue to be the highest racial group who are the subject of a CR meeting, followed by Hispanic/Latino and Black children. This appears consistent with the racial composition of children/families involved with the Department. There was a slight increase in the Hispanic/Latino population who were the subject of a CR meeting this past year. 52% of all CR-CFTM involved children ages 0-5; 24% involved children ages 6-11; and 24% involved children ages 12-17.



	Black	Hispanic/Latino	Other	White	Multi-Ethnicity	Unknown
Unknown				1		2
18>	2		1	5		
12-17	416	526	64	584	287	167
6-11	304	499	58	629	329	197
0-5	534	1162	69	1198	610	854
	1,256	2,187	192	2,417	1,226	1,220

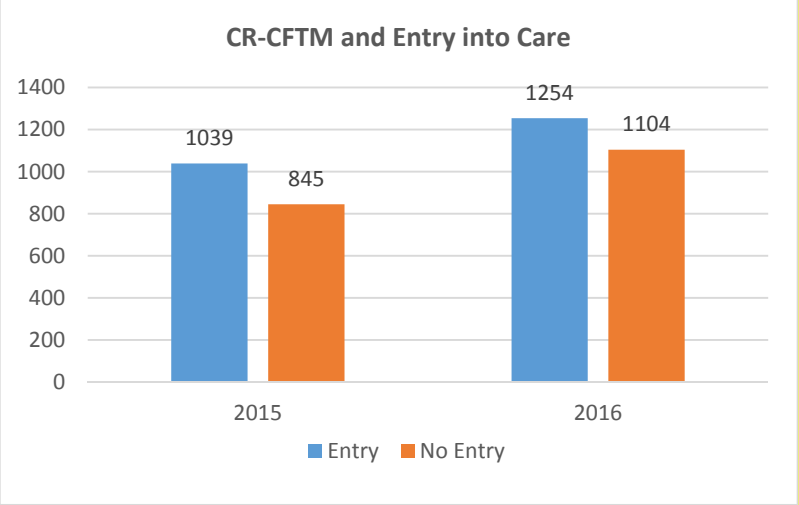
The charts below represents the CR meetings held after removal and those held prior to the child's removal by removal decision by race for CYs 2015 and 2016.

Race/Ethnicity	2015	Meetings Held Prior to Removal			2016	Meetings Held Prior to Removal	
	Meetings Held **After**	Removal Recommended	Removal **Not** Recommended		Meetings Held **After**	Removal Recommended	Removal **Not** Recommended
Black	17.4%	14.3%	19.0%		12.6%	11.4%	13.9%
Other	2.1%	3.3%	3.1%		1.0%	1.7%	1.8%
White	29.4%	38.0%	34.1%		24.3%	25.4%	27.1%
Hispanic/Latino	26.3%	20.8%	22.8%		31.6%	27.3%	27.1%
Multi-Ethnicity	17.6%	17.8%	14.1%		14.1%	16.4%	13.3%
Unknown	7.2%	5.8%	6.9%		16.4%	17.8%	16.8%



This past year, Hispanic children had the highest percentage of meetings held after removal, followed by White children. Hispanic children also had the highest percentage of meetings held prior with a removal recommendation but were tied with white children in meetings held prior with no recommendation to remove. This data will continue to be monitored through a racial justice lens.

The chart below represents children who had a CR Meeting and whether they entered care for CY 2015 and 2016. This represents data as of 2.21.17.



2015: Total Meetings held Prior to Removal: 1884
Removal not Recommended: 1374
Removal Recommended: 510

2016: Total Meetings held Prior to Removal: 2358
Removal Not Recommended: 1584
Removal Recommended: 774

2015: Of the CR Meetings held prior (1884), 845 or 45% of children did not experience an out-of-home placement.

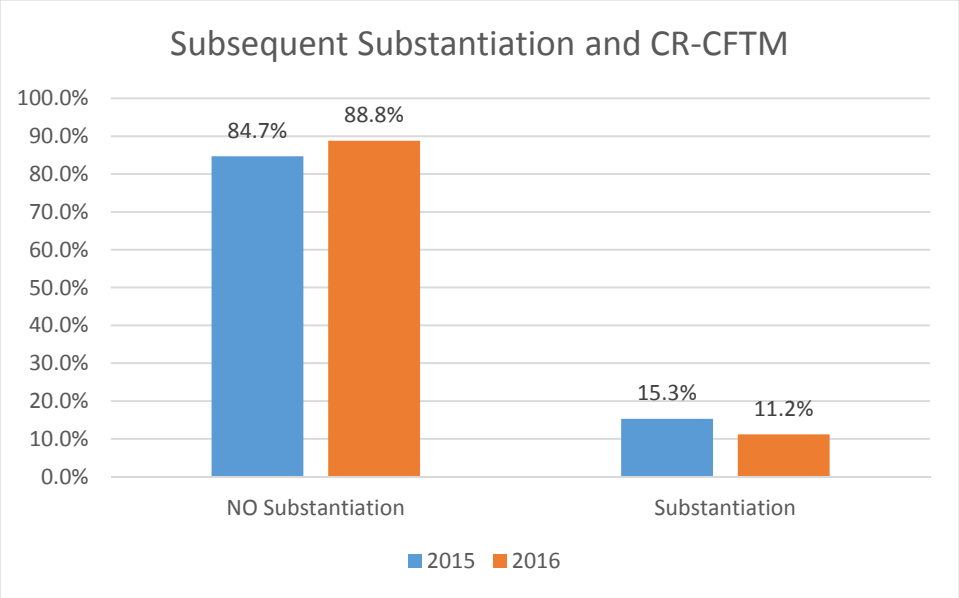
Of the 510 children who were recommended for removal, 494 children or 96.8% entered care.
Of the 1374 children who were not recommended for removal, 545 children or 39.6% entered care.

2016: Of the CR Meetings held prior (2358), 1104 or 46.8% of children did not experience an out-of-home placement.

Of the 774 children who were recommended for removal, 720 or 93% entered care.
Of the 1584 children who were not recommended for removal, 534 children or 33.7% entered care.
For children recommended for removal, we are seeing consistency in removal decision and actual entry into care. For children not recommended for removal, we are seeing fairly high rates of entry into care. This trend is continuing in 2016. Further analysis is needed. This will continue to be an area of focus for the Department.

The chart below represents children who had a CR-CFTM prior to their removal, placement was not recommended and there were no subsequent entries into care (as of 2-21-17).

- Of CR-CFTM held prior in CY15: 85% of children (702) did not experience a subsequent substantiated investigation. N=829
- Of CR-CFTM held prior in CY16: 89% of children (932) did not experience a subsequent substantiated investigation. N=1050



Permanency Teaming continues to be an area of focus for the Department, particularly as one of the key strategies to help meet our performance measures. Documentation of our permanency teaming practice continues to present challenges given our current LINK system. The current process is cumbersome and duplicative as such regions have developed strategies to document the permanency teaming process. As a result, the process of quantitative review presents challenges.

In an effort to further assess our implementation of permanency teaming from a practice perspective, a Case Review Tool was developed in collaboration with Region 6 as a result of our Racial Justice work between the region and the Clinical and Community Consultation Support Division in central office. The tool is intended to assess DCF's permanency teaming practice relative to a selected OPPLA population of youth identified by the region who have not yet achieved permanency. Additionally, the tool is designed to assess the performance of DCF contracted permanency providers relative to permanency teaming, including Wendy's Wonderful Kids, PPSP, and Therapeutic Foster Care Agencies. A sample of cases will be reviewed. Following the completion of the review, findings will be aggregated and shared with the region. It is likely a joint debriefing meeting will be scheduled between the assigned regional staff and leadership and reviewers. It is anticipated the tool will be replicated to provide opportunities for the other regions to assess their permanency teaming practice. These reviews may highlight the need for further practice guidance relative to permanency teaming.

Structured Decision Making

The Department is in process of establishing a contract with the National Council on Crime and Delinquency (NCCD) via the Children's Research Center (CRC) to update the Structured Decision Making (SDM) Tools utilized by the Careline as well as provide technical assistance and support for our Office for Research and Evaluation to conduct a Risk Validation Study of our current SDM Risk Assessment Tool. In addition, the Department intends to adopt CRC's online system to complete the SDM assessments. A train-the trainer approach will be utilized. The contract with CRC remains pending at this time. This will be a major focus of the Department this upcoming year. The Department intends to update all the SDM tools, definitions and policies, as well as invest in a comprehensive QA system, training (integration into case practice), coaching, and analytic reports pending funding availability.

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 4 children are placed in out of state residential facilities.

Efficient Use of Congregate Care

The number of children in congregate settings has approached the 10% goal and the department has remained committed to having as few children in congregate settings as possible. 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), continued service expansion in the community 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 June 2017:

- The Department has experienced a 6.5% reduction in children in placement
- The percentage of children in Congregate Care decreased 64.6%. The number of children in congregate care is 11.3%.
- The percentage of children age 7-12 in placement has reduced by 75.9%.
- The percentage of children 6 and under in placement has reduced by 94.7%
- The percent of youth in state care who live with a relative or kin has increased from 21% to 40.6%.

Limit the use of OPPLA

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

- Utilizing the permanency roundtable methodology
- Developing and implementing an OPPLA protocol
- Working group to further limit the use of OPPLA both in practice and statute
- Implementation of a Child and Family Permanency Teaming approach that puts the youth and family in the center of the teaming process
- Assignment of Permanency Exchange Specialists (PES) to youth with OPPLA as a plan to support Regional work to identify a permanent resource for the youth
- In November and December 2016 3-5-7 Model permanency training was offered to congregate care and private foster care providers. The goal of this training was to engage them further as partners in finding permanent resources for all youth in the Department's care. Monthly 3-5-7 Model Coaching sessions are being held for providers who have children who are "stuck" in care and/or lack viable permanency goals.
- Utilizing a national consultant to conduct a permanency workshop with teams of youth, their Social Worker and Clinician at the Department's only secure facility for boys adjudicated delinquent and committed to the Department.

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

Trauma Informed Continuum:

DCF was awarded the CONCEPT Trauma grant and we are in 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 has incorporated the training in preservice training for new hires.
- 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 continue to 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.
- Working in partnership with Yale and the Child Health and Development Institute (CHDI) a 10 item screen has been embedded into the Multidisciplinary Evaluation to be completed for all children 7 and above when they enter care. For younger children there is a separate screening tool that asks questions of the caregiver.
- 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 Child and Family Traumatic Stress Intervention, and Cognitive Behavioral Intervention for Trauma in Schools (CBITS).

Relative/Kinship Care

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

Results of these coordinated efforts and expectations are clear and demonstrate consistent increases in placing children with relative and kin when possible.

Relative and fictive kin placements have increased by over 20% between January, 2011 and June,

2017. As of June 1, 2017, 41.6% of children in placement are with relatives and fictive kin. The Department has also been monitoring the rate of initial placements with relatives and fictive kin – in 2011 24.3% of children entering care had an initial placement with a relative or fictive kin. In 2016, 37.7% of children entering care had an initial placement with a relative or fictive kin. The Department also saw an increase in the total number of licensed relative and fictive kin homes from January, 2011 to May, 2017, from 669 to 1071. During 2016, the Department licensed 746 relative and fictive kin homes. While, 541 relative and fictive kin homes were also closed during that same time period, the largest reason for closure is permanency (child is reunified, adopted or guardianship is transferred).

Permanency Resource Exchange (PRE)/

In 2015 there were 53 pre adoptive families available and today there are 51 available to these children as potential resources. We believe these numbers could be dropping due to the increase of staff resources to license relative and fictive kin families as well as area offices utilizing pre-adoptive families as foster care resources.

In 2016 the PRE was requested to match for 510 children. 226 of these were single children; 196 were part of 98 sibling groups of 2; 51 were part of 17 sibling groups of 3; 32 children were part of 8 sibling group of 4 and 30 children were part of 6 sibling groups of 5.

Photo listing on AdoptUsKids website, A Family for Every Child website, and on the DCF website occurs for any child who is legally free for adoption or for whom the Court has granted the permission to photo-list. The PRE also contracts with a local video production company to create compelling videos of the children waiting for adoptive families. These videos allow families to view the children and hear about their stories in their own words.

4. Service Description

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

The following chart represents our Services Continuum:

Adolescent Community Reinforcement Approach / Assertive Continuing Care (ACRA-ACC) – This is an evidence-based outpatient behavioral therapy for substance using adolescents and their caregivers. When the recovery goals are attained through ACRA, the adolescents can then be referred to the recovery support ACC portion of the service. ACC also provides case management services to assist with accessing other needed services.
Category: Family Support service
Population Served**:** Substance using youth between 12-17 years old
Geographic Area**:** Statewide
Estimated Families Served**:** 432

Adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) – Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Adopt A Social Worker - This is a statewide, faith based outreach service linking an "adopted" DCF Social Worker with a faith-based or other "covenant organization" to assist with meeting the basic material needs of DCF involved families (those with protective service Social Workers as well as foster, adoptive and kinship care families). Meeting the needs of children with, for example, beds, cribs, clothing and household furnishings, will help achieve stabilization of families and permanency for the children.
Category: Family Support and Family Preservation services.
Population served: All DCF involved Families
Geographic area served: Statewide.
Number of children and families being served: CY 15: 20,504, Children, 6,834 Families. CY 16: 13,309 children, 4,436 families

Be Responsible Be Proud - This service is designed to provide statewide sexual health education for youth involved with the child welfare & juvenile justice system or, to youth who have specialized behavioral, emotional or academic needs.

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

Category: Family Support Services

Program uses the 4 family focused fluid stages of Hello, Help, Healing and Hope.
Population served: Families with a youth with a behavioral health diagnosis. ICC's work with youth that are DCF involved.
Geographic area served: Statewide.
Number of children and families being served: Estimated Families 2012(511)-Actual Children (2012) 1,021. Estimated Families 2013(561)-Actual Children (2013) 1,122 Estimated Families 2014(608)-Actual Children (2014) 1,215 Estimated Families 2015(595)-Actual Children (2015) 1,189 Estimated Families 2016(694)-Actual Children (2016) 1,387 Estimated Families 2012(511)-Actual Children (2012) 1,021 Families 2016(3,500) - Children (2016) 7,025.
Projected to be Served 2017: 714 Families and 1,427 children
Projected to be Served 2018: 754 Families and 1,506 children Funding State and Federal

Care Coordination (Medical Model) This Medical Model links children who have special health care needs and their families to services beyond traditional health care resources. Care Coordination ensures collaboration with schools, mental health services, social services, and other community based programs to develop and implement strategies to integrate Primary Care and Behavioral Health services. The referrals are generated from the hospital department with priority given to the ED. The staff will provide care coordination services that are family-centered and culturally and linguistically competent. They will conduct needs assessments and develop Plans of Care with an emphasis on communicating with the Primary Care Provider, specialty medical providers, mental health providers, ancillary staff, and insurance providers to facilitate appropriate care.

Category: Family Support Services

Population Served: Children ages 0-18 with mild-moderate emotional/behavioral challenges; who have been recently discharged from the emergency department with a disposition to return home

Geographic Area served: 33 cities and towns served by the Connecticut Children's Medical Center

Number of Families served: 192 screened and assessed each year

Funding: State and Federal

Care Management Entity – this service is 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 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.

Caregiver Support Team - This service is designed to help prevent the disruption of foster placements and increase stability and permanency by providing timely in-home interventions with a child and family. For kinship families, this intensive in-home service is provided at the time the child is first placed with the family. The service will be available at critical points for the duration of the placement when additional supports are deemed necessary.

The Child Abuse Centers of Excellence - this service including board certified Child Abuse Pediatricians provides an array of expert medical services to children who are suspected of being victims of abuse or neglect and to their families by acting as expert consultants to the Department of Children and Families staff to help ensure the safety and well-being of children.

Category – Family Preservation / Family Support

Population served-Any child who is suspected of being victims of abuse or neglect

Geographic area – statewide

Number of children/families served – 1425 (CY 2015); ~1670 (CY 2016)

Funding – state

Child and Family Traumatic Stress Intervention (CFTSI) - This service focuses on 2 key risk factors (poor social support and poor coping skills) in the aftermath of potentially traumatic events with the primary goal of preventing the development of PTSD.

Child First Consultation and Evaluation - This service ensures provider fidelity to the Child First model which provides home-based assessment and parent-child therapeutic interventions for high-risk families with children under six years of age. To that end, the service delivers training, provides reflective clinical consultation, analyzes data, provides technical assistance, insures continuous quality improvement, and certifies sites that have met Child First model standards.
Service Category: Family Support
Population(s) to be served -Children ages 0-6
Geographic areas: Statewide
Estimated number of individuals and families to be served in 2016: 530

Community Based Life Skills: are a set of skills learned by teaching or by direct experience. These skills are used to handle problems and questions commonly encountered in daily life from adolescence through adulthood. A community based services model focuses on the development and enhancement of the participant's knowledge of essential life skills to promote preparation for adulthood and self-sufficiency. Through program design and content, the model goal is to support and maintain a youth's connection with the community as the youth mature.
This service is intended as a component of a comprehensive case plan. As such, the individual providing this service is expected to collaborate with other service providers toward the implementation of the child or youth's individual case plan.

Category: Family Support.

The population served: committed youths 14 and older in Non Therapeutic Foster Care
Geographical area served: Statewide
Number of children and families being served: 135 people. Capacity 196.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Young Child Adaptation "BounceBack": 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 5-17
Geographic areas: Statewide
Number of sites: 42 Schools

Estimated number of individuals served: 517

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: 5000 calls/year

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

Early Childhood Services - Child FIRST - This service provides home based assessment, family plan development, parenting education, parent-child therapeutic intervention, and care coordination/case management for high-risk families with children under six years of age in order to decrease social-emotional and behavioral problems, developmental and learning problems, and abuse and neglect.
Service Category: Family Support
Population(s) to be served – High risk DCF involved children ages 0-6 with social-emotional, behavioral developmental and learning problems
Geographic areas where the services will be available -Statewide
Estimated number of individuals and families to be served in 2017: 530

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

EMPS – Mobile Crisis Intervention Service - This is a mobile, crisis intervention service for children experiencing behavioral health or psychiatric emergencies. What qualifies as an emergency is defined by the child and their family. The service is delivered through a face-to-face mobile response by trained clinicians to the child's home, school or location preferred by the family, or in rare situations through a telephonic intervention. The response time to the location of the child by the Mobile Crisis clinicians is expected to be 45 minutes or less. Mobile Crisis supports maintaining children in the community with their families and reducing the need for Emergency Department visits or higher levels of care.
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: 2016 = Over 16.000 calls and over 12,000 episodes of care
Projected to be Served: 2017 & 2018 = Serving all calls for Mobile Crisis
Funding: State

EMPS-Mobile Crisis Intervention Service System - Statewide Call Center - This service is the entry point for access to the EMPS Mobile Crisis Intervention Service System for children and youth in the State of Connecticut. The Statewide Call Center receives calls through 211, collects relevant information from the caller, determines the initial response and connects the caller with a Mobile Crisis Clinician in their area. In addition to these primary functions, the Statewide Call Center also collects data regarding calls received, triage responses and referrals to EMPS Mobile Crisis contractors. The Call Center analyzes data and compiles reports for use by DCF, the Statewide Call Center, EMPS Mobile Crisis 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: 2016 = Over 16,000 calls.
Projected to be Served: 2017 & 2018 = Serving all calls through 211 Funding: State

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: CY15 (1109) CY16 (1115). Projected CY17 (1103)CY18 (1102)
Number of Families Served: CY15 (555) CY16 (558). Projected CY17 (552)CY18 (552)

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: 264 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.

First Episode Psychosis – This service will provide early identification of FEP, rapid referral to evidence-based and appropriate services, and effective engagement and coordination of care which are all essential to pre-empting the functional deterioration common in psychotic disorders.

Foster and Adoptive Families 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 Families 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: 272

Functional Family Therapy (FFT) - This service provides intensive in home family focused clinical treatment, family support and empowerment, access to medication evaluation and management, crisis intervention and case management. The service is provided 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 Functional Family Therapy (FFT) model, which includes ongoing consultation and evaluation by the model developers. Length of service averages 4 months per youth and family served. Services include family focused, strength-based, trauma informed clinical treatment, offered primarily in the client's home 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 Children and Families Served: 2015 = 488; 2016 = 503.
Projected to be Served: 2017 = 499; 2018 = 490
Funding: State

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 addition, post-partum classes and support are provided to mothers who return to YCI or arrive having recently delivered.

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: 177 pregnant women in YCI in SFY 16. Estimated number of individuals to be served: 185 SFY17 193 SFY18.

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
Number of Families Served – (2015) 1354; (2016) 1380
Projected to be Served – (2017) 1406; (2018) 1432
Funding - State

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

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. Additional BEYOND CORE elements are included for children/youth needing 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. DCFIE are for children/youth, ages 7 through 19, who are both DCF-involved and also involved in the juvenile justice system.
Geographic Area: Statewide
Estimated Families Served: 89 contracted slots statewide

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 qualifying behaviors under a Family with Service Needs ("FWSN") petition.
Geographic Area: Hartford, New Haven and Bridgeport
Estimated Families Served: 600 contracted slots.

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). This may be in the form of case management services to increase capacity or prosocial interventions to enhance the youth's experience.
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 were referred due to qualifying behaviors under a Family with Service Needs ("FWSN")
Geographic Area: Regional areas of Norwich, Willimantic, Middletown, New Britain, Meriden, Waterbury, Torrington, Danbury
Estimated Families Served: unknown

Juvenile Sexual Treatment (JOTLAB)- This is a comprehensive community based rehabilitative treatment program that serves adjudicated and non-adjudicated male and female youth ages 8 through 17, who have engaged in inappropriate and abusive sexual behaviors. Services include: a comprehensive clinical evaluation; individual psychotherapy – bi weekly for each youth; family counseling – monthly for each child and/youth and their family; psycho-educational therapy groups – twice weekly for each youth; social skill building groups – twice weekly for each youth. This service is a specialized extended day treatment program.
Category: Family Preservation, Family Support, and Adoption Promotion and Support Services.
Target Population: DCF referred children and youth ages 8 to 17, who are appropriate for community-based treatment for problem sexual behaviors.
Geographical Area: New Haven and Milford
Number of Children Served annually: 91

Early Childhood Consultation Project-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 with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) – An evidence-based treatment designed for children ages 7-15. Unlike most treatment approaches that focus on single disorders, MATCH is designed for multiple disorders and problems, including anxiety, depression and posttraumatic stress, as well as disruptive conduct.

Multidisciplinary Team and Child Advocacy Center – 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. In 2014, state statute changed to include that human trafficking cases must have a MDT response. A Child Advocacy Center(CAC) is a child-focused, facility-based program where professionals from many disciplines, including child protection, law enforcement, prosecution, forensic interviewing, mental health, medical professionals, and victim advocates work together as a team to make coordinated, well-informed decisions about the investigation, treatment, case management and prosecution of child abuse cases. CAC's are designed to meet the unique needs of a community. This is where the forensic interview, and sometimes the medical exam, for a victim will be conducted.
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 2016 calendar year over 1,722 cases were reviewed by MDT's in Connecticut.

Multidimensional Family Therapy (MDFT) - This service provides intensive home based clinical interventions for children, ages**9- 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 4-6 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 9-18 years with complex substance abuse and mental health service needs
Geographic Area – Statewide
Estimated Individuals and Families to be served: 916

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. Category: Family Preservation service.
Population Served: Youth ages 9-18 years with complex substance abuse and mental health service needs
Geographic Area – Statewide
Estimated Individuals and Families to be served: 916

Multidimensional Family Therapy (MDFT) Group Home.
This service utilizes the MDFT model in a 4-month in-care setting. Services include intensive clinical interventions for children with significant behavioral health service needs 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 return of the child to the home. Significant behavioral health needs and either alcohol or drug related problems, or are at risk of substance use are main focus areas of this program.
Population Served: Male Youth ages 14-18
Geographical Area: Statewide
Estimated individuals to be served: 32 annually.

Multi-systemic Therapy (MST) - This service is evidence-based and provides in-home treatment for youth with complex clinical, substance using, social, and educational problems. MST emphasizes behavioral change in the natural environment and uses interventions to promote the parent's capacity to monitor and intervene positively with each youth. . 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 the ages of 12-17 (and their parent/caregivers), who presents with a *DSM* 5 diagnosis and exhibit antisocial, acting out, substance using, and/or delinquent behaviors. Eighteen (18) year olds may be admitted on a case by case basis.
Geographic Area: DCF catchment areas in Bridgeport, Hartford, Manchester, Milford, New Britain, New Haven, Norwich, Waterbury, and Willimantic
Estimated Families Served: 212

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: The following DCF Area Offices: 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 substance use by at least one caregiver in the family. Core services include: clinical services, trauma treatment, empowerment and family support services, medication management, crisis intervention, case management and aftercare. Average length of service is 6 - 9 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 substance use related problems.
Geographic Area: The following DCF Area Offices: Meriden, New Britain, Hartford, Manchester, Waterbury, New Haven, Norwich
Estimated Families Served: Annual Capacity: 126

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 have 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 5-7 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.

a. Target Population: Adolescents 10-17.5 years (exceptions for older youth on a case-by-case basis) whose referral is related to problem sexual behavior, where the offending behavior includes an identifiable victim(s), lives with a caregiver who acknowledges there was a PSB, & may have other issues.

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, New Britain, Norwich, Manchester, Enfield, Hartford.
Estimated Families Served: Annual Capacity: 66

Multidisciplinary Examination (MDE) Clinic - This service provides a comprehensive multidisciplinary evaluation including medical, dental, mental health, developmental, psychosocial and substance abuse screening within 30 days of children entering DCF care. A comprehensive summary report of findings and recommendations is completed on each child referred for service and provided to AO staff including social worker and RRG.

Category – Family Preservation / Family Support

Population served – each child placed in an out of home setting

Geographic area – Statewide

Number of children served – 1439 (CY 2015); 1586 (CY 2016)

Funding source – state

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.

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.

Off the Street Mentoring - This service recruits, trains and supervises individual mentors matched who are at risk of being involved in the system but are not currently involved with the Department of Children and Families or on Probation through Superior Court of Juvenile Matters.

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 served SFY16: 158 people. Capacity of 228. Estimated number of individuals to be served: 185 SFY17 205 SFY18

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: 23,935

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

Parenting Support Services – This service is for families with children 0-18 years-of-age to support and enhance positive family functioning. Families receive one or more of the PSS interventions along with case management services using the Wraparound philosophy and process. PSS offers the evidenced-based model, Level 4 Triple P (Positive Parenting Program®) and the Circle of Security Parenting© intervention. Triple P helps parents 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. Circle of Security Parenting (COS) is designed to build, support, and strengthen parents' relationship capabilities so they are better equipped to provide a quality of relationship that is more supportive of secure attachment.

Parent Project – A highly structured, 10-16 week parent training program under the nationally recognized trade mark "Parent Project® and is designed specifically to for parents/caregivers of youth who engage in risky behaviors such as running away, truancy, or pre=delinquent behaviors,

Parent Program (St. Josephs) - This service provides both the General Parenting Program (GPP) and the Dads Are the Difference Program (DAD) for parents involved with DCF. Both programs offer parenting classes and help families connect to needed resources/supports in the community as a means to strengthen families that are at risk of child abuse and neglect by providing parenting education and support. The DAD program is exclusively for fathers.

Parent & Youth Training and Support - The Parent and Youth Training and Support program will deliver training and support to primary caregivers of children with behavioral health and other special needs and to youth with disabilities or those returning from juvenile justice programs or facilities funded by DCF.

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

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 and outpatient substance use treatment. These services are funded by both DCF and DMHAS, for parents/caregivers without medical insurance.
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 for parents and caregivers with a substance use problem byfacilitating treatment and increasing recovery capital.
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, Manchester, Meriden, Middletown, New Britain, Norwalk, Norwich, and Willimantic
Estimated Families Served: Varies (combined capacity with RSVP is 475- 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 with a substance use problem by facilitating treatment and increasing recovery capital..
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, Manchester, Meriden, Middletown, Norwalk, Norwich, New Britain, and Willimantic
Estimated Families Served: Varies (combined capacity with RCM is 475).

Reentry and Family Treatment (RAFT) This service, Reentry and Family Treatment (RAFT) Program, expands the publicly-funded adolescent substance abuse treatment system to provide enhanced Multi-Dimensional Family Therapy (MDFT) services to substance-abusing juvenile offenders being released after a year or more in a controlled environment back to the cities of Hartford, New Britain, Bridgeport, Milford, New Haven, and Waterbury. RAFT will especially target transition-aged youth 16 and 17 years of age who are being newly served by Connecticut's Department of Children and Families (DCF) juvenile justice and adolescent substance abuse treatment system.

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 and Children Served – 614 Families (2015); 1032 Children (2015); 1595 Families (2016); 2066 Children (2016)
Number Projected to be Served – 2576 Families (2017); 3100 Children (2017); 3557 Families (2018); 4134 Children (2018)
Funding - State and Federal

School-based Diversion Initiative – (SBDI) funded by Ct Judicial Branch, DCF and Department of Education. The SBDI model brings training to school staff for recognizing mental health needs, including trauma exposure, and accessing services and supports in the school and community. It aims to reduce the number of children who are arrested for minor behavioral incidents that can be addressed through in-school discipline and access to mental health services rather than formal processing through the juvenile justice system.

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. 36 beds.

Short-Term Family Integrated Treatment (SFIT): This 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.

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

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 housing certificate when needed.
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
Funding Source: State

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: Youth16 or older and Committed Abused, Neglected or Uncared For or Dually Committed to DCF
Geographic Area: Statewide
Estimated Families Served: 26

Supportive Work, Education & Transition Program Juvenile Justice (SWETPJJ) - The Juvenile Justice Supportive Work, Education and Transition Program is a community-based stand alone, staffed apartment program that serves adolescents, age 18 to 24. The program is designed to help high risk young men gain the skills necessary to successfully transition to self-sufficiency in the community**.**

Therapeutic Child Care - This service offers a range of support services for children in a child care facility, including parent-child programs and an after school program. The target population is children ages birth to 8 years old. The primary activity is the teaching of parenting skills as parents participate with their child in the child care setting. With new understanding and skills on the part of the parents, DCF is less likely to become involved and children are less likely to be removed from the home.
Category: Family Support, Family Preservation ,Time-Limited Family Reunification categories
Population(s) to be served: Children aged 0-5 with behavioral issues transitioning to regular day care or kindergarten
Geographic area to be served: Bridgeport, New Britain and Waterbury.
Estimated number of families to be served: Currently the number of children being served is approximately 19.

Therapeutic Child Care Center(Trauma-Informed) This program is designed to promote, develop, and increase the social, emotional development and cognitive capacities of children, ages 2 years 9 months - 5 years who have been adversely affected by abuse and/or neglect, are presenting with behavioral health issues, and require a therapeutic and trauma-informed program to address these behavioral challenges. The program will be housed within a licensed childcare facility and will also offer support services to parents to increase positive behaviors and promote parent bonding. It is the goal of the Trauma-Informed Therapeutic Child Care Center that children will successfully transition to a less intensive educational setting as a result of the services offered.

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.

Therapeutic Group Home - Juvenile Services Girls - This service is a small staffed home within a local community for female youth on parole. 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.

Virtual Academy Education Care Management – Virtual Academy Education Care Management – This service is designed to support a portion of the students enrolled in the Department of Children and Families (DCF) Virtual Academy, a USD2 developed and operated online school for juvenile justice and DCF involved children and young adults needing educational remediation, credit recovery, and credit accumulation. Population Served: Students ages 10-21 who have had school failures, absences, and school challenges. Students will also have a diagnosable behavioral health condition that results in moderate to acute functional impairment and limits their ability to function in family, school, or community activities. The referred students may also have had a temporary or long term incarceration or other school interruption

Geographic Area Served: Hartford, Meriden, Waterbury and New Britain Number of youth Served: 20 annually

Funding: Federal (MHBG)

Wendy's Wonderful Kids - This service is an evidence-based, child-focused model that has demonstrated positive outcomes regarding adoptions of DCF children in the following specialized groups: older children, children with specialized needs, and sibling groups. The contractor will hire an additional Permanency Specialist and develop child specific adoption readiness and recruitment activities to help move Connecticut's longest-waiting children from foster care into adoptive families.

Work To Learn Youth Program - This is a youth educational/vocational program providing supportive services to assist youth, ages 16 - 21, 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 16 to 21.
Geographic Area: .Hartford, Norwich, Bridgeport, Waterbury, and New Haven
Families Served: CY 15 (296) CY 16 (251). Children Served: CY 15 (592) CY 16 (502)

Wrap Around New Haven – Funded by a CMS Innovative Health Grant, this initiative delivers evidence-based, culturally appropriate, integrated medical, behavioral health, and community based services coordinated by a multidisciplinary team.

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

Service Grid

Family Preservation	Family Support	Time-Limited Family Reunification	Adoption Support
Adopt A Social Worker	Adolescent Community Reinforcement Approach / Assertive Continuing Care (ACRA-ACC)	Adopt A Social Worker	Adopt A Social Worker
Care Management Entity (CME)	Adopt A Social Worker	Caregiver Support Team	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Caregiver Support Team	Care Coordination	Community Targeted Re-Entry Pilot Program (CTRPP)	Community Support Team
Child Abuse Centers of Excellence	Care Management Entity (CME)	Crisis Stabilization	Extended Day Treatment (EDT)
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Child Abuse Centers of Excellence	Extended Day Treatment (EDT)	Family and Community Ties
Community Support for Families	Child First Consultation and Evaluation	High Risk Infant Program For Incarcerated Mothers	Foster and Adoptive Parent Support Services
Community Support Team	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Intimate Partner Violence (IPV-FAIR)	Foster Care and Adoptive Family Support Groups
Community Transition Program	Community Based Life Skills	Multidimensional Treatment Foster Care	Foster Family Support
Connecticut ACCESS Mental Health	Community Support for Families	Multidisciplinary Team	Foster Parent Support for Medically Complex

Crisis Stabilization	Community Transition Program	New Haven Trauma Network	Fostering Responsibility, Education and Employment (F.R.E.E.)
EMPS - Crisis Intervention Service	Connecticut ACCESS Mental Health	Outpatient Psychiatric Clinic for Children	Intensive In-Home Child and Adolescent Psychiatric Services IICAPS
Extended Day Treatment (EDT)	Crisis Stabilization	Prison Transportation	Juvenile Sexual Treatment (JOTLAB
Family Based Recovery	Early Childhood Services - Child FIRST	Recovery Specialist Voluntary Program (RSVP)	Multidisciplinary Team
Fostering Responsibility, Education and Employment (F.R.E.E.)	Elm City Project Launch	Reunification and Therapeutic Family	New Haven Trauma Network
Functional Family Therapy (FFT)	EMPS - Crisis Intervention Service	Short Term Assessment and Respite Home	Outpatient Psychiatric Clinic for Children
High Risk Infant Program For Incarcerated Mothers	Extended Day Treatment (EDT)	Short-Term Family Integrated Treatment	Permanency Placement Services Program (PPSP
Intimate Partner Violence (IPV-FAIR)	Family Based Recovery	Therapeutic Child Care	Work To Learn Youth Program
Intensive Family Preservation	Family Support	Therapeutic Foster Care (Medically Complex)	Zero to Three – Safe Babies
Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE	Functional Family Therapy (FFT)	Zero to Three – Safe Babies	
Juvenile Criminal Diversion	Intimate Partner Violence (IPV-FAIR)		
Juvenile Review Board (JRB)	Intensive In-Home Child and Adolescent Psychiatric Services IICAPS		
Juvenile Sexual Treatment (JOTLAB	Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE		
Mental Health Consultation to Childcare	Juvenile Review Board (JRB)		
Modular Approach to Therapy For Children – MATCH	Juvenile Sexual Treatment (JOTLAB		
Multidimensional Family Therapy (MDFT	Mental Health Consultation to Childcare		
Multidisciplinary Examination (MDE) Clinic	Modular Approach to Therapy For Children – MATCH		
Multidisciplinary Team	Multidisciplinary Examination (MDE) Clinic		
Multi-systemic Therapy (MST	Multidisciplinary Team		
MST- Family Integrated Transitions	Multi-systemic Therapy (MST)		
MST - Building Stronger Families	MST- Family Integrated Transitions		
MST-Consultation and Evaluation	MST - Building Stronger Families		
MST - Problem Sexual Behavior	MST-Consultation and Evaluation		
MST for Transition-Aged Youth	MST - Problem Sexual Behavior		
New Haven Trauma Network	MST for Transition-Aged Youth		
One on One Mentoring (OOMP)	New Haven Trauma Network		
Outpatient Psychiatric Clinic for Children	One on One Mentoring (OOMP)		
Parenting Class	Outpatient Psychiatric Clinic for Children		

Performance Improvement Center	Parenting Class	
Physical and Sexual Abuse Evaluation	Performance Improvement Center	
Positive Youth Development	Permanency Placement Services Program (PPSP)	
Recovery Case Management (RCM)	Positive Youth Development	
Respite Care Services	Prison Transportation	
Sibling Connections Camp	Project SAFE	
Short Term Assessment and Respite Home	Recovery Case Management (RCM)	
Statewide Family Organization	Recovery Specialist Voluntary Program (RSVP)	
Therapeutic Child Care	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	
	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	

Spending Plans 2018

Stephanie Tubbs Jones Child Welfare Services-Subpart-I-FFY2018

Services/Activities	**2018 Spending Plan**
Triple P Provider Training	$109,860
Office Assistant Positions (Meriden/Norwalk)	$166,193
JRA Consulting- Racism	$19,650
Joyce James	$45,900
CCMC	$220,500
Central Office Staff (Contract Management)	$118,424
Solnit North Positions	$1,073,787
The Connection	$200,000
KJMB Solutions	$115,000
CT-AIMH Membership	$210
CT Parents with Cognitive Limitation-Annual Meeting/Conference	$4,000

Travel/Conferences	$14,000
Total:	$2,087,524

Promoting Safe and Stable Families- Subpart II – FFY 2018

Services/Activities	**2018 Proposed Plan**
Reunification & TFT Services	$1,173,245
ABH-Community Collaboratives	$284,700
FAVOR: Foster Care Consumer Advocate	$50,000
UCONN -Adoption Enhancements	$300,000
Easter Seals Support Group	$20,000
Adopt a SW program	$95,275
UCONN SSW PIC (FAR/Intake)	$129,420
CT Association for Infant Mental Health	$39,652
NCCD – CRC SDM Work	$22,000
Total	$2,114,292

Chafee FFY 2018

Service Description	Total Funding
Personnel Expenses	$40,757
One on One Mentoring	$257,013
Community Based Life Skills	$398,430
Work to Learn	$528,449
Youth Advisory Board Stipends	$50,000
Total	$1,274,649

ETV (See Section E)

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:

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

The department has 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.

Currently, work has been completed on 90% of programs.

Tier System Classification of Contracted Services:

Tier System Classification of Contracted Services: The Department of Children & Families (DCF) is committed to obtaining the best outcomes for all its funded programs. To that end, in April 2015, the DCF formed a workgroup of internal and external stakeholders to work to develop a Tier Classification System that aligned several areas of work within the Department and formalize existing practices used to assess program performance. After several months of collaborative work, in December 2015, the DCF Tier Classification System was finalized and disseminated out to all DCF funded providers. Additionally, informational sessions were held at various non-profit Trade Association meetings and DCF Area Offices throughout the process to ensure adequate communication of this system to all stakeholders.

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

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

6 Domains (20 items):

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

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

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

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

Tier III: A program is classified as Tier III if any one of the applicable foundational requirements and/or

five or more of the elements of performance in the six domains are not met.

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

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

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

NOTABLES:

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

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

Credentialed Services

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

- After School Services: Clinical Support for Children
- After School Services: Clinical Support for Youth
- After School Services: Traditional

- After School Services: Youth
- Assessment
- Assessment: Perpetrator of Domestic Violence
- CHAP Case Management (open to current CHAP providers only)
- Community-based Life Skills
- Supervised Visitation
- Support Staff
- Temporary Care Services
- Therapeutic Support Staff
- Transportation: General Livery
- Transportation: School

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

In October 2015, staff overseeing the credentialing program joined with staff in the Department's licensing unit to develop a site visit protocol specific to each services type. Beginning with Therapeutic Support Staff, the most frequently used service, a site visit team including licensing staff, a regional representative, a central office program manager and the vendor's manager of credentialing, visit the provider's service site or office. On site, they review client records, policies and procedures and general operations of the service. Site visit reports are shared with the provider within 30 days of the visit. In addition, site visits may be conducted if a complaint is filed regarding the service that warrants on-site investigation.

<u>The Contract Management Unit Website (Share Point):</u>

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

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. While the Department knows that young children, as national data supports, have a great risk for maltreatment, the agency is mindful of the possible interpretation and meaning of these data when cross-tabulated by race and ethnicity. The Department continues to review its work and data through a racial justice lens and recognizes that there are myriad factors that may contribute to these results, and thus must be thoughtful in terms of the inferences and conclusions that may be drawn.

AGE GROUP	DEMOGRAPHIC	VICTIMS	POPULATION	RATE/1000
0 - 3	ALL	2710	159583	16.98
	MALE	1384	81626	16.96
	FEMALE	1300	77957	16.68
	Hispanic	978	37658	25.97
	Non-Hispanic, Black	578	17597	32.85
	Non-Hispanic, White	854	87513	9.76
	Non-Hispanic, Other	300	16815	17.84
4 - 17	ALL	5499	657432	8.36
	MALE	2808	336570	8.34
	FEMALE	2668	320862	8.32
	Hispanic	1924	122482	15.71
	Non-Hispanic, Black	1167	71506	16.32
	Non-Hispanic, White	1965	412201	4.77
	Non-Hispanic, Other	443	51243	8.65
0 - 17	ALL	8197	817015	10.03
	MALE	4046	418196	9.67
	FEMALE	4102	398819	10.29
	Hispanic	2899	160140	18.10
	Non-Hispanic, Black	1742	89103	19.55

	Non-Hispanic, White	2816	499714	5.64
	Non-Hispanic, Other	740	68058	10.87

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

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

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

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

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

to implement concrete actions to ensure comprehensive assessments for DCF involved families with children ages 0-3.

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

CT is currently implementing the Eckerd Rapid Safety Feedback® (ERSF) model, a unique qualitative process that relies on real-time data analytics to flag high-risk child welfare cases for intensive monitoring and case worker coaching. This model was highlighted in a report by the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF).

CT is one of five states working with Eckerd to custom-tailor the model to meet our distinct child welfare challenges and priorities. CT is also participating in a formal evaluation process including other states currently implementing the model.

Predictive analytics provided by technology partner Mindshare Technology highlights the presence of high-risk cases based on a problem statement. Mindshare's software also provides the capability to mine data along with real-time dashboards that can be used to help ensure accountability for identified safety actions and quantify improvements in case practice over time.

To date over 430 cases have been identified for a review (implemented 10-3-16). Five Clinical Social Work Associates and two managers are part of the review process outlined by the model.

DCF lead efforts to develop a public health campaign that launched in 2016 to raise public awareness of topics relevant to preventing child abuse and maltreatment. These campaigns initially focused on safe sleep and abusive head trauma were widely disseminated to hospitals, health care facilities, child care facilities, home visiting programs and other social service programs. Materials for the "Chill Daddy" and safe sleep campaigns are also available for download and printing through the Office of Early Childhood's website. This campaign is supported by a public-private collaboration of the Connecticut

Office of Early Childhood, Department of Children and Families, Department of Public Health, Department of Mental Health and Addiction Services, Office of the Child Advocate, Casey Family Programs, Connecticut Hospital Association, Day Kimball Hospital and Yale New Haven Health Systems.

Services for Children under the Age of Five

Child First

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

Child First currently has annual capacity to serve 1,031hildren and their families per year in CT through MIECHV, DCF, federal grants, and philanthropy. Funding. Across all sites, 45% are open DCF cases, and an additional 25% have past DCF involvement. Child First affiliate sites were strategically placed in all DCF Regions such that there is an affiliate serving each DCF Area Office. Even with active triaging of children and families to other less intense services, the waitlist for Child First Services always remains around 300 children statewide. With an average length of stay of eight months, significant improvement (.5 SD or greater) is noted for DCF children: 77% in at least one area, 59% in at least two areas, and 52% in at least three areas.

Highly statistically and clinically significant improvement is noted in each area among DCF children with problems at baseline. (Note: Cohen's d is "effect size," which represents strength of clinical impact. 0.2 is small, 0.5 is moderate, 0.8 is large, over 1.0 is very large.)

- Decrease in child behavioral problems ($p<.0001$, Cohen's $d=0.71$)
- Improvement in child social skills ($p<.0001$, Cohen's $d=0.96$)
- Improvement in child language development ($p<.0001$, Cohen's $d=0.85$)
- Strengthening of the parent-child relationship ($p<.0001$, Cohen's $d=0.96$)
- Decrease in maternal depression ($p<.0001$, Cohen's $d=.82$)
- Decrease in parenting stress ($p<.0001$, Cohen's $d=1.15$)

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

Child First continues to plan a second randomized trial (RCT) that will include a broader age range (to age six years), across multiple sites in CT (and perhaps in North Carolina and Florida), including additional outcomes, and following longitudinally with administrative data. This will be funded by philanthropy. Child First has continued to receive multiple inquiries from states across the country interested in working with these very vulnerable young children and their families.

<u>The Early Childhood Trauma Collaborative</u>

The Early Childhood Trauma Collaborative (ECTC) is a 5-year initiative awarded to the Child Health and Development Institute (CHDI) by SAMHSA as part of the National Child Traumatic Stress Network to expand trauma-specific services for children age birth to seven in Connecticut. ECTC is a collaboration between CHDI, the Office of Early Childhood (OEC) the Department of Children and Families (DCF), 12 community mental health agencies, and the Consultation Center at Yale University (evaluator).

The mission of ECTC is to develop a more trauma-informed early childhood system of care to improve outcomes for young children suffering from exposure to trauma through enhanced early identification and improve access to trauma-focused evidence-based treatments (EBTS). This will be accomplished

by disseminating or expanding access to four EBTs for young children and their families: Attachment, Self-Regulation and Competency (ARC); Child Parent Psychotherapy (CPP), Trauma Affect Regulation: Guide for Education and Therapy (TARGET: for caregivers), and Child and Family Traumatic Stress Intervention (CFTSI). ECTC will also provide training to a range of professionals who serve young children in order to improve their knowledge about childhood trauma and ability to identify and refer children to trauma-focused assessment or treatment when indicated.

Mental Health Consultation to Childcare

CT's **Early Childhood Consultation Partnership (ECCP®)**, Advanced Behavioral Health, Inc., funded by DCF, is a nationally recognized, evidence based (three random control trials) early childhood mental health consultation program designed to meet the social-emotional needs of infants, toddlers, and preschoolers, ages 0-5 and children Birth to 72 months (6 years old) for DCF children in Foster Care with challenging behaviors and/or social and emotional needs. Services may also be provided to DCF-involved women and their children housed in substance abuse residential programs. The geographic area served is statewide.

Mental Health consultation is an intervention that builds the capacity of families, providers and systems by offering support, education and consultation to promote enduring and optimal outcomes for young children.

This project has 24 full time mental health consultants, including 5.5 FTE funded by the CT Office of Early Childhood. 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 consultants 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 program's 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 2016, ECCP has served 3,015 children with classroom services and individually, 222 centers and 789 teachers and assistant teachers. 100% of children who received Child-Specific services were not suspended or expelled at the one-month follow-up visit after completion of services.

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

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

- ECCP Program Director Elizabeth Bicio, LCSW was identified by Georgetown University and the National Office of Head Start as an expert leader in the field of IECMHC and through Advanced Behavioral health (ABH) was selected to contribute to national learning materials and to work as a part of a national expert panel to begin to establish a set of national Early Childhood Mental Health Consultation (ECMHC) competencies to guide the work in the field.
- ECCP was invited, by the Early Childhood Development Administration for Children and Families U.S. Department of Health and Human Services to present at the BUILD Conference in July 2015, the presentation session focuses on how states can support children's social-emotional and behavioral health and prevent detrimental practices like expulsion and suspension in early childhood settings. CT focus is on the ECCP early childhood mental health consultation model across early childhood settings as well as a brief overview of Connecticut's new policy on expulsion and suspension practices in early learning settings.
- ECCP was profiled in a national project "Learning about Infant and Toddler Early Education Services" (LITES): Identifying What Works and Advancing Model Development. The project was conducted for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services. (March 2016)
- ECCP was selected by the Substance Abuse and Mental Health Services Administration (SAMHSA), HRSA Health Resources and Service Administration (HRSA), Administration for Children and Families (ACF) and the Education Development Center, Inc. (EDC) to join the national expert leadership team for the Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC). The Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC)

Training and Technical Assistance is managed through a contract between the Substance Abuse and Mental Health Services Administration (SAMHSA) and Education Development Center, Inc. (EDC).

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

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

The purpose of this service is to decrease involvement with Child Protection and ensure infants are with family. In SFY 15, 100% of babies were placed in non-DCF care. The service provider struggled with service provision subsequently the number of babies being place in DCF care began to increase. In SFY 16, 74 % (15 of 27 total) of the babies born were placed in DCF care.

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, ages 2.9-5, 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 Department currently funds two therapeutic child care programs, Bridgeport (ABCD) and New Britain (Wheeler/YWCA) to capitalize on young children's resilience by utilizing **The Center for Social Policy's Strengthening Families Approach and Protective Factors Framework http://www.cssp.org/reform/strengtheningfamilies/2014/ The-Strengthening-Families-Approach-and-Protective-Factors-Framework_Branching-Out-and-Reaching-Deeper.pdf** and the **Attachment, Self-Regulation and Competency (ARC) treatment framework** (Blaustein & Kinniburgh 2010; Kinniburgh et al. 2005). These therapeutic childcare settings take a family-centered approach in which families and professionals collaborate to improve outcomes for children, and in particular, facilitate children's transition to a less intensive early care environment.

The greatest number of admissions were boys. In addition, Black and Hispanic boys and girls were referred/admitted more often than children of other ethnicities. Externalizing behaviors are more likely to result in a referral which may help to explain why boys are referred more often than girls. The Gatekeeper's Screen has been revised to capture internalizing behaviors.

CT Association for Infant Mental Health

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 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.

The eight full day training series has, of this year, been delivered to DCF staff and Community Providers in all six regions. The training's focus is on working with young children and their families who are dealing with unresolved loss and trauma and how that impacts relationships, particularly their relationships with their infants and toddlers. The topics will be related to the Competencies for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

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

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

Circle of Security Parenting (COS P)

Circle of Security Parenting© is a manualized, DVD-based, eight-session, attachment-centered parent education intervention. It is being provided statewide in English, Spanish, and French. Circle of Security

Parenting (COS P) equips parents and other attachment figures (teachers, caregivers) with some basic relationship capacities that help them provide a quality of relationship with infants, toddlers, children, and students that builds, supports, and strengthens secure attachment. This is crucial because it is within quality relationships that various capacities needed by kids to thrive in life are built. These capacities include curiosity, self-regulation, perseverance, joy of learning, connectedness, empathy, self-motivation, impulse control, comfort using power, and trust. Parents, educators, and caregiver learn to view children's behavior from a secure base and safe haven perspective and then identify the children's underlying need being communicated by the child's behavior. COS P equips parents, teachers, and caregivers to reflect on children's behavior, reflect on their reaction to the children's behavior, and reflect on the parenting they received in their own childhood. The capacity to reflect is essential to building a child's secure attachment. COS P also addresses two forces that are crucial to kids being equipped to thrive in life. One force is the desire in every child to explore their world. The other force is the need to be welcomed in when experiencing distress. COS P helps parents be able to recognize and support both of these forces, which is highly supportive of children's healthy development. They also learn about the importance of repairing ruptures in relationships and how to do that.

The population served includes parents with children 0-12 years of age. Priority is given to parents involved with DCF. Caseload permitting and in consultation with the DCF area office, providers may serve parents referred by other community providers. Some programs have expressed interest in using COS P with parents of adolescents as they view the relationship tools gained from COS P very applicable parent relationships with their adolescents. The estimated number of families to be served annually is not known yet since the first COS P training for staff and supervisors was held in March 2016.

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

Over 1000 staff from CT have been trained in COS P. Interest continues to grow and will result in five trainings being offered in CT this year, including a training in Spanish.

Progress in this past year includes the following:

Communities

- More communities are becoming interested in building capacity to offer COS P in their communities, including Groton, Marlborough, Bristol, Manchester, and Enfield. New Haven and Middletown continue to build capacity to offer COS P and are interested in supporting COS P facilitators' capability by having some facilitators trained as fidelity coaches. New Haven and Middletown are also expanding.

Education

- Barbara Stern has developed a one-day day training to help teachers gain and apply an attachment perspective to students' classroom behavior and learning. Nearly 1000 teachers have been trained, and many teachers are reporting it is changing their teaching. This has been offered several times to pre-K and elementary teachers in Middletown Public Schools and in Meriden, CT.
- Approximately 25% of the teachers receiving this training request participation in a COS P group in order to get more relationship tools.
- Middletown Public Schools is offering COS P groups to preschool teachers. This grew out of several preschool teachers receiving Barbara Stern and Pat Howley's training for teachers.
- Susan Averna is a developmental psychologist and former professor at Trinity College. She has developed trainings on resilient classrooms and resilient students.

Licensed Family Child Care

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

Foster Parents

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

Intimate Partner Violence Program

- Over 20 staff from the Intimate Partner Violence Program were trained in COS P in fiscal year 2017.

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

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

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

- NFN approved the use of COS P as a group parenting intervention several years ago. Several NFN programs are currently doing this.
- A small group of NFN home visiting staff from the Fair Haven Community Health Center's (FHCHC) NFN program were trained in COS P and use in as part of their in-home intervention. FHCHC is also working to make COS P available to parents in their health center.

Birth to Three (statewide early intervention program)

- Staff from several Birth to Three Program have been trained in Circle of Security Parenting. Staff are using COS P with a variety of families including parents with differing needs and children with special needs.

Churches

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

Integration within Agencies

- Klingberg Family Centers has 30-35 mental health clinicians trained to offer COS P. They are working to integrate COS P into their agency have been offering COS P groups for staff, including clinicians, managers, and administrators. They have added a 90 minute overview of COS P to their new employee orientation. They are now using concepts from COS P to strengthen their supervision of their clinicians. They are reporting that families are successfully completing treatment quicker in their Child Abuse Treatment Services since they added COS P.
- We have several other agencies that are working to have all staff complete a COS P group so they have a shared attachment perspective of parent-child relationships and children's behavior and a shared attachment-rich language for communicating about family struggles and child behavior.
- Several agencies from DMHAS' Young Adult Services are now offering COS P groups for staff as a way to integrate COS P into their agencies.

Pediatricians

- All three pediatricians and all of the office staff from Rocky Hill Pediatrics received COS P. They report more trust and improved parenting with their own children. One of the office staff will be trained in COS P and will start a COS P group in their office next fall.
- Middletown is letting local pediatricians know about COS P and availability of COS P groups for parents.

Child First

- Child First has trained many of its staff members to use COS P. Sites are offering COS P to parents on their wait lists. The remaining Child First staff not trained in COS P will be trained in COS P this summer.

Child Welfare

- One of the DCF regions has begun an effort to integrate COS P into their work with families and as a way to build caseworkers' capacity to engage with parents.

Other Innovations

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

Systems Thinking

- While the initial focus has been on building capacity in CT communities to offer COS P to parents, the use of COS P has been expanding to reach educators, including preschool teachers, and family child care providers. This is expanding the capacity and opportunity for kids to have quality relationships not only with their parents but also with their teachers and other important caregivers.
- COS P is being viewed not just as an intervention that results in improved behavior, but, more importantly, it is equipping parents, teachers, and caregivers with new relationship capabilities. These relationship capabilities allow them to provide a better quality of relationship with infants and children that best equips them with the personal and relational capacities needed to thrive in life. These capacities include curiosity, self-regulation, perseverance, joy of learning, connectedness, empathy, self-motivation, impulse control, comfort using power, and trust.
- Quality of relationship is particularly important within an infant/child's family because it creates the foundation for children's future development. Infants and children with a secure attachment have a strong, secure foundation for future development. Infants and children with an insecure attachment have a weakened or even quite damaged foundation that limits or even severely damages their future development.
- We are beginning to view communities and families from an attachment perspective. All infants and children have relationships with their parents. However, a large number, 40% or even more in higher risk communities, of these relationships are not of the quality that best equips and supports infants and children to thrive in life.

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

Connecticut Elm City Project LAUNCH Framework

The purpose of Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is to promote the wellness of young children ages birth to 8 by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. The long-term goal of Project LAUNCH is to ensure that all children enter school ready to learn and able to succeed. Project LAUNCH seeks to improve coordination across child-serving systems, build infrastructure, and increase access to high-quality prevention and wellness promotion services for children and their families. The grant targets the New Haven Dwight Neighborhood with a plan to expand to other communities in the New Haven area.

CT-ECPL will focus on addressing the seven priority goals, listed below, that will aid in the development of a comprehensive system of early childhood supports and services for children birth to eight years and their families. The following are local and state updates relative to each ECPL goal. The data provided represents Year 2 of the grant.

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

- Fully incorporated developmental screening in three pediatric practices within New Haven, with efforts to expand to a fourth pediatric practice.
    - Includes training, screening, and referral coordination
    - Local pediatric practice now conducts universal developmental screenings during routine well-child visits

  For FFY 2016:
    - 473 children were screened; 83% of children had positive screens and were connected to services
- Collaboration with Christian Community Action Agency (CCA), a local homeless shelter in New Haven, CT
    - All shelter staff received training around the importance of developmental screening and early identification and in the administration of the ASQ.
    - Intake process inclusive of developmental/mental health screening and screening for maternal depression
- LAUNCH clinician conducted training in ASQ administration to local home daycare providers
- MOMS Partnership: Inform families about available resources in community based on needs identified.

For FFY 2016:

- 177 caregivers were screened for depression either in a local homeless shelter or through Mom's Partnership; 90% of caregivers had positive screens and were connected to services
- 67 children were screened in a homeless shelter or childcare setting; 28% had a positive screen and were referred for services

- Collaboration/participation with state level partners to align goals and to support developmental promotion, screening, surveillance, and timely linkages to services.
  - ECCS: help me Grow Advisory Group
  - SHP: Developmental Screening Workgroup

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

- Coordinated three Meet/Greet opportunities between local home visiting programs and pediatric practices to facilitate referrals and linkages in community
- Two pediatric practices engaged in EPIC trainings, targeting developmental and mental health screening
- Clifford Beers Clinic exploring opportunity for Mental Health Clinicians to become embedded within local pediatric practices
  - Designed to enhance sustainability of screening efforts and promotes prevention and early detection
- Coordination with the Maternal, Infant and Child Health (MICH) Coalition designed to promote screening and assessment
- Developing a tool to enhance communication between home visitors and pediatric practices

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

- Ongoing training opportunities for Home Visiting providers on Infant Mental Health (6 day training series)
  - Completed 2nd IMH Training Series in October 2017
    - 33 participants attended, representing 11 different programs
  - Added a 6th day to Infant Mental Health (IMH) Home Visitors Training on topics of self- care and self-awareness
- LAUNCH awarded 7 scholarships to local Home Visitors for IMH Endorsement
- Current waitlist for training demonstrates need and success of the series
- 12 local clinicians receiving TI-CPP training (18 month training series)
- Linked local Nurturing Families Network providers with Pediatric Practices focusing on Infant Mental Health, Maternal Depression, and accessing services
- Collaborated with local and state home visiting staff to identify gaps and barriers that impede collaboration between home visitors and pediatric health providers
- Developed a survey for pediatric health providers to improve communication between home visitors and pediatric health care providers

- Successful collaboration with CT Home Visiting Consortium and CT-AIMH Professional Development Workgroup

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

- Early Childhood Consultation Partnership (ECCP) provides child-specific intervention, core-classroom services, and intensive center-based services in early care and education settings within New Haven community.
    - ECCP provided training, core classroom and child specific services to 3 New Haven Schools
    - Securing NH school sites has presented challenges given competing initiatives and priorities. Site has been identified for next year. MOUs are currently being written.
- Testing feasibility of expanding the ECCP model to older children, K-3 to create a complete birth to age 8 early childhood mental health intervention.

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

- Connected with local provider to conduct Adult English as a Second Language and GED classes to parents in the New Haven community, inclusive of Health and Wellness
- Collaboration with School Based Resource Center of Troup School located in the Dwight Neighborhood
    - Connecting families to social/emotional support agencies in New Haven including MOM Neighborhood
- Mom's connecting families to social/emotional support agencies in New Haven including MOM's Partnership
- Mom's Partnership provides increased case management opportunities for families through LAUNCH and offers skill building classes and workshops (Stress Management and Work Readiness classes)
- State agency collaboration to share strategies for increasing parent participation on infant/early childhood advisory groups
- Sharing/exchanging information at the local and state level with local parents and providers
- Recruited parents to serve on the CT-ECPL Local & State Young Child Wellness Councils
- Beginning January 2017, Circle of Security Parenting groups offered at Clifford Beers Clinic with local parent serving as co-trainer
- New Haven Early Childhood Council (NHECC) is committed to engage parents in a meaningful way
    - Survey conducted to gather information about authentic family engagement/involvement and identify best practices
- Parent Wellness Group focusing on Eight Dimensions of Wellness
    - Functioning as "Ambassadors" in their community
- New Haven Early Childhood Council applied and received the Race Equity Exploratory Grant
    - Members participated in Beyond Diversity Training
- Parents providing consultation to LAUNCH's public awareness campaign
- Concerted efforts to engage and involve parents at the state level in YCW Workgroup

- Collaboration with the Early Childhood Alliance

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

- Local Wellness Coordinator secured endorsement as an appointed member of the New Haven Early Childhood Council
- Recruited parents/caregivers representing the target population to serve on the New Haven Early Childhood Council
- Local LAUNCH team have met with over 50 community-based providers to discuss opportunities to align and expand reach of current programs
- The New Haven Early Childhood Council involving parents in a substantial, meaningful way. An intern of the local Evaluator conducted research and interviewed parents and LAUNCH staff to identify factors that contribute to parent involvement. The intent is to inform local and state entities around authentic parent engagement. An infographic has been created and shared with state and local committees
- Established partnership with Office of Early Childhood (OEC) to co-lead state planning workgroup
- State Young Child Wellness Workgroup was established as a standing committee of the Early Childhood Cabinet in October 2016. Workgroup is in process of identifying priority areas in alignment with the goals/strategies of ECPL

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

- Collaborated with United Way to develop a media campaign for Project LAUNCH. A subcontract has been developed to assist in media campaign
- Local participation in shaping the public health campaign.
- Organized parent focus group from local community to identify topical areas to promote the health and wellness of children and their families.
- Interviewed system level workers and clinical providers to inform messaging.
- Media campaign will utilize multiple strategies to increase awareness and understanding of 0-8 population
- A tagline has been finalized "Healthy from Day One". Messages are currently being developed and will be shared with parents, local and state providers to gather feedback.
- Once messaging has been finalized, a local event will be planned to announce campaign

Evaluation: ECPL is assessing outcomes in the following areas:

- Coordinating and integrating primary care, behavioral health and early care/education systems
- Conducting developmental, social/emotional and mental health screenings in homeless shelters, early care settings and supermarkets
- Changes in core knowledge of professionals working with young children as a result of ECPL interventions
- Caregiver capability to assume leadership roles within their local and state community
- Linking and coordinating services and priorities between state/local level entities
- Impact of a social marketing and public awareness campaign promoting child mental health

LAUNCH activities will continue to further the goals and objectives of the grant. Data is being gathered to document efforts. The public awareness campaign, data collection, and work of the local and statewide councils will continue to be areas of focus this upcoming year. In addition, the ECPL core team will update their Strategic Plan and Evaluation Plan and developing/finalizing plans for sustainability.

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.

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.

As of April, 2016, there are over 400 adoptive parents and professionals who 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

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.

Early Childhood Training Series

During the 2016-2017 fiscal year the five day, Early Childhood Development Training "Promoting Health and Wellness for Infants, Toddlers, and Preschoolers in Child Welfare was offered three times. There

were 49 DCF staff and 48 Head Start staff who participated. The series consists of a compilation of trainers from the community, academy and agency subject matter experts who have experience in the topic of child development, poverty, trauma, and brain development. An additional cohort will start in the fall 2017.

The training series has been well received by internal staff and external partners. Below please find examples of feedback received about the training over the course of this fiscal year:

- Training was informative
- Resources provided during the training will be helpful in the field
- Learning about available programs for children 0-5 was very insightful

As a compliment to the training series, a five day webinar series was created and offered to DCF staff and providers. Topics for the webinar included:

- Fathers and Children: The Effects of their Development
- Maternal Mental Health and the 0-5 Population
- Working with Parents with Cognitive Limitations and their Children under the Age of 5
- The Most Useful Tips for Documenting the interactions for the 0 to 5 Population
- What is the Data Telling Us About the 0-5 Population

Staff who participated in the webinars found the information useful in relation to their daily responsibilities.

Staff Training

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

The DCF Academy provides competency-based, culturally-responsive training in accordance with national standards for practice in public child welfare. The Academy encourages staff and its community partners to pursue professional education and to utilize learning opportunities to improve their work with children and families. An array of professional development programs are offered on a regular basis. The Academy offers pre-service preparation to newly hired caseload carrying social workers (Social Worker Trainees) and in-service training to experienced employees. Classes are also made available to community service providers when possible 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.

Internship Programs

The Department is committed to assisting staff with efforts to pursue their education. The Academy for Workforce Development has established joint efforts with several universities and colleges to develop internship and other educational opportunities for all students pursuing educational degrees in the field of social work and other related fields of study. The internship process is coordinated by the Academy and is available for students, both inside and outside the agency.

The following programs are available for existing employees to assist in balancing workload responsibilities and school work:

MSW Field Program

The MSW Field Program grew out of a need for additional staff development opportunities for those DCF employees seeking an MSW degree. 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.

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 provides opportunities to learn to service their clients more effectively with predictably better outcomes.

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. The 2016-2017 cohort of (3) MSW students, who participated in the traditional DCF MSW Field Program, took full advantage of this opportunity to excel in areas providing insight and enhanced service delivery in their area offices. One student explored her own positionality and racial identity and the impact on her case practice and clients. She chose to focus on re-structuring the racial justice committee in her office because it was defunct. She facilitated several group conversations, engaged her office with a case study on positionality and invited external partners to participate in the exercise. Another student utilized trauma theory when working with her caseload and the various human trafficking issues that required a higher level of sensitivity and assessment skills. Her work with human trafficking clients included group and community work in which she presented to the Community and assisted her supervisor with group processes for this vulnerable population. This included completing intake and assessments, running groups, and psychoeducation. The third student was introduced to the restorative justice practices and was able to serve as a conduit and facilitate several meetings within his office. He was charged with introducing restorative justice practices to his local area office and DCF community. He provided several examples through process recordings and a paper in which he held several restorative circles at work and for class assignments.

Through a competitive interview process, in 2016-2017 seven students participated in the program and successfully completed their field placement. In addition to the (3) MSW students who participated in the traditional MSW Field Program; there were (4) MSW students from the University of Saint Joseph's who participated in their Clinical Preceptor model. Field instruction is provided by an outside LCSW field instructor obtained by the school.

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 2016 cohort included three employees that

applied and were accepted. The 2017 cohort will include eight employees located across six area offices and central office.

NCWWI University Partnership

The DCF Academy for Workforce Development, 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 (2014-2017), who are either currently employed at the Department or who will receive priority consideration for employment. Since 2014, 27 students have participated in the CT Partnership; including 7 new students who will become part of cohort 4 in the 2017-2018 academic year. Of the 20 students that successfully completed the first 3 cohorts; 15 are employed at the CT -DCF, 4 are employed by a private CW agency, and 1 student is employed by another public CW agency. All students successfully received employment in either a public or private child welfare agency.

In the current cohort (2016-2017), there was a disproportionate number of DCF staff in the program; four of the six students were DCF staff. We adapted our Field Education model to support the internship needs of 4 DCF employees, who were approved to use their paid positions for their 20 hour/week field placements. We identified and supported 4 senior DCF leaders not affiliated with the interns' work sites to serve as their Field Instructors; and we also maintained connections with their current supervisors as "Task Supervisors". This model worked well for the employed students, who

met weekly with their Field Instructors at sites convenient to their busy schedules. Emphasis was placed on the students' ability to manage demands of high caseloads and requirements of field education. Class offerings at UCONN are generally offered during the week days. This often presents a problem for caseload carrying staff in balancing to workload for school and work. The CT Partnership continues to develop strategies to address this issue.

We also identified specialized field education placements for (2) interns not employed by DCF, matching experience and interest as best as possible. The two field instructors were selected because they had completed The National Child Welfare Workforce Institute (NCWWI) Leadership Academy for Supervisor (LAS) Program. This is keeping in-line with NCWWI's Workforce Development Model, adapted by the agency, to further develop and support supervision and leadership capacity within the agency. The traineeship program participated in group supervision to promote practice change through focused activities around Racial Justice, Teaming, Structured Decision Making and Family Centered Practice.

External Student Internships

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.

The Department of Children and Families offers unpaid internship opportunities for students pursuing a degree in social work or a related field, and for which the internship is an academic requirement. On average, the internship program provides field placements to over 100 unpaid interns, during the academic year, in fourteen area offices. Interns are assigned a field supervisor to provide weekly supervision. Field Supervisors are expected to provide students with activities that meet the students' learning objectives as outlined in a learning contract and / or class syllabus. At times, schools may require the Field Supervisor be certified via the Seminar in Field Instruction (SIFI) course. The field instruction seminar is an opportunity to enhance the supervisor's professional development and designed to provide field supervisors with the knowledge and skills to facilitate a quality educational field experience for students.

DCF Stipend Program

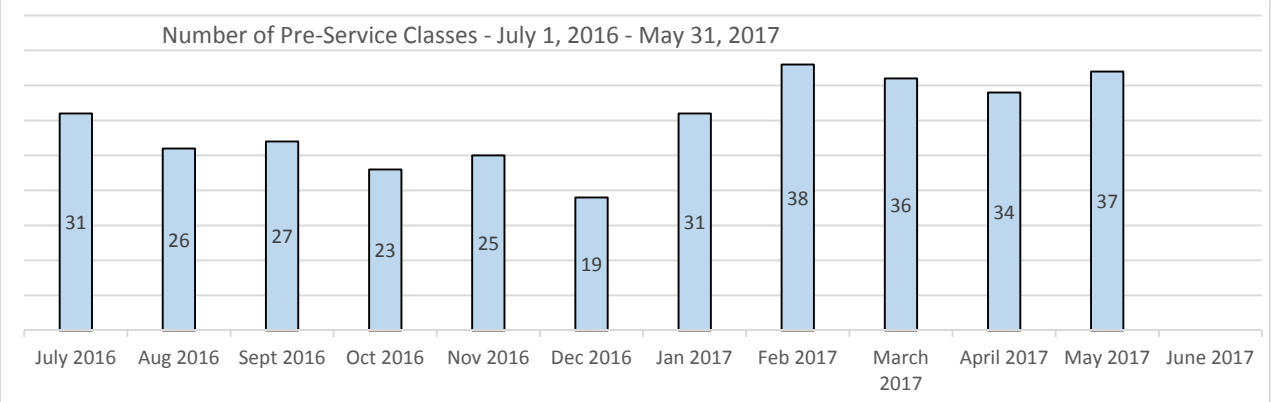
The Department of Children and Families also offers a limited amount of paid internship opportunities for external students pursuing a BSW or MSW degree. In this competitive program, students in their final year of a BSW or MSW program are selected to participate in an internship process in a regional office where they receive orientation, training, supervision, 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. 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 these intern cohorts. This strategy will increase the number of (BSW/MSW) students who apply to the Department and increase the number of qualified applicants being considered for employment. The 2016-2017 cohort successfully graduated 9 (BSW/MSW) students. Efforts are being made to develop a tracking mechanism with Human Resources to identify the hiring status of interns. To date, all interns have been hired or anticipated being hired. One student has deferred applying while she pursues her MSW – Advanced Standing Program.

Training for new workers to ensure competencies

The Academy for Workforce Development continues to offer pre-service training for new social workers who are hired to conduct child welfare related case activities in the regional offices. The pre-service training program is designed to prepare each staff member for effective protective service/child welfare practice. The training is 31 days consisting of 20 course topics. Below please find a chart summarizing the number of pre-service classes held per month for this fiscal year to date.

This past year, the Academy has focused its efforts on training 183 new social workers and 9 case aides hired by the agency. Several modifications to pre-service have been made to improve course delivery and staff retention of information. These modifications consisted of the incorporation of parent partners in one of the classes for the purposes of role playing with staff to highlight the techniques needed to properly engage a family or individual. Additionally, the Academy has strengthened the transfer of learning process with the creation of an on-line discussion board. This discussion board provides a venue for staff to reflect upon competencies and skills gained in class at different intervals of their training. The Academy has also developed and provided to the training supervisors brief power point presentations to review with their staff as supplemental material to some of the classroom curriculum. To date, presentation topics include the role of the foster and adoptive service units, fiscal responsibilities, and permanency/adoption. Training supervisors are encouraged to partner with the appropriate subject matter experts in order to deliver a comprehensive presentation. Additional presentations will be forthcoming.

In recognition of the importance of professional development, 18 of the 20 courses within pre-service training have been awarded continuing education credits. This is of great assistance to those who are pursuing or attempting to maintain their licensure.



The Academy is also in the midst of increasing simulation training to occur in several of the classes including but not limited to engaging families, substance use, intimate partner violence and legal. To date simulation training occurs for car seat training and one of the legal trainings, and has proven to be extremely effective.

In 2016-2017 the Academy staff spent considerable time evaluating the multiple choice test that is administered to the new social workers as a pre-test the first day of training and as a post-test upon completion of pre-service. As a result of the test evaluation, several of the questions were either omitted due to overlap or reworded in order to minimize possible test confusion. In preparation for the final test, two quizzes have been developed and incorporated in pre-service at different intervals of the training. This provides the trainees with the ability to recall information taught and provide clarity and context around different topic areas. As a result of the test reorganization, we have found that pre and post test scores have increased. There will be ongoing analysis of the test and the scores as groups enter and exit the Academy. In addition to the multiple test portion of the training, staff are also required to read narratives from a mock case in order to develop a genogram, complete a risk and safety assessment utilizing the agency's structured decision making tools, and complete a portion of a case plan. Group supervision has also been incorporated into the test day, in order to allow staff the ability to gain skill in presenting cases in a factual yet succinct manner. They learn the value of hearing different voices and opinions in order to move away from the notion of group think. Staff have reported finding this component valuable in their learning and necessary in the process of discussing cases.

It is noteworthy that pre-service training was deemed to be an area of strength during round 3 of the CFSR process.

<u>Social Work Case Aides:</u>

In 2016-2017 the agency hired 9 Social Work Case Aides. These individuals were provided with a training schedule that reflects classes synonymous to their roles and responsibilities and provides them with the opportunity to take courses with social workers. This is all in an effort to provide them with the competencies and skills needed to perform their job. These classes included the following:

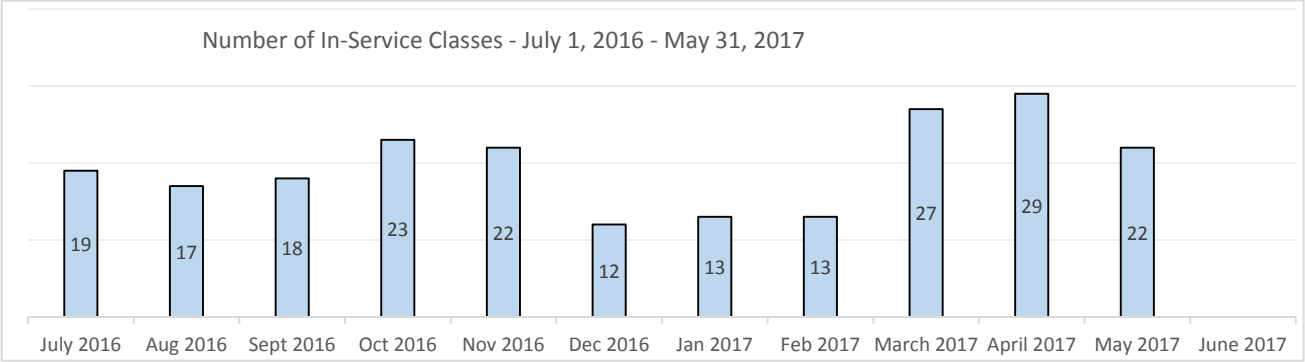
- Introduction to Best Case Practice
- Worker Safety
- Car Seat
- Racial Justice
- Trauma
- Legal
- Documentation/Testifying/Supervised Visits

- The Role of the Case Aide
- Intimate Partner Violence
- Substance use
- Sexual abuse
- Online Mandated Reporter Training

In-Service Training for Staff –

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 a quarterly online catalog, and staff can "self-register" with supervisory approval.

The Academy has significantly increased the numbers and types of training offered to experienced staff. Please see the chart below that summarizes the number of in-service training offered per month to date this fiscal year.



Per agency policy, all staff must attend five days of in-service training annually. Compliance with this policy is tracked during the supervisory process and continues to be emphasized as a significant factor in the professional development process by agency leadership. While significant progress has been made to increase the number of in-service training offered and develop a Learning Management System to manage training data, tracking of in-service training was deemed an area needing improvement during round 3 of the CFSR process. The Department is in the process of designing a new computerized database system, which will allow for enhanced tracking of this policy. The projected launch date of the new system is 2018. Efforts are also being made to encourage supervisors

to better identify training needs and document training completed. To date this fiscal year the Academy offered 215 unique in-service training sessions to staff.

Differential Response System (DRS) Training Series-

From 2015 to the present, the Academy has continued to offer the Differential Response System (DRS) Training Series to social work staff from across the area offices and Careline. The DRS Training Series was offered on three occasions, with 101 unique staff participating. Components of this series included a strong emphasis on the following:

- DRS Best Practices
- Investigation of child sexual abuse allegations
- Legal Issues
- Health & Wellness
- Drug Endangered Children (DEC) Program & Substance Use
- Human Trafficking

During the past year, efforts were undertaken to update the DRS Training Series via focus groups with stakeholders from across the state. As a result of the focus groups, enhancements were made to the Series, including but not limited to, the addition of a full-day of training related to Intimate Partner Violence (IPV); a mock administrative substantiation hearing; and an in-person visit to a Child Advocacy Center (CAC).

During the year, training staff from the DCF Academy also responded to numerous requests from across the state for 1:1 or customized development programs for Intake staff. Formal training sessions were provided regarding the use of Structured Decision Making (SDM) tools; critical thought and assessment; purposeful visitation; early childhood practice; and documentation. Additionally, coaching and shadowing of individual staff in the field occurred.

Life Skills

The Academy for Workforce Development continues to offer a 3 day Life Skills training aimed at preparing adolescents for adulthood. The Academy provides the training for community providers in order to ensure that the process for administering the LIST is properly followed. To date, 235 providers have been trained in this tool. To ensure that trainees are aware of the process, the LIST has also been incorporated into a pre-service class. Most recently, the Academy developed a train the trainer model

that will be offered to providers so that they have the internal capacity to offer training to incoming staff within their respective organizations.

Webinars

The Academy for Workforce Development has advanced in its approach and understands the notion that training presentations and delivery can and should be varied in order to meet independent needs of the learner. In 2016-2017, the Academy focused its efforts on the development and delivery of two webinar series related to early childhood (topics can be found in the section of the Early Childhood Training Series) and fatherhood. Each series is multiple days and incorporates the use of internal agency resources and external partners in order to present the material. Topics included in the fatherhood webinar include:

- Engaging Fathers in a Leadership Role
- Adolescent Fathers
- Incarcerated Fathers

Future considerations for additional webinars will include legal, and substance use.

Adolescent Training Series

The Academy for Workforce Development remains committed to ensuring that staff are knowledgeable in the area of adolescents in order to provide them with the best care and advice necessary for their success. In 2016-2017 the Academy offered three ten-day training series for social workers, supervisors and juvenile justice social workers. To date, 21 people have participated. The ten-day series consists of the following topic areas.

- Adolescent development,
- Post- secondary education,
- Risk taking,
- Permanency
- Substance use
- Teen sexuality and parenting
- Juvenile Justice
- Collaborating with external partners/planning for aftercare

To strengthen the series, two components were added. Staff participating in the series were able to participate in a full day team building at the Wilderness School with identified youth on their caseload. This provided the opportunity for the two entities to build comradery, and plan for the youth's future endeavors. The second addition was the introduction of staff to the Restorative Justice framework

through the use of circles in order to build a community in the classroom. This framework is being introduced to the Connecticut Juvenile Training School, and several residential facilities for the purposes of reducing harm and recidivism. Staff were made aware of this process should they be called to participate in a circle with the youth on their caseload.

Mastering the Art of Child Welfare Supervision

The Academy for Workforce Development continues to offer "Mastering the Art of Child Welfare Supervision" to newly promoted supervisors. In 2016-2017 three cohorts were offered with 41 people participating. The training content includes the following:

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

This training series has proven to assist newly promoted supervisors to become more self-aware and self-reflective of themselves professionally. Many of the discussions allow them to look inward in order to determine how and why they may respond to certain situations or how they make certain decisions. The course utilizes several different inventories that focus on the issue of conflict, empathy, learning styles and power. Many of the participants have found the inventories to be applicable to several facets of the work and it allows them to see themselves from a different vantage point. Supervisors often request assistance from the Academy to provide brief training sessions with their units utilizing the inventories and then facilitate a dialogue around the results. These mini sessions have provided supervisors and their staff with insight and ideas as to how to improve working relationships.

Yale Supervisory Training

The DCF Academy continues to support the critical role supervision plays in child welfare practice, and continues to partner with Yale University to provide a two-day training entitled "Strengthening Supervision."

The "Strengthening Supervision" model includes three phases of supervision (engagement phase, work phase, and ending & transition phase), which encompass four functions (quality of service, administration, support, and professional development). Supervision purpose, content, frequency,

length, and documentation are significant components of the two-day training. Additionally, a large component of the model is grounded in the utilization of group supervision. Group supervision allows for diverse conversation, critical thinking, and effective feedback to play a role in critical case issues.

Twenty six supervisors completed the two-day training this fiscal year. Additionally, Yale consultants provided customized coaching and consultation to supervisory and managerial staff in five divisions and nine offices throughout the state to support continued implementation of the supervision model.

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

In addition to the two-day coaching, Academy staff have embedded group supervision activities into the pre-service and in-service training curriculums, as well as the post-test trainees are administered at the end of their pre-service training. These activities have demonstrated to new staff the value, structure, and benefits of group supervision; and have oriented them to the process in preparation for real group supervision sessions with their units.

Leadership Academy for Supervisors (LAS)

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 second state-sponsored cohort of the LAS began in September 2016 and is scheduled to be completed in June 2017 with an anticipated 20 participants completing the program. Many of the change initiatives proposed by the LAS participants could have statewide

implications for practice. This second cohort of the LAS included coaching for participants, as well as full-day in-person "learning networks" which included relevant guest speakers in leadership positions within the agency.

In-Service for Managers

Throughout this fiscal year, the Academy has continued to offer training opportunities specifically designed for managers. Classes have included Public Sector Management, Managing the Money, and Data Leadership taught by Commissioner-level and Academy staff. This fiscal year 33 unique managers participated in one or more of these classes.

Leadership Academy for Middle Managers (LAMM) - Connecticut Version

In 2016, the Academy continued to offer the Connecticut Leadership Academy for Middle Managers (LAMM). Mirrored after the national leadership program developed by the National Child Welfare Workforce Institute, this program is designed to enhance the ability of middle managers to apply leadership skills to the implementation of sustainable systems change aimed at improving the lives of children and families. This series of facilitated dialogues and structured learning experiences provides 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. Assessing participant's leadership style and strengths is an integral part of the process. The 2016 LAMM cohort completed 4 assessment tools: Disc Leadership Profile, The 360 Evaluation, Strength Based Leadership Tool and Straight Talk Communications Inventory. Each tool provided leaders with essential feedback regarding strengths and areas needed improvement. While each tool had a slightly different approach to assessing strengths, interrater reliability between the tools was quite evident. Participants found each assessment to be an accurate reflection of their performance and in some situations made light of blind spots not readily known.

Participants regularly 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. To further enhance the transfer of learning, each participant is assigned to a "Super Coach" to provide support, leadership and guidance necessary to successfully integrate classroom content into practice and 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. In addition to the classroom experience, coaching and the leadership assessment tools, each participant was offered an opportunity to engage in a mock interview process for a promotional opportunity where they receive immediate feedback on interviewing skills. Participants were also invited to participate in a Professional Feedback Meeting with the Deputy Commissioner and members of the Academy staff to obtain feedback on their overall performance in LAMM.

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. As an example, a Regional Administrator publically recognized a LAMM participant's Change Initiative as the impetus for the significant reduction in youth with the permanency goal of OPPLA in her region. This particular LAMM participant completed the program last year yet her Change Initiative has been sustained and has had an obvious impact not only in the manager's units but to the entire region.

Fourteen additional managers successfully completed the Connecticut LAMM during this fiscal year.

STRIVING TOWARDS EXECELLENT PRACTICE (STEP) – Data Leaders

The Department, in collaboration with Casey Family Programs, has begun implementing STEP—Striving Toward Excellent Practice—Data Leaders, a nine-month blended learning program focused on data-driven decision-making and Continuous Quality Improvement (CQI).

STEP is designed for DCF staff who seek to strengthen their skills in using data through a racial justice lens, to identify problems, research solutions, and collaborate with colleagues and partners. As STEP is a hands-on experiential program, participants are working on DCF Region, Facility or Division specific Change Initiatives to address challenges and improves outcomes for children and families. For this inaugural round of STEP Data Leaders, the curriculum and Change Initiatives are focusing on improving outcomes for children and families in the areas of "Case Planning" and "Needs Met."

STEP was launched this past April. There are 9 Teams (18 total participants) representing five Regions, the Solnit Centers, and three Divisions within Central Office. Many of the Teams have selected Change Initiatives that directly address or are materially related to an area of challenge identified by CT's Round 3 CFSR.

Update on 5 Year Plan

Pre-Service

The pre-service training offered to newly hired, caseload carrying social workers is comprehensive and very well received by staff. Despite this, continued efforts will be made to improve aspects of the program.

1. Ongoing efforts will be made to infuse more opportunities for both online and simulation training. The integration of online training will allow staff to obtain information regarding policy and national best practice standards in that format allowing the majority of classroom time to be spent practicing skills necessary to do the job.
2. The completion of transfer of learning activities continue to be a challenge due to competing work demand of the area office staff. While area office supervisors find the activities to be useful, they often do not have time to implement them. The Academy will continue to facilitate the transfer of learning process by developing useful and realistic activities that can be used without drastically increasing the responsibilities of the supervisors in the field.
3. Currently, the Academy is providing training to new social workers who receive a graduated case assignment. It is not uncommon for a social worker to carry several cases while attending a fairly rigorous training schedule. While the Department remains committed to ensuring that workers have caseload carrying experience while training, efforts are now being explored to frontload the first few weeks of training for social workers without cases, then subsequently move to the graduated case assignment. This will expedite the training process without entirely compromising the value of applying real experience to the classroom setting.

In-Service

In January of 2016, the Academy launched its first online, in-service catalog for DCF employees and providers. The rollout included self- registration which has proven to streamline the entire registration process. Feedback regarding the catalog has been very positive. Efforts have been made to ensure that staff at all levels in the Department have access to a variety of training opportunities.

While the policy and standard around requirements for in-service training is clear, Round 3 of the CFSR rated it as an area needing improvement. This was largely due to a lack of standards and process around tracking compliance of the required training. Efforts are now underway to work with supervisors and managers to improve documentation of completed training. In addition, a new CCWIS will also enhance the ability to track training effectively.

Evaluation of the effectiveness of on-going training also contributed to the rating of an area needing improvements by the CFSR. With this, efforts are currently underway to develop an infrastructure to evaluate the effectiveness of in-service training. Two Academy employees are currently involved with the Striving Toward Excellence Program (STEP) and their Change Initiative is centered around this issue.

Much like the efforts being made to change pre-service training, the Academy is also planning to offer more simulation experiences during in-service training. To date, two in-service classes are offered in that format. Simulation training, when done well, has proven to improve the transfer of learning process. Given the fact that this was deemed an area needing improvement for in-service during the CFSR, simulation training along with the development of an evaluation tool post training will be areas of emphasis for the Academy.

Lastly, the Academy is currently partnering with the Office of Clinical and Community Consultation and Support Division to develop and implement a statewide retraining for staff on Structured Decision Making (SDM). Contract development is underway with a plan for statewide training to begin later this year.

Training Class Descriptions

Appendix 1 summarizes the current classes offered at both the pre-service and in-service level. Efforts to offer these classes along with the aforementioned classes under development will be made throughout the remainder of this review period.

NEW TRAINEE GROUPS

The Academy is in the process of exploring ways to deliver training to New Trainee Groups and continues to coordinate with other divisions of the Department to develop and implement. The target audience of this short term training will be relatives and guardians receiving kinship guardianship payments for providing support and assistance to foster and adopted children. The Academy will collaborate with the prospective trainee groups to develop training for relatives; staff members of State-licensed or State-approved child welfare agencies providing services to children receiving title IV-E assistance; staff members of child abuse and neglect courts personnel; agency attorneys, attorneys representing children or parent; guardians ad litem, or other court-appointed special advocates representing children in proceedings of such courts. In seeking IV-E reimbursement, we will ensure that such training measures are properly allocated according to The Public Assistance Cost Allocation Plan (PACAP).

The Cost Allocation Process for In-Service, Pre-Service, and New Trainee Groups consists of the following:

- Total Department expenditures are assigned into Cost Pools that combine similar expenditure types. This procedure also includes the allocation of expenditures into multiple pools when they don't belong in any single pool. When an allocation needs to be made within a single department to multiple cost pools funded through the same federal award, the allocation is typically made based on staff counts or salary amounts determined based on the judgments of the responsible supervisor. If salary allocations need to be made across more than one federal award or between a federal and non-federal cost pool, appropriate personnel activity reports are used to make that allocation. If an allocation is made based on the salary of staff, an additional allocation is made for fringe benefits and other expenses. The fringe benefit and other expense allocation are typically calculated by applying the same percentage allocation that was used for salaries. (i.e. there is not an attempt to identify the actual fringe or other expense costs associated with the salaries.)

- The Academy courses and hours of instruction are accumulated. This step summarizes hours of instruction that qualify for 75%, 50% and 0% reimbursement. On average the total cost of training at the DCF Training Academy is 3,500,000 per year. Approximately 86% of the Academy pre-service courses are reimbursable at 75% while approximately 14% are reimbursable at 50%. Approximately 38% of the Academy in-service courses are reimbursable at 75% while approximately 62% are reimbursable at 50%.
- Federally reimbursable expenditures are calculated based on allowable costs (from cost pools and the Academy curriculum), allowable children (from eligibility schedules) and allowable activities (from RMTS).

Research Agenda and Institutional Review Board (IRB)

ORE has developed a Research Agenda, which summarizes the Department's research needs and interests in child welfare. The Research Agenda was developed by consulting the leadership and staff of all DCF facilities, most Central Office divisions/units as well as other stakeholders.

Research interests are summarized into the three central goals of child welfare agencies, i.e., safety, permanency, and well-being plus an "other" fourth category. In addition, ORE conducts a series of studies aiming to examine performance of service programs both at the state level and at the individual provider level, using information collected in the Program Information Exchange. Currently, two reports (one for the evaluation of Care Coordination program and the other for the Work to Learn program) have been drafted.

The Connecticut Department of Children and Families Institutional Review Board is responsible for reviewing and approving research involving clients and staff prior to the initiation of research and through continuing review and monitoring of approved studies. The purpose of this review is to ensure that studies are being conducted in accordance with the ethical principles of autonomy, beneficence and justice as set forth in the Belmont Report, and in compliance with federal regulations and internal policies. The DCF IRB is established by policy of the agency.

The following research has been reviewed and approved by the CT DCF IRB. These projects are reviewed and monitored on an annual basis by the full IRB membership. Procedures are in place for identification, tracking and analysis of any adverse events that occur in the process of the research.

- Evaluation of the Connecticut Trauma Focused Cognitive Behavioral Therapy Dissemination Initiated 2007 is ongoing

- GIRLS-Girls in Recovery from Life Stress Initiated 2004, is ongoing

- Evaluation of the Recovery Specialist Voluntary Program (RSVP)
  Initiated 2010, is ongoing

- Family-Based Treatment for Parental Substance Abuse & Child Maltreatment Initiated 2010, is ongoing

- Community Support for Families Performance Improvement Center Initiated 2012, is ongoing

- An Evaluation of Connecticut's Family and Community Ties Foster Care Program Initiated 2014, is ongoing

- Evaluation of the Family-Based Recovery Program Initiated 2012, is ongoing

- Partnerships to Demonstrate Effectiveness of Supportive Housing for Families in the CW system
  Initiated 2013, is ongoing

- Steps for Youth Mental Health (CT MATCH) Initiated 2013, is ongoing

- CT Collaboration on Effective Practices for Trauma (CONCEPT) Initiated 2013, is ongoing

- Evaluation of the Village Collaborative Trauma Center
  Initiated 2014, is ongoing

- Substance Abuse Family Evaluation, Recovery & Screening (SAFERS) Initiated 2014, is ongoing

- Child Abuse and Neglect in Home Visiting: Accounting for Surveillance Bias Initiated 2015, is ongoing

- Foster Home Placement Quality & Satisfaction Survey
  Initiated 2014, is ongoing

- The Spatial Concentration of Child Maltreatment in CT
  Initiated 2014, is ongoing

- Defense Mechanisms & Functioning in a Sample of Adolescents Undergoing Residential Treatment
  Initiated 2015, is ongoing

- Supportive Housing for Child Welfare Families: A Research Partnership
  Initiated 2015, is ongoing

- CTDCF Human Anti-Trafficking Response Team (HART) Evaluation Initiated 2015, is ongoing
- QIC-CT New Haven/Milford Court Teams Initiated 2015, is ongoing
- Evaluation of the Connecticut Network of Care (CONNECT) Expansion Implementation Initiated 2015, is ongoing
- Documenting DCF's Racial Justice Initiative Initiated 2015, is ongoing
- Evaluation of the Deep End Diversion Project
  Initiated 2016, is ongoing
- An Appreciative Inquiry Program Evaluation of the Statewide Racial Justice Workgroup's Efforts
  Initiated 2016, is ongoing
- Effectiveness Trial of Treatment to Reduce Serious Antisocial Behavior in Emerging Adults with Mental Illness
  Initiated 2016, ongoing
- The Geographic Placement Stability of Children in Foster Care Initiated 2016, is ongoing
- The Impact of Mobile Crisis Services on Rates of Emergency Department Utilization Among Children
  Initiated 2016, is ongoing
- Multi-systemic Therapy - Intimate Partner Violence (MST-IPV) Initiated 2016, is ongoing
- Evaluation of Eckerd Rapid Safety Feedback (ERSF) Implementation & Outcomes Initiated 2017, is ongoing

Technical Assistance

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

Services to Substance-Exposed Newborns

Connecticut concluded its In-Depth Technical Assistance (IDTA) from the National Center for Substance Abuse and Child Welfare (NCSACW) for the purposes of building a statewide infrastructure to address substance exposed infants. CT had used this TA for the following activities:

- The establishment of a statewide Fetal Alcohol (FASD)/Neonatal Abstinence (NAS) statewide coordinator,
- The completion of a shared values inventory with project partners to identify mutual priorities related to the six IDTA goals (screening and assessment, engagement and retention in treatment, data and information sharing, joint accountability and shared outcomes, services for pregnant women and substance exposed infants, and safety, permanency and well-being of children and families),
- The assessment of the state's capacities and needs related to FASD/NAS
- The development and execution of a statewide plan to address FASD and NAS
- Recommendations on how to conduct financial mapping to identify and maximize fiscal resources to support ongoing FASD/NAS efforts.
- Support to create a cross-system response, inclusive of all state entities involved in the development of a plan of safe care, such as hospitals, early childhood, and adult service providers with the purpose of establishing a multi-system response to SEI.
- Additional TA to support the implementation of the developed plan.

During the final phase if the IDTA,

Technical assistance focused on the following content areas:

- SEI notification process
- Plan of Safe Care content development
- Legislation language for CAPTA state legislation
- Data collection
- Stakeholder engagement in a collaborative process for SEI notification and plans of safe care

Through the IDTA, three key staff were able to attend the SAMHSA sponsored CAPTA summit in February 2017. A total of sixteen state teams gathered to share knowledge, lessons learned and next steps as it relates to the implementation of SEI Notification and Plans of Safe Care development. As a result of the summit, these states have been actively sharing information and resources to assist one another in the development of successful implementation strategies.

Although the IDTA is complete, Connecticut has been asked to stay on as a "mentor" state and offer support and assistance to other states.

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. Formal activity with the tribes is most often initiated after an accepted or non-accepted child maltreatment report to the State's CARELINE. The volume of reports on tribal families and children accounts for a small fraction of overall reports in the geographic area where the tribes are located.

When reports are made, 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 formal notification to the tribe. 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 takes action similar to non-tribal cases. The State does provide immediate notice to the Tribe of the report.

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

Most ICWA activity has centered on the State's federally recognized resident tribes. On occasion there is activity regarding tribes in the neighboring states of Rhode Island (Narragansetts), 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 past (and all required) ICWA notices to be filed with Tribes across the nation and BIA. This has included the Passamaquoddy and

Cherokee Nation Tribe activity this year.

Standard operating protocol across the State includes addressing ICWA/Native American status in every investigation/FAR response. Native American status is inventoried in the CCWIS under "person management". Case Plans also serve as additional forum for addressing tribal status and Native American identity. 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.

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

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

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.

Consistent with ICWA, all tribes are notified of State legal activity in writing, by USPS certified mail. For the States' two federally recognized tribes, by working convention and courtesy, telephone notice precedes written notification.

Common Juvenile Court practice finds representatives of the two local tribes present, at least for initial

proceedings. Neither tribe has a formally developed system of resources (foster/host homes/group care) that allows for a divergent path from State care, should removal from home become necessary. In 2013, the State adopted Considered Removal Child and Family Team meetings and in 2014, Child and Family Permanency Teaming was implemented. For tribal families, there is explicit instruction offered by the State that the family is welcome to invite tribal resources to these meeting forums. When Indian children do require placement into care, commensurate with behavioral health level of care needs, the first attempt as with non-native American children, is to identify family or fictive kin options in lieu of entry into traditional foster care. Additionally, the State employs the concept of non-legal entry into care by way of "family arrangements"; this allows short term, family driven alternative care solutions to remedy temporal risk/safety issues. Family arrangements can also serve to keep Native American children with their own cultural/familial connections during times of hardship/need.

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 eight years, or with other federally recognized tribes across the nation. Newly hired Social Workers are trained on ICWA during pre-service training. Additionally, when local training opportunities arise, invitations are often issued to the tribes. Over the past year, this including soliciting tribal representatives to participate in infant safe sleep public initiatives. Over the past year no MPTN or MT cases have been transferred to tribal courts. One MPTN litigated case had a Native American father contesting the State's position but the Tribe supported the State's argument.

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).

Finally, the Department outreached directly to both tribes requesting their participation in the various activities pertaining to the CFSR results and the development of the PIP. While the tribes did participate in the stakeholder groups for the CFSR, neither was able to send representatives to the

meetings pertaining to the PIP. They are, however, part of the PIP distribution list and will be provided with any PIP updates and materials. Similarly, a copy of the State's most recent Annual Report will be provided to the tribes post submission.

7. Monthly Caseworker Visitation

Funding has been allocated to each region to develop plans designed to promote monthly caseworker visitation. It is important to note that CT reported a 94.9% compliance last FFY. We expect to meet or surpass the 95% threshold for FFY2018.
All regions have decided to utilize funding to promote our permanency teaming practice, specifically focusing on engaging youth in the case planning process. It is anticipated that funding will be fully expended by the end of the federal fiscal year.

CT continues to do well in relation to monthly caseworker visitation. Frequency of visitation continues to be discussed and monitored in supervision. The implementation of permanency teaming will further enhance the quality of worker/child visitation as the model is designed to promote discussions around the child/youth's need for safety, permanency, and wellbeing.

In addition, CT has also utilized funding to support training of supervisory coaches to support social workers in conducting purposeful visits with children and caregivers facilitated by Dr. Rose Wentz series on ***"Purposeful Visitation"***

Learning Objectives:

- Describe the three steps and activities of high-quality, purposeful social worker visits.
- Describe interpersonal helping skills, verbal and non-verbal techniques, and solution focused questions that encourage a child or adult to fully share information about his/her safety, permanency planning, a child's well-being or services.
- Demonstrate planning, with a social worker, how to conduct a visit based on the facts of the case.
- Identify effective listening and question strategies to use with adults and children.
- Practice using information gathered during an interview with a child or adult to assess the situation, make commitments, and determine the next steps in the case.
- Name what, when and where to document a visit in the case record (LINK).
- Practice documenting a visit.

Training sessions will continue.

Some further examples of how funds were spent include;

- Purchasing supplies for workers to use when completing permanency tools with children (markers, plastic accordion folders).
- Training to SW, SWS staff and area managers by Jen Agosti, to review and process implicit bias that social workers and supervisors may harbor with respect to the families that we serve. It is intended to strengthen assessments made during visitation with families and assist in creating case plans that are free of bias that may result in poor outcomes for a selected population. A blend of videos, lecture, case visitation vignettes, large group discussion and small group exercises will be used. Office managers/supervisors will provide leadership and reinforce the vision for the application of a social justice lens in our direct practice with families that will result in positive outcomes for children.

The Department will submit our monthly caseworker visitation data by 12/15/17 as required.

8. Adoption and Legal Guardianship Incentive Payments

In 2015, Connecticut received $171,250 in adoption and legal guardianship incentive payments and in 2016, Connecticut received $200,519. Expenditure of these funds is documented in a budget spending plan. Limited funds have been utilized to date and they have been expended to offer training and coaching on the 3-5-7 Permanency Approach, attendance of key staff at a National Permanency Conference and creation of child specific recruitment videos for children on the Heart Gallery. The intent is to utilize these funds for initiatives and activities that support the Department's permanency work, including searching, identifying and securing adoptive homes for those children/youth for whom a permanency placement has not been previously identified. In 2017, the Department plans to bring in a consultant around racial justice and permanency, hold a statewide permanency conference, and develop a Public Service Announcement with youth from the Youth Advisory Board to recruit foster and adoptive parents.

9. Child Welfare Waiver Demonstration Activities

Connecticut has no Child Welfare Demonstration Activities.

10. Quality Assurance System

The Department engages in various activities to ensure the effective functioning of its quality assurance system statewide and across it various regions. A compendium of some of the recurrent qualitative activities in which the Department engages can be accessed via this link.
Each region is assigned a Quality Assurance (QA) Manager. Some regions have also created additional QA Social Work Supervisor and QA Social Worker positions. The Regional QA position count is below:

QI PM	5
QI PD	1
CSC- social security liaison	1
QA/QI SW	7
SW - social security liaison	1
SW - NYTD/social security liaison/ Adol. Spec	1
QI CSC	1
QI SWS	1

These positions engage in a variety of quality functions to support the ongoing review of the efficacy of the local child protection work. They engage in routine data analysis and review, report production, ongoing and ad hoc qualitative case reviews and performance monitoring. For example, these positions have begun leading monthly quality reviews of the Department's Differential Response System. They and other managers support Enhanced Case Planning, which consists of monthly reviews by Area Office managers of the narrative findings from the Administrative Case Reviews. This information is used to better contextualize the metrics available to Regions regarding the ACR ratings. The Exceptional Case Planning process is used to generate Individualized Support Plans for Social Work Staff based upon observed recurrent areas of challenge.

The Department also 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 Performance Management, 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 are also be identifying key reports and dashboards for to better support outcome and performance monitoring
Other positions in the Region also complement the work of the QA staff by focusing on the service array and the provision of clinical services. All Region have a Systems Program Director (PD) and a Clinical PD. The Systems PD is responsible for:

> Management and oversight of the regional service system; develops program goals and objectives to conform with department policies, standards and legal matters: assists in directing and coordinating the allocation of staff and resources to maintain service delivery system programs; manages systems/programs to ensure compliance with federal, state and department mandates; develops and monitors budgets for specific programs or administrative area; maintains liaison functions with individuals and organizations that impact on area or program activities; prepares and/or analyzes management reports; performs related duties as required.

The Clinical PD is charged with the following duties:

> Directs the Clinical Supports and Services of a Region; develops program goals and objectives to conform with department policies, standards and legal matters; assists in the directing and coordinating of staff and resources to maintain the clinical service delivery system and programs; manages clinical systems and programs to ensure compliance with federal, state and department mandates; acts as the hiring manager for Regional Resource Group (RRG)[1]; identifies training and developmental needs of clinical staff; supervises and evaluates RRG staff; maintains liaison functions with clinicians and clinically related organizations that impact on area or program activities; prepares and/or analyzes management reports; reviews work of units for general efficiency and effectiveness with target client population(s); uses data to

1 The RRG are a team of clinical experts housed in the DCF Regions. They consist of Clinicians, Substance Abuse Specialists, Nurses, and Intimate Partner (Domestic) Violence consultants.

inform RRG activities and practice; performs related duties as required. Reports to the Regional Administrator, providing leadership, guidance, recommendations, and information for regional clinical services. The Director of Clinical Services also serves as a member of the Regional Executive Leadership team consisting of the Regional Administrator, Systems Program Director, Office Directors, Quality Assurance Program Manager and Quality Improvement Program Manager.

Designs and implements an integrative support service system that provides direct clinical and administrative support services to social work staff. Additionally, the Regional Program Director of Clinical Services will work closely in collaboration with the region's Quality Improvement and Systems Development/Management efforts to assure clinical integration occurs throughout the Region.

As the above indicates, the Department has invested in resources to support implementation and oversight of its quality assurance system at the Regional level. Each Region, DCF Facility and the Administrative Teams, has created Operational Strategies to support achievement of the following standard, agency wide performance expectations:

1. Successfully exit from Juan F. Consent Decree
2. Ensure children reside safely with families whenever possible
3. Achieve racial justice across the DCF system
4. Prepare children and adolescents in care for success
5. Prepare and support the workforce to meet the needs of children and families

These Operational Strategies are presented every quarter to the Commissioner's team. The presentations follow the Results Based Accountability format whereby data and narrative about the efforts to "turn the curve" are discussed. The presentations allow the Regions to share the progress they have made in achieving the identified annual performance expectations. Feedback is provided by the Commissioner's team noting the successes and the areas that appear to be a challenge. Subsequent presentations are used to monitor the progress on all performance expectations, especially any in which concerns have been raised. Notes are taken at these meetings by the Director of Performance Management to ensure appropriate follow-up by the Regions and all other presenting Teams occurs.

In addition, Regional quality assurance work is further aided by assigned Grants and Contract Specialists. These positions provide local fiscal and procurement related support. They are also key partners in supporting the provision of individualized services for the children in the Department's care.

In particular, the Grants and Contracts Specialists are expected to:

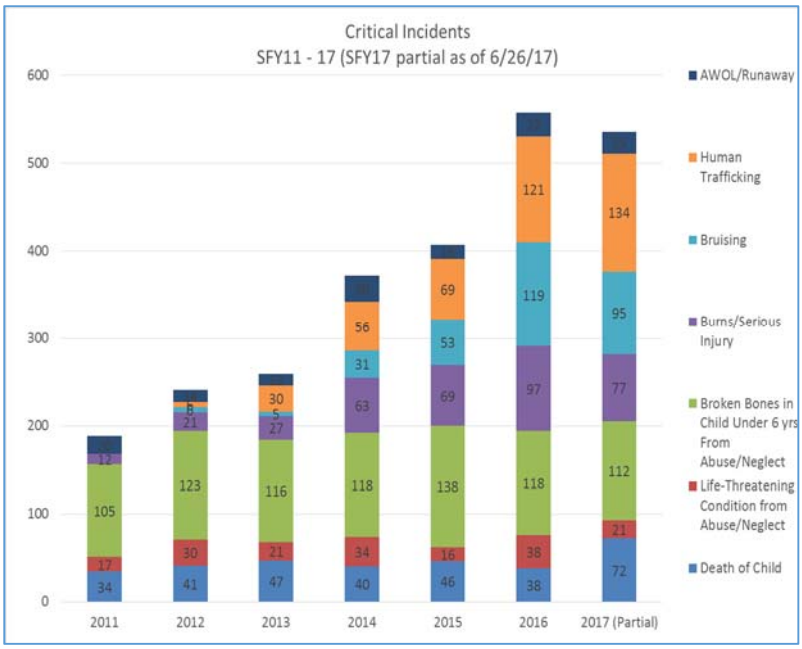
> Provide knowledge, expertise, guidance and technical support to all staff on appropriate use of WRAP funds. Perform a wide variety of fiscally focused, specialized tasks in contracts or service acquisition that would lead to efficient and effective procurement to meet the needs of children and families. Assist Social Workers to assess and assemble HUSKY, Contracted, Credentialed and ad hoc services to provide a comprehensive, effective and efficient plan of care. Provide fiscal leadership in making procurement arrangements, identifying service gaps and generating utilization data.

Next, The Department's Office for Research and Evaluation (ORE), which report to DCF's Chief of Quality and Planning, supports myriad qualitative and evaluative within the Department. For example, ORE, through its Risk Management Unit, maintains a database of all significant events. This includes, but is not limited to, data on children and youth in congregate care and Therapeutic Foster Care who may have had calls to the police and arrests, emergency services for medical or psychiatric reasons, single and group runaways, calls for EMPS, youth's self-injurious behavior, and adverse events in a facility. These data points are available and used by the Department to comprehensively assess the functioning and performance of service types that are expected to safely and appropriately care for a child/youth in a congregate care or private foster care setting.

The Department also maintains a Risk Management Database to monitor significant events (e.g., arrests, AWOLs, and run-aways) and critical injuries[2] that involve the health and safety of DCF involved children. Information on such events is received from the DCF Careline, our centralized intake, and DCF contracted providers (e.g., congregate care and Therapeutic Foster Care). The Department maintains a repository to monitor Emergency Safety Interventions such as restraints and seclusions. These data are received from DCF owned Facilities (e.g., Connecticut Juvenile Training School) and DCF contracted

2 Critical injury and fatality data reflect any child or youth reported to the Department. These data do include both DCF and Non-DCF involved children.

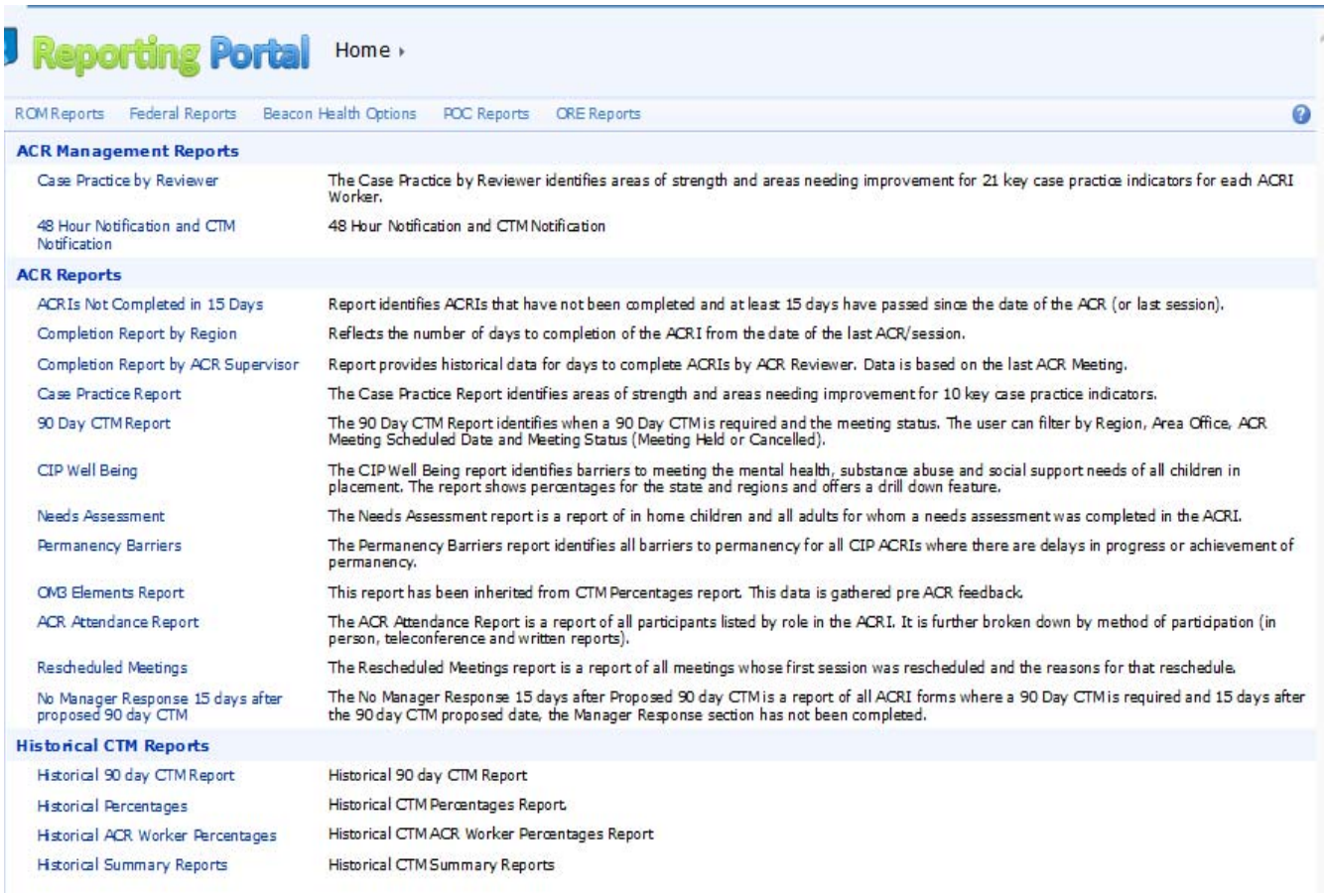
providers.



The Department's ACR process contributes greatly to DCF's quality assurance system. Congruent with federal requirements, administrative case reviews occur every six months for children in foster care. Last year, the Department conducted over 13,000 ACR meetings. DCF uses a cadre of Social Work Supervision level staff assigned specific to conducting ACRs. They use a comprehensive, 37 pages, electronic, Administrative Case Review tool whereby a variety of process and qualitative items related to safety, permanency, health and well-being are rated. This tool, referred to as the Administrative Case Review Instrument (ACRi) is based on the CFSR Round Two items. Some of the areas assessed through the Department's ACR process are as follows:

- Quality of the case plan
- Frequency and quality of visits
- Appropriateness of services to strengthen education/development in place
- Is the child involved/engaged in services to address behavioral health issues or strengthen coping skills? (Including medication management)
- Is the child involved/engaged in services to address physical health limitations/disabilities issues.
- Have frequent quality contacts been made with service providers actively involved with the child in the last six months.
- If the permanency goal is Reunification, have there been timely and accurate SDM Assessments (FSNA/Reunification Assessment/Reassessments) at 90-day intervals as required by policy?
- Did the Department conduct initial and ongoing safety and risk assessments? If concerns were noted, were they adequately and appropriately addressed by the Department?
- If a safety plan was developed, did the Department continually monitor and update the safety plan, including encouraging family engagement in services designed to promote achievement of the goals of the safety plan.

- There are a variety of Office of Administrative Case Review (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:



Reporting Portal Home

ROM Reports | Federal Reports | Beacon Health Options | POC Reports | ORE Reports

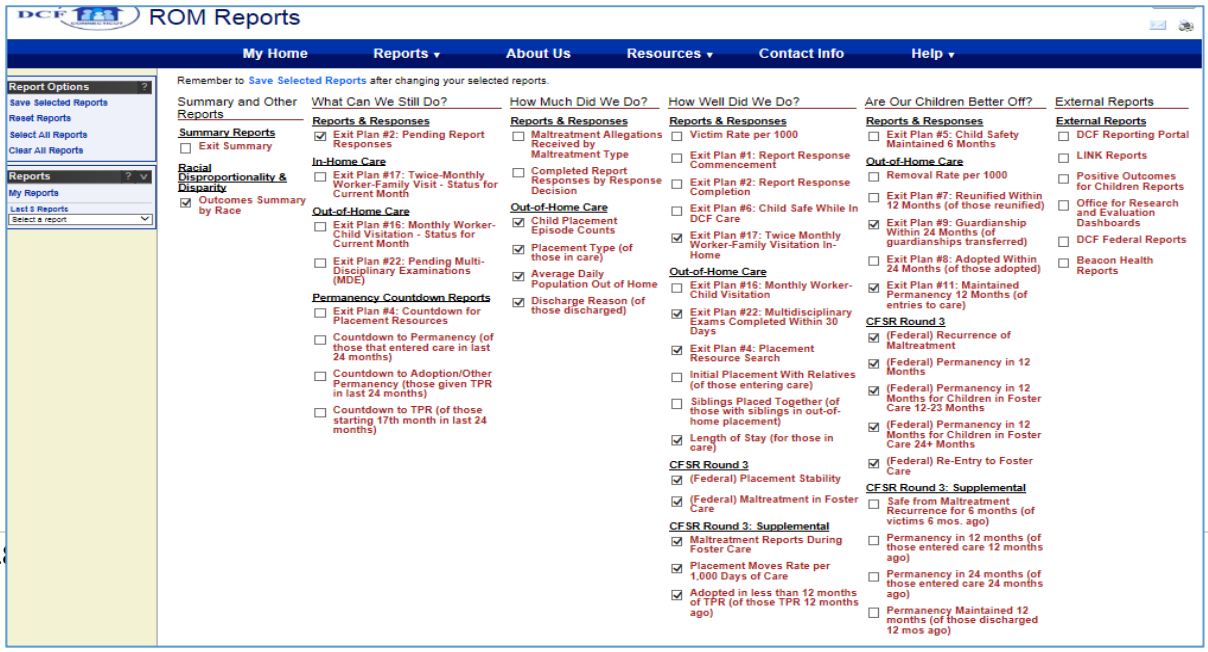
ACR Management Reports	
Case Practice by Reviewer	The Case Practice by Reviewer identifies areas of strength and areas needing improvement for 21 key case practice indicators for each ACRI Worker.
48 Hour Notification and CTM Notification	48 Hour Notification and CTM Notification
ACR Reports	
ACRIs Not Completed in 15 Days	Report identifies ACRIs that have not been completed and at least 15 days have passed since the date of the ACR (or last session).
Completion Report by Region	Reflects the number of days to completion of the ACRI from the date of the last ACR/session.
Completion Report by ACR Supervisor	Report provides historical data for days to complete ACRIs by ACR Reviewer. Data is based on the last ACR Meeting.
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 ACRIs 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.

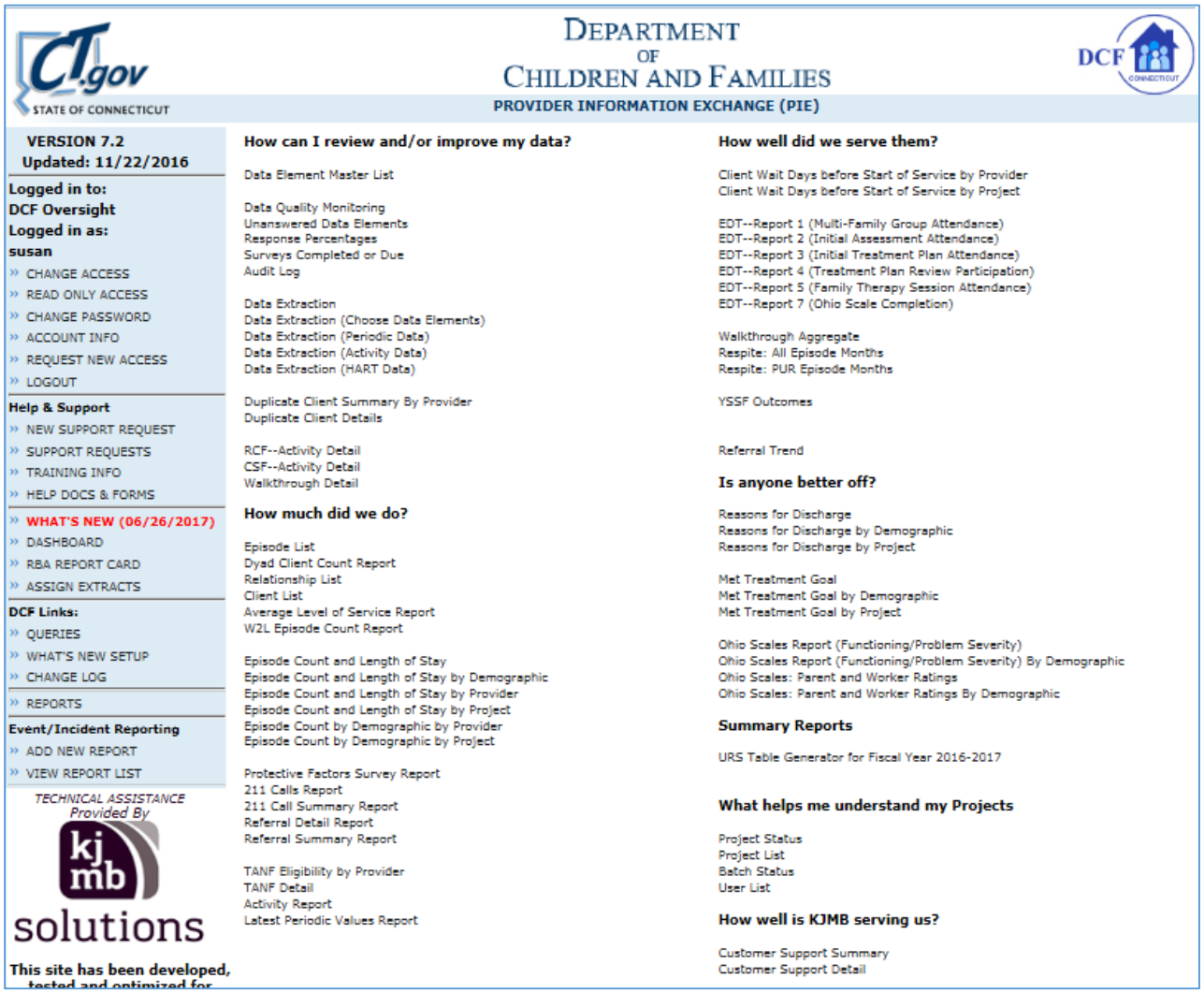
The Department continues to implement an Exceptional Case Planning (ECP) practice as noted earlier. ECP requires Area Office Managers to regularly review the findings in the ACRi for their staff to assess case practice strengths and systemic areas needing improvement. Individual Support Plans are developed 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.

The Department also monitors the qualitative of services through standard Outcome Measures under the Juan F. Consent Decree. There are 22 OMs upon which the Department and the Court Monitor evaluate on a regular basis. Copies of the Court Monitor's reports and the Department's most recent achievements on the above outcome measures are accessible on the DCF website.

The University of Kansas (KU) has provided significant upgrades to our Results Oriented Management (ROM) reporting portal. The Department has been using ROM for a number of years, but the current upgrades give DCF access to a variety of new reports, filtering options and data displays. These reports include all seven (7) of the national indicators required under CFSR, as well as expanded views of related data that help the agency manage permanency and placement outcomes from a more comprehensive viewpoint. The system continues to also include a number of pro-active views of CPS Report response completion, worker and child/family visitation, and achievement of permanency for children in care. We believe that offering such views of this information allows staff to better organize their time, and helps them stay focused on achievement of outcomes without having to maintain myriad manually produced logs. Another exciting new feature of the system is that users can now disaggregate any outcome measure very quickly in a new Crosstab View by a variety of fields including (but far from limited to) age, race and gender. There are also a set of reports focused on displaying information related to Racial Disproportionality and Disparity that have been built, and are currently in testing by Office for Research and Evaluation staff, that should be released to staff soon. Having such data continually updated and available at the fingertips of our staff will help further our goals to minimize this issue for the populations that we serve. The below is a screenshot of the report that will be available in ROM:



PIE (Provider Information Exchange) 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 PIE allow the assigned Program Development and Oversight Coordinators (PDOCs) and Contracted Providers to evaluate the quality and efficacy of DCF funded services. PIE 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* and with a focus on outcomes by race and ethnicity. The below screen shot shows the reports layout within PIE.



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

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

YSSF Outcomes -- Selected Filters

Logged in to: DCF Oversight
Date run: 06/26/2017 04:52:01 PM ET
Episodes Ending between : 01/01/2016 to 12/31/2016

Total Responses Required	31540

Data Element	Total Responses	Valid Response %	% English	%Spanish
LanguageVersionQuestionDischarge	5213	17%	92%	8%

YSS-F Domains: Calculated Variable	Total Responses*	Valid Response %	Mean*	Standard Deviation
YSSFAccess	5783	18%	4.58	.64
YSSFSatisfaction	5792	18%	4.47	.66
YSSFOutcomes	5773	18%	4	.83
YSSFTreatmentPlanning	5789	18%	4.47	.64
YSSFCultural	5761	18%	4.68	.56
YSSFSocial	5754	18%	4.33	.68
YSSFFunctioning	5772	18%	4.02	.82

	Data Element	Total Responses	Valid Response %	1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree	Mean	Standard Deviation
	YSS-F Access Domain									
	YSSFLocationConvenient	5790	18%	1%	1%	2%	28%	67%	4.6	.69
	YSSFServiceTimesConvenient	5788	18%	1%	1%	3%	30%	65%	4.6	.7
	YSS-F Cultural Domain									
	YSSFStaffTreatedMeWithRespect	5787	18%	1%	%	1%	20%	77%	4.7	.61
	YSSFStaffRespectedBeliefs	5754	18%	1%	%	3%	24%	72%	4.7	.63
	YSSFStaffSpokeInWayUnderstood	5762	18%	1%	%	1%	24%	73%	4.7	.61
	YSSFStaffSensitiveToCulturalBackground	5733	18%	1%	%	3%	27%	69%	4.6	.66
	YSS-F Functioning & Outcomes Domains*									
F	YSSFResultofServicesChildBetterAble	5744	18%	2%	5%	17%	44%	33%	4	.91
O/F	YSSFResultOfServicesChildHandlesDailyLife	5761	18%	2%	5%	16%	40%	38%	4.1	.93
O/F	YSSFResultOfServicesChildGetsAlongFamily	5760	18%	2%	5%	16%	42%	35%	4	.93
O/F	YSSFResultofServicesChildGetsAlongFriends	5765	18%	1%	5%	17%	42%	35%	4	.9
O/F	YSSFResultofServicesChildBetterSchool	5745	18%	2%	6%	19%	37%	36%	4	.99
O/F	YSSFResultofServicesChildBetterCopes	5762	18%	2%	7%	19%	42%	31%	3.9	.98
O	YSSFResultofServicesParentHappyWithFamily	5759	18%	3%	7%	16%	41%	33%	3.9	1.01
	YSS-F Satisfaction Domain									
	YSSFOverallSatisfied	5793	18%	2%	1%	4%	30%	63%	4.5	.77
	YSSFPeopleHelpedNoMatterWhat	5777	18%	1%	1%	3%	26%	69%	4.6	.72
	YSSFChildHadSomeoneToTalkTo	5760	18%	1%	1%	5%	32%	61%	4.5	.73
	YSSFServicesReceivedRightForUs	5786	18%	1%	1%	7%	32%	59%	4.5	.78
	YSSFFamilyGotHelpWantedForChild	5780	18%	1%	2%	8%	33%	55%	4.4	.83
	YSSFFamilyGotAsMuchHelpNeeded	5771	18%	1%	4%	10%	32%	53%	4.3	.88
	YSS-F Social Domain									
	YSSFResultofServicesParentKnowsPeopleListen	5752	18%	1%	1%	7%	43%	48%	4.4	.75
	YSSFResultofServicesParentKnowsPeopleComfortable	5751	18%	1%	1%	6%	41%	51%	4.4	.73
	YSSFResultofServicesParentHasCrisisSupport	5750	18%	1%	2%	9%	42%	46%	4.3	.81
	YSSFResultofServicesParentHasPeopleEnjoyable	5746	18%	1%	3%	11%	43%	42%	4.2	.83
	YSS-F Treatment Domain									
	YSSFHelpedChooseServices	5781	18%	2%	2%	5%	38%	53%	4.4	.81
	YSSFHelpedChooseTreatmentGoals	5769	18%	1%	1%	4%	39%	55%	4.5	.72
	YSSFParticipatedinChildTreatment	5784	18%	1%	%	2%	32%	64%	4.6	.67

The federally promulgated Youth Satisfaction Service for Families (YSS-F) has also been built into PIE. DCF funded behavioral health service providers are required to complete the YSS-F with the families they are serving, and input the results into PIE. The YSS-F data are submitted to the federal government annually to support compliance with the Mental Health Block Grant.

The federally promulgated Youth Satisfaction Service for Families (YSS-F) has also been built into PIE. DCF funded behavioral health service providers are required to complete the YSS-F with the families they are serving, and input the results into PIE. The YSS-F data are submitted to the federal government annually to support compliance with the Mental Health Block Grant.

Last calendar year, January 1, 2016 – December 31, 2016, over 5,700 Youth Satisfaction Surveys for Families were completed. This is about 18% of the 31,540 clients identified by PIE as being served in various DCF contracted services. Results from the YSS-F are below. As these data reveal, in all domains collected, the majority of responses were positive (e.g., "Agree" or "Strong Agree."). In particular, out of a Likert score of 1- 5[3], the mean scores for the domains of "Access," "Satisfaction," "Outcomes," "Treatment Planning," "Cultural," "Social" and "Functioning," ranged from 3.9 – 4.7.

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.

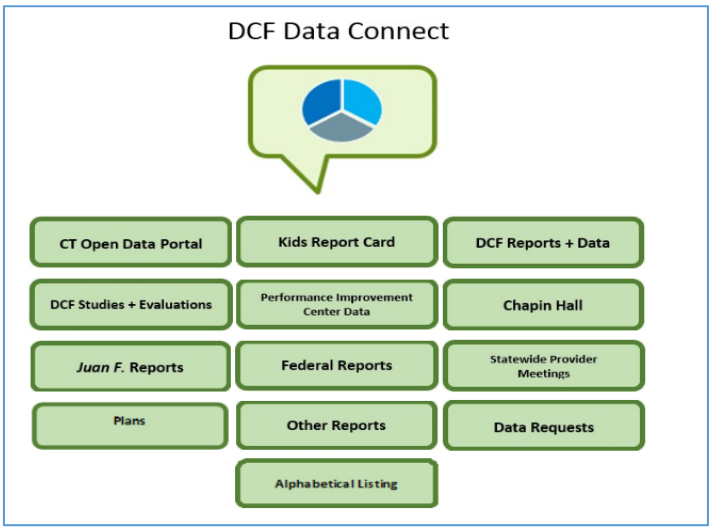
Site visits by PDOCs and DCF licensing visits are another means by which the functioning and performance of contracted providers is evaluated. Both site visits and licensing visits typically involve the qualitative review of provider records, including client files. Site visits may range from a half 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.

[3] 1-Strongly Disagree 2-Disagree 3-Undecided 4-Agree 5-Strongly Agree

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



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

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

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

Department also supports stakeholder access to meaningful data and reports. In February 2016, the Department launched DCF Data Connect. It provides links to a host of DCF related data portals, relevant reports, evaluations/studies, and plans. For example, on the CT Open Data Portal, the Department has posted a variety of data, including nearly a decade of non-identifiable datasets regarding children in DCF placement. These data postings support the Departments efforts to be accountable and transparent. It also aids with stakeholders such a researchers having more ready

access to raw data needed to assess a variety of facets of the Department's work.

Section D: Child Abuse Prevention and Treatment Act (CAPTA)

CHILD ABUSE AND PREVENTION TREATMENT ACT (CAPTA) FFY 2017

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 2016 and FFY 2017.

Services/Categories	Total Funding	Protect Services	Family Preser.	Family Support	Time-Limit Fam-Reun	Foster Parent Rec & Training	Adoptive Parent Rec & Training	Staff & Partners training
Multidisciplinary Teams	$175,000	$175,000						
FAVOR	$36,828	$7,365	$7,365	$7,365	$7,365	$7,365		
CT Association for Infant Mental Health	$39,652	$39,652						
KJMB FBR- Pay for Success - PIE	$12,000	$4,000	$4,000	$4,000	$4,000			
IPC – IPV - FAIR Admin Costs	$5,000		$2,500	$2,500				
Travel	$1,883						$1,883	
Total	**$270,363**	**$226,017**	**$13,865**	**$13,865**	**$11,365**	**$7,365**	**$1,883**	

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. Additionally, the Governor's Task Force on Justice for Abused Children has the task of evaluating each of our MDTs in Connecticut.

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.

FAVOR: There are a number of parent advocacy groups in the state that are designed to review Department practices specifically in the areas of behavioral health. FAVOR is a statewide Family Advocacy Organization for Children's Mental Health. Their mission is to enhance mental health services for children with serious emotional disorders by increasing the availability, accessibility, cultural competence and quality of mental health services for children through family advocacy. This organization agreed to broaden their focus and responsibilites 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.

CT Association for Infant Mental Health - See description under Promoting Safe and Stable Families.

KJMB- (FBR Services): will provide database development, networking consultation and quality assurance services to providers of Family-Based Recovery (FBR). To ensure that the providers integrate the standards and practices consistent with FBR model requirements and FBR quality improvement programming. This database development will be through PIE.

ABH-MST IPV: Funding was allocated for the licensing of the MST adaptation relative to Intimate Partner Violence.

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

Citizen Review (CRP): Citizen Review Panels are responsible for providing 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. Funding is used to support CRP activities.

CAPTA Spending Plan FFY 2018 (Proposed)

Services/Activities	2018 Spending Plan
Multidisciplinary Teams	$175,000
Favor-(Stipends for CRP Work)	$36,828
CT Association for Infant Mental Health (Spring/Fall 8 week series)	$39,652
KJMB FBR- Pay for Success - PIE	$12,000
ABH – MST IPV Admin Costs	$5000
Travel	$ 2000
Total	$270,480

Preventing Sex Trafficking and Strengthening Families Act, P.L. 113-183

Connecticut's Human Anti-trafficking Response Team (HART) is coordinated by the Department of Children and Families (DCF). DCF includes child trafficking under its mandated reporting guidelines requiring all cases be called into the DCF Careline. This structure uniquely affords all child victims of trafficking the resources needed to ensure safety and service provision.

The Governor's Task Force on Justice for Abused Children (GTFJAC) continues its efforts on the critical issues of Domestic Minor Sex Trafficking (DMST) which begun in 2013. ALL MDTs in the state were trained in the *Introduction to DMST in Connecticut* curriculum. In addition to the rollout of the training the Co-Chair of the Executive Committee visited every team in an effort to meet the various team members, understand the local challenges and discuss the Human Trafficking initiative ensuring commitment across the state. This outreach continues to happen. MDTs continue to report monthly on the number of associated cases and outcomes to the Governor's Task Force: of the 202 unique DMST referrals in 2016 to DCF 74 referrals were reviewed by an MDT.

The HART Leadership Team continues to include all the DCF HART Liaisons, 3 MDT Coordinators and the Director of the Connecticut Children's Alliance (CCA) with specialty membership based on current team efforts. In 2016, the Director of Survivor Care Services through Love 146, a local service provider for trafficked youth was added to the team. The HART Team has a tri-chaired structure which includes one DCF HART Liaison and CCA Chapter Director. The coordinator for the GTF continues to be 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.

Connecticut's Human Anti-trafficking Response Team (HART) Project 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. A stakeholder assessment and interviews with survivors has occurred and the data from both are currently being analyzed. 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. The PIE system went live in October of 2016 and HART Liaisons are entering data into this system but as we work through some complications; current indicators continue to be collected manually.

Our HART webpage continues to ensure state and national sharing of information and direct connections to the teams doing this work on a daily basis. In 2015 we published our first HART Helps Newsletter which provides updates on our trafficking efforts in the State. The newsletters can be found on our HART webpage:

http://www.ct.gov/dcf/cwp/

On June 1, 2016 ***Public Act No. 16-71***: AN ACT CONCERNING HUMAN TRAFFICKING was signed into law by Governor Malloy. This public act improves upon our previous trafficking law. The following is a summary of the changes to the law:

- To revise the duties and composition of the trafficking in persons council;
- require state's attorneys and municipal chiefs of police to provide data and information concerning human trafficking prosecutions and investigations to the General Assembly;
- require that the Commissioner of Children and Families and the Commissioner of Emergency Services and Public Protection develop a training program to raise awareness of incidents of human trafficking,
- institute reforms that are designed to prevent human trafficking at hotels, motels and similar lodgings;
- raise the age for a person to be convicted as a prostitute;
- eliminate the requirement that a person knew the victim was under eighteen years of age or was a victim of coercion or human trafficking in order to be convicted of a class C felony for patronizing a prostitute;
- create mandatory fines for patronizing a prostitute and require such fines be used to fund investigations of prostitution and human trafficking;
- raise the age of a minor for purposes of enticing a minor to engage in prostitution; expand requirement for display of notice concerning services available to victims of human trafficking;
- Amend forfeiture requirements related to prostitution.

The state of Connecticut submitted new legislation for the 2017 legislative session. The following are the bills that were submitted this legislative session:

SB 930, AN ACT CONCERNING THE RECEIPT OF ANNUAL REPORTS ON ANTI-HUMAN TRAFFICKING FROM LAW ENFORCEMENT AGENCIES.
https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=SB00930&which_year=2017

1. Amends last year's law to have individual reports from prosecutors and police sent to the TIP Council.

HB 7309, AN ACT CONCERNING HUMAN TRAFFICKING.
https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB07309&which_year=2017

1. Adds Department of Education to the TIP Council.
2. Expands the charge of the TIP Council to include; a list of key indicators that a person is a victim of human trafficking; develop a training curriculum for health professionals, school personnel, DCF, and DPH to identify and assist victims of trafficking; develop and conduct training for DCF and DPH to identify at-risk youth in foster; develop a plan for mental health, support, and substance abuse programs for individuals identified as victims of human trafficking and those arrested for prostitution; and examine the plight of victims of trafficking without legal immigration status.
3. Amends Trafficking in Persons felony charge to expand the definition to include an act that constitutes sex trafficking and increase the charge to a Class A felony.
4. Removes patronizing a minor from the Patronizing a Prostitute statute and makes current law gender neutral.
5. Creates a new stand-alone felony charge of 'Commercial Sexual Abuse of a Minor' to address the issue of patronizing a minor and increases the penalty from a Class C felony (patronizing a prostitute under the age of 18) to a Class B felony.
6. Expands the types of entities required to have signage regarding human trafficking and includes a financial penalty for not adhering to the law. Expanded entities to include; farms, illicit massage parlor, massage parlor, public airport, emergency room, urgent care, passenger rail station, passenger bus station, and employment agency.
7. Requires DCF & DESP to create an education program for law enforcement, prosecutors, judges, public defenders and attorneys who must be trained not later than July 1, 2018.
8. Requires DAS and others to review federal Executive Order 13627, Strengthening Protections Against Human Trafficking in Federal Contracts, for purposes of adapting and implementing similar provisions for contracts entered into by the state.
9. Prohibits hotels, motels or similar lodgings from offering hourly rates.
10. Requires Hotels, motels, or similar lodgings to obtain a form of ID before renting a room.
11. Amends sections 53a-84 and 54-36p to remove Sec 53a-83a, patronizing a Prostitute from a motor vehicle.

HB 7310, AN ACT CONCERNING SEX TRAFFICKING.
https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB07310&which_year=2017

1. Amends Patronizing a Prostitute to increase the penalty for Patronizing a minor to a Class B felony and if an individual is convicted more than once, must register as a sex offender.

SB 1043, AN ACT CONCERNING PRIVILEGED COMMUNICATIONS MADE BY VICTIMS OF HUMAN TRAFFICKING TO A HUMAN TRAFFICKING COUNSELOR.
https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2017&bill_num=1043

1. Adds a new classification of human trafficking counselor and agency to the state's privileged communication statute.

Trainings on DMST have increased in Connecticut including but not limited to: 1) Introduction to DMST in CT, 2) Day 1 Basics of DMST, 3) Day 2 Responding and Interventions, 4) Demand, 5) Boys and DMST, 6) CT POST training for law enforcement and 7) specialized foster care training. In 2016, 61 trainings were conducted and 1,806 people were trained across the state from 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 DMST, 2) Not a #Number, 3) Boys and DMST 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. Long-term Survivor Care is a service that is best described as a combination of intensive case management and 1:1 mentoring by a person specifically training in DMST available 24/7 as long as the youth is willing to engage in services. Our Survivor Care capacity increased in 2016, we now have 60 slots for this program and 10 social workers have been hired by Love 146 to provide this service. The process of "training up" our service provider network continues allowing DMST referrals based on provider competencies. The new foster care training was implemented in 2015, currently there are 40 specially trained foster families in Connecticut for youth at high risk or confirmed victims of trafficking. We have eight Therapeutic Foster Care Providers across the State that has foster parents and staff that have been trained in the one day foster care training curriculum; recruitment efforts continue to increase statewide capacity. Specialized mentoring resources exist in two regions in the state; training of all mentoring providers will occur in 2017. 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.

Substance Exposed Infants

Comprehensive Addiction and Recovery Act of 2016 (CARA).

The expectations outlined in the CARA legislation have been folded into the Department's work specific to Substance Exposed Newborns. Given the scope of the expectations and the importance of establishing a coordinated and integrated approach, it was critical to include a diverse range of partners. With the benefit of a technical assistance opportunity, Connecticut established a strategic plan, gathered stakeholders to assist with the development and implementation of a systemic response to the expectations inclusive of legislative and policy development and intentionally reached out to consumers to obtain feedback about how to best manage implementation. On June 6, 2016, CT hosted a full day meeting facilitated by consultants from the National Center on Substance Abuse and Child Welfare. The audience included key stakeholders including, DCF, Department of Mental Health and Addiction Services (DMHAS), Office of Early Childhood (OEC), ACOG, AAP, Department of Social Services (DSS), Department of Public Health (DPH), CT Hospital Association. The meeting set the legislative context, providing an overview and outlining the expectations and identifying recommendations for next steps.

A smaller workgroup derived from this body was developed and added additional pediatricians, neonatologists and critical stakeholders to inform policy and practice changes needed to align with the CARA legislation. That group was actively involved in the drafting of legislation to support the CARA expectations which passed just as the regular session concluded.

The workgroup was aware that advancing these important steps required activities specific to practice and protocol, communication, documentation and data collection. As such the working group has developed a draft set of guidelines to be used by the Child Protection Careline (centralized reporting) and Healthcare Providers who will be making the notifications and are developing material to be shared with consumers. The partnership has also expanded to include the Information Technology team at the Department to insure that technological changes needed will be incorporated into the design of the case management system under design currently while also informing potential changes to the existing system.

DCF has cross-walked elements of a plan of safe care with the Department's case plan. Families have repeatedly discussed the importance of having one plan to guide their work and service provision, as

such we have confirmed that the elements of a plan of safe care fit squarely within the domains of the agency's case plan. Based on feedback from stakeholders, we understand that notification will not always equate to an open DCF case but instead families will continue to be supported through their involvement with other systems. As such, those other complimentary systems are cross-walking their case plans to assure consistency with the elements of a Plan of Safe Care.

At the time of notification, the guidance for Healthcare providers includes a review and submission of the plan of safe care at the time notification is made. For those cases that may become actively engaged with DCF, the plan of safe care (aka the case plan) is subject to an ongoing review process and one that includes any partners working with the family to assure a coordination of efforts.
The Department also recognizes that plans developed by other serving systems, like DCF, also abide by firmly established expectations and regulations related to the time frames, content, and review of client treatment planning. The DPH, the regulatory body for the adult treatment system has well-established regulatory guidelines related to treatment planning and care of clients.

Partnership has been critical. Key stakeholders have expressed concern that the legislation nests notification within child protection although acknowledging that such notification should not be construed as a mandated report. Concern extends to the worry that such a notification would have a chilling effect on a caregivers comfort and confidence in seeking out treatment and support through the prenatal experience. As such the collective feedback has been and will continue to be critical to the legislative, practice and implementation phases of this work. Though DCF has led this effort, it has done so with tremendous insight and expertise from key stakeholders including:

- Medical practitioners (Pediatricians, Obstetricians and Gynecologists, Neonatologists) to inform the process of how to message, engage and prepare mothers in a proactive way, assure that there is accurate and clear documentation that outlines treatment and active engagement.
- Department of Mental Health and Addiction Services (DMHAS) – working closely with adult substance use treatment providers and supporting focus groups that empower consumers to be actively engaged in the development process and establish a system to allow for feedback
- Office of Early Childhood (OEC)– the bridge to nurse-family partnerships, in-home supports and Birth to Three programs to further inform how to best access critical services to these young children, assure that plans of safe care are incorporated into the providers work
- Department of Public Health (DPH) – developing recommendations to assure continuity in the Plan of Safe Care, assisting with available data sets, providing a public health approach specific to the needs of infants with substance exposure.
- Department of Social Services (DSS) – a key partner in drafting legislation, offering critical expertise both from practice and funding perspectives and examining the service system given their role as Medicaid partner

- CT Hospital Association (CHA)– representing all hospitals in the state and playing an active role offering feedback to the legislative and policy development process as well as offering information about how to most effectively communicate with the range of providers
- Substance Exposed Infant (SEI) Coordinator - The statewide SEI coordinator, works on the state's strategic plan to address SEI and FASD and has been key in convening all of the stakeholders and coordinating the activities in an organized and meaningful way. This position is also critical to ensuring that this effort aligns with other state efforts related to substance use policy.
- Consumers - The input of persons with lived experience and experience with services has been present in the workgroups, through intentional membership of these critical members. DCF in partnership with DMHAS has begun conducting focus groups with women in treatment throughout the state that will continue to inform this process.

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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 Chaffee 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 continues to have 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.

Federal Fiscal Year 2016-2017 saw the culmination of a year-long project to collect YAB members' feedback and insights on what youth need from the child welfare system in Connecticut prior to transitioning out of foster care. In January 2017, the statewide YAB members proudly presented their final draft of the *Adolescent Needs Prior to Transitioning from Care* document to the Commissioner and her senior management for implementation. Statewide YAB leaders have helped to present this important work at the state's Connecticut Association for Foster and Adoptive Families (CAFAF) annual conference for foster parents as well as the Connecticut Coalition to End Homelessness (CCEH) hosted Annual Training Institute. Similarly, the 6th annual Youth at the State Capitol Day offered an opportunity to current youth in care and foster care alumni to speak to their experiences and anxieties regarding their transitioning out of care in front of an audience of lawmakers, advocates and professionals seeking to improve services and supports available for foster youth.

The statewide YAB members have been instrumental in providing feedback resulting in newly implemented Connecticut legislation effective January 1, 2017. Among the new enacted provisions from Public Act 16-123 are a new Foster Home Survey to be administered to youth after they leave a foster home and the creation of a Foster Parent Profile to be available to youth prior to their placement.

The regional and statewide boards continue to partner with the DCF Wilderness School to provide teambuilding and leadership days. YAB members have additional opportunities to participate in a life-changing 5 day Wilderness School expedition course in which youth hike and camp overnight with experienced instructors working on life skills and engaging in self-reflection.

Federal Fiscal Year 2017-2018 will see continued efforts by the statewide YAB to implement the program suggestions captured in *Adolescent Needs Prior to Transitioning from Care* such as a process that would allow postsecondary education graduates to apply to extend their transition time from three months to up to six months, and the development of a DCF Adolescent Services policy "cheat sheet" in youth-friendly language. The statewide YAB members also plan to provide feedback to aid the state's efforts to end youth homelessness, continue to work toward implementation of a DCF Foster Care Alumni Association, and provide input to the state's Program Improvement Plan to comply with the Federal Child and Family Services Review (CFSR) recommendations.

How CT provides youth with certain documents when they age out of foster care:

The department provides youth 18 and older who are discharging from care copies of the following documents: educational records; medical records including medical history of family members, to the extent known and obtained from the case records, as the law allows; original birth certificate and an extra copy; original social security card and an extra copy; passport; immigration and/or citizenship papers.

How CT includes youth age 14 and over more fully in case planning:

The department invites and encourages youth to participate and if possible to attend the Administrative Case Review (ACR). Accommodations are made to hold the review at a time and location that is convenient to the youth. At age 16, the department develops a Transitional Plan for each youth in the department's care for the purpose of permanency planning and preparation for discharge from care. The plan is youth-driven and based on the youth's identified needs prior to and at the time of discharge. The Transition Plan is reviewed at the first Administrative Case Review after the youth's 16th birthday and reviewed and revised at subsequent ACR's as long as the youth remains in care. The implementation of CR-CFTM and Permanency Teaming will promote active engagement of youth's involvement in case planning and decision making activities.

Planned use of funds (Chaffee) to support engagement in age or developmentally appropriate activities

The Department builds into the Chaffee grant funding for developmentally appropriate activities as well as annually providing funding to each Regional Youth Advisory Board for such activities. Regions utilize these funds to sponsor activities such as college fairs, holiday parties and graduation celebrations.

National Youth in Transition Database (NYTD)

This year marks the beginning of the Departments ability to view and analyze NYTD Survey data as the first cohort completed their survey cycle (baseline, 19 and 21 years). Preliminary data suggests that most youth at age 21 have completed secondary education, have received some employment training and/or vocational training and, have high rates of unemployment or are underemployed. Additional survey information indicates more positive outcomes such as the majority of youth report having positive adult connections, health insurance and no children. The Department will continue to analyze this cohort data to see how it can be utilized in adolescent case practice, training and for service development and delivery.

The Department has increased staff efforts to locate and survey youth no longer in foster care and, as a result, has seen more youth participation. NYTD regional staff have begun to document efforts to locate youth as well as take the opportunity to collect and document additional information provided by youth. Youth are asked to voluntarily share their experiences while in care including what was the most helpful or beneficial service and/ or experience and what was not. Additionally, youth are asked to share freely any thoughts or ideas that could help guide the Department with staff & service development and or service delivery. The Department will continually collect and review this information along with the NYTD survey data to improve its service delivery.

Lastly, review of the NYTD survey data has provided the Department with an opportunity to enhance the electronic data collection and reporting systems that will allow the NYTD staff to more easily identify cohort populations and information to assist locating youth for surveys.

NYTD Independent Living Services data is available but unfortunately, continues not to be used for service delivery improvements nor is it being shared with stakeholders. Data elements collected for

this report are based on several Adolescent Services Payment codes attached to youth that are available in LINK and do not include nor accurately represent many services that are paid for by the department through contracts or by fee for service. DCF provides services through "fee for service" payments as well as through contracts for many independent living services that provide one or more of the elements identified in the "Independent Living Services" data report and these are not reflected in this data, thus negatively skewing the number and type of services youth receive.

While there is a 'snapshot' format of the NYTD data, it can be used as a resource to talk with youth, providers, the courts, and other stakeholders about service and youth transitioning out of foster care. The Department continues to address the above issues by providing technical assistance and training to the staff who are assisting youth with completing the surveys so more accurate data can be gathered. Central office staff regularly contacts area office staff to alert them of surveys needing to be completed and assists with questions related to these surveys in order to better capture quality survey data. Additionally, the Department is in the process of redesigning the State SACWIS and this new system will allow for additional services to be captured by linking services to individuals in order to better capture the many independent living services provided to Connecticut foster youth.

The Department is in the process of developing a work plan based on the "Guide to the NYTD Review" issued by the Children's Bureau in order to prepare for the NYTD Review. This detailed review guide has allowed the Department to re-examine its original design for data collection and quality assurance process. As a result, the Department is in the process of identifying required child welfare data collections system changes that will allow for more quality data collection and an increase in compliancy standards. It has become apparent that the Departments original design for data collection omitted several key requirements contained in the NYTD regulations and, as a result, the Department is in the process of correcting and enhancing the system.

The Department periodically reviews the data available on the NYTD portal to gauge youth outcomes as well as service utilization. Again, this process has uncovered areas in the system that needs to be improved. NYTD data was presented during this years "Youth at the Capitol Day" for interested legislators, youth and youth advocates. NYTD data presented added additional support to the day's theme of the importance of successfully preparing youth in care for their transition to adulthood. As a result, additional modifications to present practice have been enacted as well as the release of a youth

written document titled "State of Connecticut Adolescent Needs Prior To Transitioning From Care". This article can be found on the Departments internet website http://www.ct.gov/dcf

The Department continues to make improvements to the NYTD data collection system by identifying additional appropriate services available to youth in care as well as modifying the follow-up surveys for a more accurate collection of youth outcomes. Training materials for staff are being updated as well as an improved quality assurance process.

The Department utilizes its Regional and Statewide Youth Advisory Boards to provide and disseminate information regarding issues related to adolescents in care. As the Department develops additional materials related to NYTD, youth from the various boards will be asked to provide feedback, review, and edit all materials. When completed, same youth will be asked to assist with disseminating the information to their peers in care. The Department is not asking for youth involvement prior to having draft documents due to the many initiatives board members and members at large are involved with. The Department continues to partner with other federally funded programs for older youth. Many of the federally funded agencies are existing providers and the Department partners with these providers to share resources and assist youth in their transition into adulthood. The Department partners with the Department of Labor and provides funding for Summer Youth Employment and contracts with several community agencies to provide work to learn services. The Departments Community Housing Employment Enrichment (CHEER) Program provides funding and support for youth participating in local workforce agency sponsored programs, as well as other employability programs that assist youth with necessary employability skills for them to become gainfully employed when they leave care.

Pregnancy Prevention

The Department continues to partner with the Connecticut Department of Public Health as part of their federal Personal Responsibility Education Program (PREP) with the goal to reduce the rates of pregnancy, STD/STI's and HIV among foster youth and at risk youth in Connecticut. The program will continue to focus on providing evidence based interventions to youth in and aging out of foster care, high risk youth in the community as well as youth involved with the juvenile justice system. Program interventions also include providing much needed training to caretakers of foster youth, service providers for youth in and transitioning from foster care as well as educators and providers for youth at risk in the community.

Additionally, this grant allows the Department to continue to offer staff development and training to our Adolescent Social Work staff as well as to other professionals working with at risk youth, including juvenile justice youth involved with the child welfare agency. It is important for Department staff to continue to receive the latest prevention and intervention information that will allow them to provide the needed information and services to our youth who are at a higher risk for pregnancy, HIV, STD's and STI's.

Coordinate services with other federal and state programs for youth.

In November 2011, the DCF contracted provider for housing services for families, agreed to allocate existing contract funds to pilot a housing program for youth and young adults homeless or at risk of homelessness but could not re-enter the Child Welfare system due to ineligibility. The Homeless Youth Pilot Program was created a system of care to address the needs of youth aging out of foster care. The pilot's objective was to prevent or end homelessness for young adults struggling to maintain safe and stable housing. In this two- year model young adults have the opportunity to gain employment and/or vocational or higher education while living in their community, are offered case management services, linkages to services including mental health, substance abuse, and medical, along with an opportunity to re-connect with family, friends and build a new network of support and resources to maintain their success and continued growth into adulthood. The program was a great success, with 73 young adults stably housed or self-sufficient and connected to employment and/or educational programs and additional resources and services they need in their community within the first year. Due to the time limitations on the Federal FUP vouchers this program did not access or utilize these vouchers. The program has found that with its ability to assist with housing more flexibly and longer than the FUP voucher would, it was not effective. The program did help parenting youth and young adults access FUP vouchers when eligible as there was no time limit and more effectively provided stable housing. In SFY 2015, the State Legislature re-instated the original $1 million from the original 2010 Homeless Youth Project. DCF was also mandated to no longer leverage $1.5 million in funding from the Supportive Housing for Families program but specify those dollars into a Homeless Youth Program with its own funding. The program was re-named by young adult program participants to "Start". The new funding was allocated between the existing and newly named Start Program to build on the success of the existing program and allow for additional program components such as Crisis Response and Outreach services, to DCF involved youth and non-DCF involved youth ages 16-24. This additional

component provided Street outreach for youth and young adults in the Hartford area, Emergency Housing for youth and young adults statewide, Family mediation, Survival aide, including, emergency food, blankets, coats, etc., LGBTQ Specific Services and access to the two–year transitional model.

Also, with the re-instated dollars DCF also allocated $50,000 to the CT Coalition to End Homelessness to conduct the first annual Homeless Youth Count in 2015. With the support of these dollars Connecticut will be the first state to engage in a statewide effort to count homeless youth. The Count allows for DCF and the Department of Housing (DOH) to gather data on the length and number of episodes of youth homelessness, social networks, family relationships, and reunification with family.

Describe any planned use of funds (Chaffee) to support engagement in age or developmentally appropriate activities

The Department builds into the Chaffee grant funding for developmentally appropriate activities as well as annually providing funding to each Regional Youth Advisory Board for such activities.

The Virtual Academy

The Virtual Academy was established by Unified School District (USD#2) in February 2016 to serve secondary youth in the care (inclusive of Juvenile Justice youth) of Department of Children and Families. This creation was based on 2015 standardized assessment results in the state of Connecticut. The 11th grade results (Connecticut only takes standardized assessments in grades 3-8, and 11) saw over 95% students fail to meet the achievement level in math and over 90% fail to meet the achievement level in reading. The Virtual Academy provides these youth an online opportunity at remedial courses in Math and English Language Arts. There are credit recovery options for all content areas (Math, English Language Arts, Social Studies, and Science), elective course offerings, career pathway classes, and SAT/ACT prep classes. As of June 2016, over 100 youth have accessed the Virtual Academy and its seven state certified teachers across the state. These youth have earned over 40 credits toward their high school graduation.

Education and Training Voucher Program

Attachment E

Annual Reporting of Education and Training Vouchers Awarded 2017

Name of State: State of Connecticut Department of Children and Families

	Total ETVs Awarded	Number of New ETVs
2014-2015 School Year* (July 1, 2014 to June 30, 2015)	178 computers to be distributed + 33 students summer intersession +2 students over budget +3 Students of adoption/guardian (new) Total = 216 ETV awarded	New recipients 181 (178 computers + 3 ETV grants = 181)
2015-2016 School Year* (July 1, 2015 to June 30, 2016)	122 computers distributed (August 2015) + 4 ETV grants adoption/guardianship (3 new and 1 repeat award) +1 Special student funding request +44 summer funding requests (2015) +29 summer funding requests (2016) Total 200 ETV awarded	New recipients 125 (122 computers + 3 new ETV grants)
2016-2017 School Year (July 1, 2016 to June 30, 2017)	137 Computers distributed for 2016 cohort of students. (August 2016) +8 ETV grants adoption/sub-guardianship (5 new and 3 repeat) +3 special funding requests +32 summer course funding requests Total = 180 ETV awarded	New recipients 142 (137 Computers + 5 ETV grants)
2017 -2018 School Year Anticipated projections for the next school year	Anticipate 200 computers (2018 cohort) through ETV funding; supporting 2 Pupil Services Specialist, 8-5 ETV grants adoption/guardianship; Anticipate 60-80 summer and winter course funding, Mailing 80+ ETV application for grants to eligible youth who have been adopted or subsidized guardian transfers.	

Narrative:

The State of Connecticut Department of Children and Families (DCF), continues to utilize a portion 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. Due to the fiscal restraints of the state of Connecticut's budget the third Pupil Services Post-Secondary Education position was not filled after the person left to pursue another position at the Department of Children and Families Unified School District #2.

The Post-Secondary Education (PSE) Consultants support Social Workers, community providers, foster

youth and foster families with transitional services offered by the Department of Children and Families. The Post- Secondary Education Consultants also assist staff, community providers, youth and educational institutions who are working with foster youth in Post-Secondary Education programs with transition services and resources through adulthood/out and of DCF care. The Post-Secondary Education Consultants continue to provide training for professional development and certification through the Departments Training Academy. Trainings also include foster youth meetings, foster parent trainings, for community service providers regarding the Department of Children and Families Post-Secondary Education programs, transitional services, retention and policies. The Post-Secondary Education Consultants also provide community outreach, consultation and program development services in support of the Department's quest to support foster and adoptive youth through the age of 23.

The Post-Secondary Education Consultants primary focus is identifying needs and resources for youth transitioning to Post-Secondary education as well as youth transitioning out of the foster care system. Increasing the Post-Secondary Education Consultants professional knowledge, skills, and abilities, the Department will adjust the annual budget to include for the next reporting period (continually thereafter) funding for the Post-Secondary Education consultants to receive specific designed Professional development training.

Data collection and maintenance for PSE in Connecticut DCF has remained a challenge for the department since the durational position that focused on data collection ended in October 2014. To assist with this challenge, in 2016, the Department of Children and Families Unified school District # 2 has created and maintained Educational Data Dashboards for foster youth in DCF care cohorts. DCF in collaboration with the Connecticut State Department of Education have developed a system that allows both agencies to access student data to assist with identifying transitioning youth in care. Both Post-Secondary Education Consultants consult with staff regarding Post-Secondary Education Data Dashboard.

The State of Connecticut Department of Children and Families continues to directly distribute and monitor Education Training Voucher (ETV) funds to eligible youth does not contract out to providers. Eligible youth have been adopted after the age of 16, sub-guardianship after the age of 16 and are current youth in the foster care system. The Department has focused on expansion of these services

and funds for eligible youth by collaborating with the adoption and subsidized guardianship department to identify resources and eligible youth. The two departments now have regular communication regarding policy, funding, student needs etc.

The ETV grant was awarded to 416 recipients from October 1, 2014 to June 30, 2016. During this time period there were 306 new recipients of the ETV grant. The ETV grant has been awarded and distributed to eligible current and former foster youth across Connecticut (in all state regions. The eligible populations served with the Education Training Vouchers, statewide are:

1. Foster youth who have graduated high school and are enrolled in a formal post-secondary education training program,
2. Former foster youth who have been adopted or subsidized guardianship transferred after the age of 16 and have graduated high school and also entering into post-secondary education institutions and
3. Foster youth who are already in post-secondary education institutions and programs and are transitioning to adulthood and may need additional funding to support them in their education.
4. Current and former foster youth who live outside of Connecticut in another state with their adopted parents, subsided guardians, or foster parents and remain eligible for services.

The college graduation rate among foster youth continues to be a struggle, not only nationally but in Connecticut as well. To help address this issue in Connecticut the Department is planning to expand programming through ETV by partnering with Connecticut state universities to develop bridge summer programs to support foster youth transitioning to campus and also for those students currently on campus. The program design will include the opportunity for foster, adopted and sub-guardianship population who have graduated high school to participate in a summer bridge program focused specifically for their success in the program, through a plethora of support services on campus that will focus on transition, academic and retention supports. The pilot program is in development with one Connecticut State University and will most likely be ready to accept students for next summer. Funds provided through the ETV grant will assist with the costs of the college level courses the students will earn during the summer.

From July 2014 – June 30, 2015, 3 new ETV grants were awarded to eligible youth. From July 1, 2015-June 30, 2016 period, the Department provided 4 ETV grants to eligible youth. From July 1, 2016 – June 30, 2017, there were 5 new ETV grants awarded to eligible youth. In April 2017, there were 86 applications mailed to eligible youth and (adoptive and guardians) parents. To date 12 applications

have been returned via US Postal Service mail and 2 partial ETV applications for funding which will be included in next year's calculations. Any additional applications that are received prior to June 30, 2017 will be included in the calculation for next year as well. The deadline for submission of an application is August 3, 2017.

During the year July 2014 - June 2015, CT DCF covered summer tuition expenses for 44 youth foster youth who took summer courses. From July 1, 2015 - June 2016, the Department of Children and Families awarded and additional 29 foster youth ETV grants for summer tuition expenses. From July 1, 2016 –June 30, 2017 there were 32 summer funding grants awarded to foster youth taking summer courses to assist with completion of their certificates and degrees. It is anticipated that 5 more ETV grants will be awarded prior to June 30, 2017. Due to the identified needs mentioned directly from foster youth, youth will have the opportunity to apply for funding for winter courses that will be applied toward their certificates and degree completion.

In July 2015- June 2016 there was 1 youth who requested and received special permission to utilize ETV funding for post-secondary education expenses outside of their annual budget. During this reporting period (July 1, 2016- June 30, 2017), there are 3 foster and former foster/adopted youth who applied for special funding requests to assist with educational expenses not covered by their annual budget. All 3 youth have been awarded the ETV grant funds for these various post-secondary educational expenses, demonstrating an increase in directly servicing foster youth with the ETV grant funds.

The Department continues to purchase computers, printers and supplies for foster youth that have graduated from high school and are enrolled in a Post-Secondary Education program. For the cohort of foster youth graduating high school in June 2014, the Department purchased and distributed a total 178 computers. The foster youth, who were in the June 2015 cohort, the Department purchased and distributed 122 computers to eligible youth. The Department purchased 207 computers, printers and supplies for eligible youth in the 2016 cohort. In 2016, a total of 137 youth transitioning to Post-Secondary Education institutions received a computer, printer, programs and supplies. The youth who did not receive a computer, printer and supplies became in eligible for various reasons such as: not graduating from high school, did not complete their GED, remained in their Individualized Education Plan (IEP) for another year, left the departments care and returned home to biological parents, adoption, guardianship transfers, did not enroll in Post-Secondary Education institutions following high

school graduation, or entered into the Department's work program. The gap between the purchased and distributed computers can also be attributed to additional options/programs to remain in the foster care system past the age of 18 and after secondary education for foster youth. The left over computers from the purchase last year will be absorbed in the distribution for the 2017 cohort.
In 2015, the Post-Secondary Education Consultants reviewed academic profiles of 230 youth in the foster care system. There were 183 post-secondary education plans reviewed for foster youth who graduated from high school and attend post-secondary education in the fall 2016. There was an additional 24 foster youth who have not have a final post-secondary education reviewed the Post-Secondary Education Consultants. This did not affect their eligibility for receiving the grant funds. During the 2016-2017 academic year, there have been 240 pse plans reviewed. There are an additional 29 outstanding pse plans that have not been submitted for review. Although the number of pse plans reviewed assist the Department with identifying how many eligible youth are transitioning to Post-Secondary Education, not having a pse plan does not affect a student's eligibility to receive ETV funding. The Department will again purchase 125 computers, printers, and supplies to add with the left over from last year to service this population of foster youth entering into Post-Secondary Education programs in the fall of 2017. The Department has developed a system and practice to focus on transitional planning at an earlier age/grade for all youth in care; with the opportunity of kinship placements and other placement types and services to allow youth to remain at home, the Post-Secondary Educational Consultants review more pse plans each year. These pse plans are shared with the local school districts, and families and assist with matching and planning for youth who will enter into Post-Secondary Education Institutions. It is anticipated that the cohort for 2018 is estimated to be 200+ youth.

From July 1, 2014 – June 30, 2015 the Department awarded a total of 216 ETV grants (with 181 being new recipients). From July 1, 2015- June 30, 2016 the Department has awarded 200 The ETV grants with 125 being new recipients. In the reporting period of July 1, 2016 – June 30, 2017, there have been a total of 180 (142 being new recipients) ETV grants awarded thus far with an expecting of at least 5 more to be awarded before June 30, 2017.

Section F. Updates to Targeted Plans

Foster and 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;
- Museums;
- Cultural arts centers;
- Theaters;
- Insurance Companies;
- Hospitals;
- Guest Speaker at civic organizations;
- Open Houses; one to one with individuals in the community;
- Open Houses in the community – in home settings;
- Heart Gallery Display (photos and brief biographies of youth);
- Social Media posts about foster care and adoption needs, highlights, events, etc. Facebook, Twitter, CT Parent web site;
- Department of Motor Vehicle advertising on internal digital screens;
- Clear Channel, iheart Radio advertising and child specific recruitment
- WIHS Radio Interviews, child specific recruitment
- Television Interviews;

Support/Retention Activities:

- Accepting and allocating donations from community providers, such as bicycles, theater and sporting tickets and gift cards;
- Coordinating special interest stories with foster, adoptive and biological families to increase the community's awareness of our goal for permanency. These stories highlight the work that is being town and the collaboration between the foster, adoptive, biological and DCF staff;
- Awareness Month events [May and November], recognizing foster and adoptive parents who have demonstrated a level of commitment and passion to the work.

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 really took hold in 2016, but will be expanded upon in 2017. Additional strategies will be identified and additional training in extreme recruitment will be offered.

During calendar year 2016, the Department successfully licensed 980 new foster and adoptive homes. The breakdown of those new licenses is as follows:

- Foster homes - 142
- Adoptive homes - 73
- Special Study homes - 170
- Independent homes - 51
- Relative homes – 543

The Department will continue to move towards placing children with relative/kin throughout 2017.

In 2014, the Department started Caregiver Support Teams (CST) in all six regions. There are 676 slots statewide. At the end of State Fiscal Year (SFY) 2015, 616 families were served, and at the end of SFY 2016, 806 families had been served. To date, 711 families have been served over the last three quarters of SFY 2017. The caregiver support team provides much deserved in-home supports to both kin and non-kin family based placements. CST services are also available on a case by case basis to support families without legal status with the Department. These families may have children who are exiting out of Congregate Care, Residential Care and Hospital settings and are returning home, as well as adoptive families and "family arrangements" at risk of disruption.

The Heart Gallery

Since 2003, the Heart Gallery, a collection of photograph's and personal bio's, continues to bring awareness to the Connecticut public about children in state care who 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. Since 2013, the Heart Gallery has been displayed in a minimum of six (6) locations throughout the state. The Heart Gallery has been featured in venues such as the State Capital, children's museums, theaters, art galleries, community centers, libraries, daycares, malls, churches, hospitals, town halls and commercial spaces throughout Connecticut. The Heart Gallery has also been displayed in digital format and is on permanent display at Jordan's Furniture in New Haven, CT.

From 2005 to early 2017, 368 children have been featured in the Heart Gallery. In 2015 and 2016, forty eight (48) new children and youth were featured in the Heart Gallery and currently there are thirty one (31) children featured in the Heart Gallery. Since the last report, seventeen (17) children have left the Heart Gallery so that their permanency plan can be established.

GOOGLE and technology based recruitment:

While DCF continued to recruit on the web via the purchase of a Google ad during 2016, all advertising campaigns all advertising campaigns are on hold because DCF's current websites are not "mobile friendly" and therefore not compatible with Google's advertising parameters and requirements. The new website, which is scheduled to go live in the fall, will be compatible with all mobile platforms. Key words entered into a Google Search including "adoption" and other related phrases connecting a viewer directly to the Department's website – www.CTFosterAdopt.com. . The following results from

January 1, 2016 to December 31, 2016 are as follows:

- Total of 426,109 page views
- 81,501 unique visitors
- 112,466 sessions
- 70.8% are "new visitors"
- 29.2% are "returning visitors"

The visitors viewed an average of 3.79 different pages per visit and spent an average of 2 minutes and 22 seconds on the site. As a result of the "Google" ads, in 2016 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.

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. In 2015 the Department began a regular segment on WFSB's Better Connecticut program for youth who are in need of a home. In 2016, the Department became a regular partner with iheart radio and WIHS radio where Heart Gallery children are featured weekly. The Department is actively pursuing several major TV networks in hopes to collaborate on a consistent basis for Heart Gallery children. It is our expectation that the current partners will continue through 2017 with additional media sources.

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 recruiter has a caseload of 15-20 children and youth in need of permanency. They work with the PRE Supervisor for referrals to their program. This resource was expanded in 2014 and there are now 4 full time Recruiters in CT doing this work. with the employment of a 5th recruiter pending 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), Puertorriqueñisima 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.

Furthermore, the Therapeutic Foster Care private providers were given a rate increase in May 2016 to create a Child-Specific Recruiter position based on their contract capacity. All positions have been filled and monthly recruitment meetings began in March 2017. Central Office is providing support and oversight to this initiative by the development of a standardized referral process, identification of priority cohorts, and collection of data on a quarterly basis. The Department's Statewide Recruiter is actively involved in the collaboration of recruitment and retention events and linkage to the Heart Gallery.

<u>While You Wait Events:</u>

Since 2005, DCF's Adoption Resource Exchange staff, continue to manage ongoing training opportunities for pre adoptive families called "While You Are 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 the Adoption Assistance Program Staff.

DCF Adoption/Permanency Resource Exchange child specific recruitment activities:

In 2016, the Permanency Exchange Specialists from PRE provided child specific recruitment for 20 children and youth in need of adoptive families. The majority of these children were between the ages of 10 and 17. Many had significant medical or developmental disabilities with an increase in servicing children with a diagnosis of autism.

Child specific recruitment activities in 2016 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, and magazine and newspaper articles and ads. The PRE also contracts with a local video production company to create compelling videos of the children waiting for adoptive families. These videos allow families to view the children and hear about their stories in their own words. The PRE also works with the LGBTQ community to conduct child specific recruitment by attending events sponsored by True Colors and submitting advertisements in 'Gay Parent Magazine.' Child specific recruitment for minority children assigned to the PRE has occurred through collaboration with Puertorriquenisima Radio and the Latino Way.

Technology Based Recruitment Activities in the Adoption Resource Exchange/Permanency Resource Exchange:

Since 2013, the PRE 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. The PRE also contracts with a local video production company to create compelling videos of the children waiting for adoptive families. These videos allow families to view the children and hear about their stories in their own words. This work continued throughout 2016.

Permanency Planning Services Program (PPSP):

The Permanency Planning Services Program (PPSP) provides core contracts with 17 clinical 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.

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 is now utilized by the Department and private Child Placing Agencies (CPAs) which creates 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 included a component on Health and Wellness. That component, Foster Health for Children in Foster Care is now a required module that all prospective foster and adoptive parents attend pre-licensure. This component also includes a section entitled "Medication Safety for Foster Parents".

The Department of Children and Families has continued concerted efforts to enhance strategies and activities to offer post-licensing training to licensed core foster and adoptive families, ensure accessibility (varied days, times and locations, reimbursement for child care and transportation), ensure that training is available to those for whom English is not their primary language, to document completion of training and improve compliance with the expectations.

In January and February 2016, the Department engaged in heightened activities to improve outcomes in those areas noted above. The requirements were reiterated to all DCF FASU staff and disseminated to all licensed foster and adoptive families (by the Regions and CAFAF) in a Frequently Asked Questions format. The Commissioner generated a letter (in English and Spanish) to all licensed foster and adoptive families conveying these expectations and emphasizing the importance of compliance February 3, 2016). Consequences for non-compliance were also communicated: licensing actions (putting homes on hold at time of re-licensing, no additional placements, in extreme cases revocation of license). Regions developed and enhanced systems to communicate ongoing with foster parents around completing post-licensing training. These included, mass email blasts of upcoming trainings, increased use of support groups to share information about trainings and to deliver trainings, regular newsletters with information on training, discussing training needs during monthly phone calls and quarterly home visits.

In February 2016 an electronic database went live in Sharepoint for all Regions to utilize to document completion of post-licensing training. The database has built in functionality to generate reports to show how many licensed core foster and adoptive families are completing training, including the required elements, and the number who are in compliance. To date, 722 Core foster parents (an increase of 131 from last quarter) have completed one or more mandatory trainings. Because the license cycle and training requirement is based on a two-year cycle, this database will become most valuable beginning in February 2018 when it will be possible to generate reports based on a full two-year licensing period of the first families entered into the system. Additional functionality is being developed to make it possible to generate additional reports.

<u>Connecticut Alliance of Foster and Adoptive Families (CAFAF)</u>

CAFAF had one staff member trained in TIPS-MAPP in Spring of 2017 to partner with DCF in facilitating pre-licensing training. The DCF Statewide Recruiter met with the new recruiter at CAFAF to discuss

recruitment and retention strategies and a "while you wait" pilot program. CAFAF is partnering with DCF to recruit emergency foster homes for use by the Careline after hours.

CAFAF partnered with DCF Information Systems to bring CAFAF post-licensing training online using the ProProfs web-based system. There are currently three online training offerings to date. The ProProfs system allows foster parents to complete post-licensing trainings accessed by the foster parent from their home, including pre- and post-testing, and enables CAFAF to track participation and completion rates. The Department partnered with CAFAF to develop a post-licensing training related to foster parent support for older youth which was provided at the CAFAF conference on May 5th. CAFAF continues to provide each Regional FASU Unit with a quarterly summary of inquiries, post-licensing trainings and Liaison activities. All post-licensing trainings, regardless of the source, are currently entered into Sharepoint location where the data can be aggregated and reviewed to inform post-licensing training enhancements.

Additional achievements/progress in foster and adoptive parent recruitment and training in 2016 has included:

- Expanded our partnership with the Dave Thomas Foundation, Wendy's Wonderful Kids (WWK). There are currently three (3) recruiters funded through the WWK foundation and two (2) recruiters funded by DCF. This allows 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 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 Alliance of Foster and Adoptive Families (CAFAF) 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. To date, all of the recommendations made during the Lean process have begun implementation. Updated Policy and a new Practice Guide were issued and became effective on June 1, 2017.

In early 2017, The Department began researching training curricula for kin and fictive kin families. The impetus being that the existing 9 hours of training should become more trauma-informed and include additional elements that would develop competencies in kin and fictive kin providers. In the late Spring of 2017, the Department decided to move forward with the Caring For Our Own curriculum by the Children's Alliance in Kansas. Children's Alliance also created and trains TIPS-MAPP. Much of the rationale for selecting this particular kin/fictive kin training is that it comports with the same messaging that Core families are getting through TIPS-MAPP. The Department expects to hold trainings for trainers in the Summer and Fall of 2017 and begin operationalization of a shift in training requirements before the end of the calendar year.

These are the following accomplishments/activities this past year:

- Partnered with the Connecticut Association of Foster and Adoptive Families (CAFAF) to implement a centralized training web list for families.
- Central office staff had duties re-structured and they were deployed the majority of their 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 are 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 CAFAF and DCF Regional staff to expand a foster parent/youth satisfaction survey.
- To comport with new legislation effective January 2017, the Department created a survey for youth ages seven (7) and older that will be offered to each youth upon discharging from a foster home placement. The data collected from the survey will inform the Departments foster parent training, recruiting and retention efforts.
- 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 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.

Health Care Oversight and Coordination Plan

DCF continues to work on programmatic and infrastructure initiatives aimed at enhancing the health of children in care. This includes progress on the specific projects and partnerships identified by the Health Standards and Practice Committee (HSPC). These include: the 'claims health profile' project with the Department of Social Services (DSS) medical ASO CT Health Network; the partnership with Yale and CT Children's Medical Center child abuse pediatricians to enhance DCF staff education regarding child abuse prevention and intervention; the partnership with DSS dental ASO CT Dental Health Partnership to promote oral health; and partnership with the CT Alliance of Foster and Adoptive Families (CAFAF) to expand and enhance caregivers understanding of the health needs of children in foster care. We also continue to work to enhance other existing programs including the Multidisciplinary Evaluations (MDE) in an effort to further enhance outcomes for children.

Since the restructuring in September 2015, the Division of Health and Wellness has successfully developed a regional nursing structure inclusive of nurse supervisors and full nursing support; an outcome achieved through both promotion as well as effective hiring. Through this structure we have ensured ready availability of nursing support to the Area Offices (AO). We also continue to develop

and enhance the supervisory skills of nurses as well as standardize nursing practice with attention in 2016 to documentation and best nursing practice in child welfare. We are confident that together these activities are improving nursing within DCF.

To promote health and encourage effective utilization of available health resources, Health and Wellness Division staff, including nurses and health advocates, have worked within their own regions and offices to educate staff and promote awareness of resources. Strategies have included: presentations at staff meetings, targeted conversations with specific AO/regional units (e.g. intake or complex medical units), as well as memos and targeted emails about specific issues impacting children in care (DSS transitioning of Medicaid information system from EMS to ImpaCT).

Health & Wellness Policy and Practice Guide: Translating Policy into Practice:

DCF continues with initiatives and activities aimed at implementation of the Departments Health and Wellness policy and practice guide entitled "Standards and Practice Regarding the Health Care of Children in DCF's Care". Specific strategies include education of stakeholders as well as ensuring consistent messages to reinforce key principles and build on fundamental practices.

Specific education initiatives include the following:

- Training of AO staff: DCF nurses continue to work to support and educate staff and community providers through individual case consultation. Other ongoing efforts include partnerships with DCF's Academy of Workforce Development in the provision of education as part of routine training of social workers in preservice and investigators in in-take training. The Health and Wellness Division has also partnered with CT's Child Abuse Pediatricians (CAPs) on an education initiative focused on child abuse prevention and early identification. Specific strategies include 1) ongoing quarterly training by CAPs to DCF nurses on topics impacting children in care and case review and 2) RRG Nursing/CAP partnerships in education to specific AO/Regions they serve. The DCF nurse training is aimed at enhancing capacity and preparing nurses to best support AO and community providers. Initiatives with AO/Regions focus on prevention and early recognition of child abuse and include a review of the fundamentals, with attention to key issues identified through research as well as experiences in CT. CAPs will also use AO/Regional cases to reinforce strategies for prevention in addition to providing strategies

and information which will promote appropriate and prompt consultation with RRG nurses/CAP.

Education for 2017 will again build on state and national experience and trends with topics including sentinel injuries and sexual abuse.

DCF's Health Advocates continue to work with DSS' ASO for dental care, CT Dental Health Partnership on the "Health Mouths, Healthy Kids" initiative, a project aimed at promoting oral health. In 2016 attention was paid to ensuring consensus on DCF's expectations for oral health and communication of consensus to both internal and external stakeholders. Work has been done collaboratively with DCF's Administrative Case Review (ACR), AOs, communities of practice and senior leadership. Health advocates also promote oral health in individual cases by including information about outstanding dental health needs as part of their case consultation responses.

- Training of Foster Parents and Caregivers including relative/kin: In partnership with both internal and external stakeholders, the Health and Wellness Division has continued to enhance the training series launched last year. This series has been streamlined to provide trainings that prepare the caregivers to safely manage and care for this unique population. The training still includes the CORE courses of *Fostering Health for Children in Foster Care* and *Strategies and Resources for Managing Health Care.* A third on-line training was added; *Medication Safety for Foster Parents.*

- Fostering Health is now available Spanish for both in-person and on-line.

- The core courses and other initiatives are described here:
    - ***Fostering Health for Children in Foster Care*** has now been a requirement for all foster parents and has been very well received by caregivers. It continues to be mandatory for all foster parents and is taught both by DCF staff and on-line.
    - ***Medication Safety for Foster Parents*** was introduced at the end of 2016 as an on-line training. It covers topic such as, how to read a medication label, how to measure

medication, safe storage and control of medication, keeping track of medication doses administered, and what to do if their child as a side effect to a medication.

- ***Strategies and Resources:*** Continues to be provided for relative and kin foster parents and is now a pre-requisite for any foster parent wanting to become a medically complex foster parent. This is both done in a typical classroom setting and as a 1:1 training upon request.

- **Surveys are collected for *Fostering Health for Children in Foster Care* and *Medication Safety for Foster Parents* with a sampling of results below;**
    - ***Fostering Health for Children in Foster Care***
        - Surveys were collected from 458 foster parents/caregivers of mixed race and ethnicity with questions ranging how the training met their needs as caregivers, what they liked most/least, and the training format.
            - **98** % said they either agreed or strongly agreed that they have a better understanding of their responsibilities as a foster parent/caregiver
            - **98**% said they either agreed or strongly agreed that the training helped them better know who their key resources are in DCF
            - 98% said they either agreed or strongly agreed that the training helped them understand how to provide a safe sleep environment
            - **98**% said they would recommend the training to both new and experienced foster parents/caregivers
    - ***Medication Safety for Foster Parents***
        - Surveys were collected from 259 foster parents/caregivers of mixed race and ethnicity with questions on whether the training gave them new information, helped them better understand what to do if a medication caused serious side effects, and how to read a label, and if the format was easy to use.
            - **90** % either agreed or strongly agreed that they learned new information in the training
            - **97** % agreed or strongly agreed that they have a better understanding on what they can do is their child experiences a serious side effect from a medication while in their care

- **93%** agreed or strongly agreed that the training helped them better understand how to read a pharmacy label or over the counter medication label.
- **98 %** said they would recommend this training to both new and experienced caregivers/foster parents

- ***Medically Complex Certification Course***
  - This training is for foster parents interested in caring for children with complex medical needs: DCF continues to provide enhanced and targeted education to individuals interested in caring for children DCF serves who have complex medical needs. Based on a 4 tiered classification, the course led by nurses in the Complex Medical Unit of the Health and Wellness Division, explores the unique needs of this population and explores components which contribute to a child's medical complexity.
  - The revisions to the Medically Complex Certification program were completed and launched at the end of 2016. It builds on the other training offerings – making them prerequisites for all parents wanting to become Medically Complex Foster Parents. Requiring these pre-requisites allowed the overall certification process to decrease the previous two full day in-person training to a one day overview class. This change allows the caregivers to complete much of the training in their own home. Pre requisites for participation in the One-Day overview class are:
    - *Strategies and Resources for Managing Health Care*
    - *Fostering Health for Children in Foster Care*
    - *Age appropriate CPR*
- Child Specific Medical Training
  - Remains a requirement for all DCF Core, TFC, Back-up and respite providers as well as kinship and pre-adoptive caregivers who are caring for children with complex medical needs in classifications 1 – 4 prior to or the day of placement of a child into their home.

- Training for Congregate Care providers: Health and Wellness Division has partnered with DCF licensing to review and enhance congregate care standards and best align them with DCF practice. There is a new training for Nurse Consultants and Supervisors of the congregate care settings that reviews the regulatory requirements for medication administration in the congregate care settings. The Medication Administration Certification training, for non-licensed congregate care staff, is being revised and will be adding in 2017 an on-line offering.

DCF's Enhanced Multidisciplinary Evaluations (MDEs)

DCF's Multidisciplinary Evaluations continue to ensure that children entering care receive a comprehensive screen of their physical, behavioral and dental health as well as trauma within 30 days of placement. DCF continues to work to enhance the all aspects of the MDE including the tool as well as process with the goal of ensuring that it provides quality information to inform planning for children entering DCF care. Described here are activities and outcomes in 2016:

- MDE clinics continue to meet the needs of the Department and to provide examinations within 30 days of a child's entering care. Ninety-three % of children entering care in 2016 had an MDE completed within 30 days of entering care. MDE clinic data shows timely completion of reports and distribution and ongoing partnerships with AO to schedule appointments including collaboration between MDE clinics when needed to accommodate the needs of families caring for children outside the region. Data as well as feedback from bi-monthly MDE Committee meetings informs MDE practice.

  The MDE program continues to partner with the CONCEPT trauma grant team to enhance trauma screening of children entering care. The MDE clinics complete the Connecticut trauma screen (CTS) as part of the MDE for all children ages 7 and older and where indicated recommend referral for therapeutic intervention children and youth entering care. Having completed work on the CTS for children ages 3-6 years old, the CTS Young Child (CTS-YC) will be added to the MDE in 2017.

- The MDE committee continues to work on the development of QI/QA tools and systems to support and enhance the MDE system and outcomes. Provided here is a description of the tools currently in use or in development. They include:
    - The MDE customer survey which assesses MDE practice and quality including quality of report has been finalized, piloted and will be implemented in 2017. The surveys were developed using ProProf software which in addition to providing data about individual MDE clinics, through its online format facilitates monitoring.
    - The MDE consumer survey is administered by the MDE clinics and collects information about the experience at the actual MDE appointment. An invaluable tool, our hope is to identify a mechanism to permit online completion of this tool using ProProf.
    - The MDE audit tool has been drafted and will be used, at least initially, by DCF staff who oversee the MDE contract. The plan is to pilot the audit tool in early 2017. Once finalized we plan to use it to review 1-2 completed MDE reports from each clinic each month.
    - Work continues on the development of the peer review process of the MDE report's "Summary and Recommendations". The primary purpose of the Summary and Recommendations is to provide a snapshot of the MDE and to provide clear recommendations that can inform case planning and follow up. The team of MDE clinic clinicians continues to work to develop the assessment tool.

- The MDE Committee continues to monitor the MDE components including screening tools to ensure that they are up to date and consistent with best practice. In 2016 the following changes were made or undertaken:
    - Decision was made to use the BASC 3 to replace the BASC 2. Work is underway to revise the MDE Report Template in anticipation of full implementation by all clinics by August 2017. Many clinics are already using the newer screening tool.
    - In partnership with DCF's Substance Exposed Infant (SEI) initiative, we are working with on the development of a Fetal Alcohol Spectrum Disorder (FASD) screen for use in the MDE. Research suggests that anywhere from 55-80% of

children in DCF care are impacted by fetal alcohol exposure. Partnering with a FASD expert at Yale, the goal is to develop a tool that will identify 'levels of suspicion'. These levels of suspicion will inform the triage tool which will provide age-appropriate guidance on domains and areas of functioning to monitor and of potential concern for the child or youth. These 'levels of suspicion' will also identify which children may need additional evaluation.

Care Coordination and Community Partnerships

DCF continues to work on efforts to enhance outcomes for children in care through improved coordination and collaboration with health care providers in the community. In addition to encouraging and promoting partnering with community providers as part of routine care and practice, DCF continues to work with other agencies and stakeholders on some focused initiatives. These include:

- State Level Care Coordination Collaborative. DCF continues as a member of the State Level Care Coordination Collaborative, a grant-supported initiative aimed at increasing the number of children and youth with special health care needs who receive a patient / family centered medical home approach to comprehensive, coordinated service and approaches. Building on the Department of Public Health's Medical Home Initiative and their Regional Care Collaboratives, this statewide initiative seeks to increase state's capacity to coordinate policy, program development and collaborative partnerships across agencies. DCF continues to work with this group to enhance outcomes for children in care.

- DPH Medical Home Care Coordination Collaboratives (HCCC). DCF continues to participate in the Regional Collaboratives and ensure ongoing representation by DCF staff including health advocates, nurses and social workers. In addition to identifying ongoing resources, the collaboratives continue to be an invaluable tool and have provided immeasurable support and assistance to DCF and the families we serve helping children who are transitioning to families as well as maintaining placements.

Health Information and Documentation

Work continues to ensure access and ready availability of reliable health information to inform practice

and planning and improve outcomes of children in care. These efforts include:

- Standardization of nursing / health documentation: The guideline for nursing documentation developed by the Nursing Standards and Practice Workgroup has been implemented and is helping improve practice. Nurse supervisors are using it as a guide to review regional and central office nurses practice and where needed offer support and ideas to improve practice.
- Ongoing involvement in planning for new SACWIS / CCWIS system: In addition to ongoing participation in planning for CCWIS, the Nursing Standards and Practice Workgroup, the MDE committee and other teams within DCF worked to ensure that all DCF forms pertaining to health were reviewed and if needed updated in expectation of their becoming part of the new CCWIS system. Expected to continue into 2017, initial work included suggested revisions to DCF medical consents.
- SharePoint: The Division of Health & Wellness continues to refine the Health and Wellness SharePoint site and ensure that it has up-to-date information about programs and valuable links to resources about health and wellness.
- Claims health profile: Recognizing the importance of health information to informing planning and safety for children upon their entry into care, DCF partnered with DSS to create a claims health profile for children entering care. Developed with CT Health Network, DSS' ASO for health, and DSS, the claims health profile provides a snapshot of health and is provided within 24 hours of request. Information collected include:

    - Identification of PCP and one year of claims diagnoses
    - Identification of any other providers and two years of claims diagnoses
    - Pharmacy information including medication, date last filled, prescriber and pharmacy
    - Immunization information based on two years of claims
    - Inpatient admissions including hospital, dates and diagnoses for two years
    - Emergency department visits including dates and diagnoses for two years

    In early 2016, a claims health profile pilot was launched in Regions 4 & 6. Guided by a Claims health profile principle and summary document, the Regions developed their own claims health profile protocols which outlined specific steps and activities. Given their key roles in the process, regional nurses and health advocates took the lead in educating area offices about the

process and monitoring outcomes and used their experience and data gathered to inform modifications to the process. Follow-up meetings with key AO stakeholders led to refinement of the protocols and improved results. This iterative process is informing the development of a standard claims health profile which will inform implementation in other DCF regions with the goal of statewide use in 2017. Lessons learned will inform its integration into SACWIS.

Total MDEs Performed
from Health & Wellness Data

Reg.	Area Office	Total # of MDEs Performed by CALENDAR Year		Total # of MDEs Performed by FISCAL Year	
		CY 2015	CY 2016	FY2014-2015	FY2015-2016
1	Bridgeport	99	91	77	119
	Norwalk	72	84	59	98
	Total MDEs Reg. 1	**171**	**175**	**136**	**217**
2	Milford	80	117	51	117
	New Haven	80	103	88	109
	Total MDEs Reg. 2	**160**	**220**	**139**	**226**
3	Middletown	36	39	35	33
	Norwich	173	170	136	191
	Willimantic	143	132	112	142
	Total MDEs Reg. 3	**352**	**341**	**283**	**366**
4	Hartford	168	188	169	196
	Manchester	121	107	92	124
	Total MDEs Reg. 4	**289**	**295**	**261**	**320**
5	Danbury	65	88	69	81
	Torrington	50	45	33	61
	Waterbury	172	225	178	208
	Total MDEs Reg. 5	**287**	**358**	**280**	**350**
6	Meriden	71	50	66	50
	New Britain	109	147	123	135

	Total MDEs Reg. 6	**180**	**197**	**189**	**185**
		1439	**1586**	**1288**	**1664**

Centralized Medication Consent Unit (CMCU)

Established in 2007, the CMCU is staffed by child psychiatrists and APRNs who are responsible for reviewing psychotropic medication treatments recommended by psychiatric practitioners for DCF-committed children/youth. A Psychotropic Medication Advisory Council (PMAC), a DCF-organized council of public and private physicians, clinicians, nurses, family members and pharmacists, advises CMCU in establishing and maintaining, practice guidelines for the use of psychotropic medications in DCF-committed children/youth. The PMAC meets regularly to recommend dosing parameters and monitoring guidelines; review adverse drug reaction reports; consider changes to the CMCU medication formulary.

CMCU outcome data highlights:

1. The number of unique youth treated with psychotropic medication continues to trend down from a high of 1135 in 2011 to 849 in 2015 to 763 in 2016.
2. The number of concurrent psychotropic medications per youth is trending down from 8 in 2009 to 5 in 2016. In 2016 the total number of unique youth on four or more concurrent psychotropic medications was 84 (11.1% of the youth treated with psychotropic medication in DCF care).
3. Intraclass polypharmacy (i.e. use of two anti-psychotic medications) has been brought down to a minimum (from 52 youth in 2012 to one youth in 2016). No children age five or under in 2016 were approved to be treated with two psychotropics from the same class.
4. DCF reviews the CMCU data for racial disparities in prescribing practices.

Next Steps:

1. Continue to actively address the prescribing of two or more anti-psychotic medications concurrently and four or more psychotropic medications concurrently to children/youth committed to DCF.
2. Continue to closely monitor the requests to prescribe psychotropic medications for children age five and under. Work collaboratively with regional staff to identify non-medication treatment alternatives and fully integrate these into the care plans.

3. Continue to monitor the prescribing of pro renata (PRN) medications, analyze data in PMAC and develop guidelines as needed.

Disaster Plan

The state's disaster plan protocol was not activated and no changes have been made.

Training Plan

No changes to the Plan have been identified. See Section 5.

Section G. Statistical and Supporting Information

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. Applicants who do not have a BSW or MSW but have a related degree and prior CPS or Child Welfare experience are also prioritized 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 or other qualifying degree with prior CPS or Child Welfare experience.

- 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 opportunity, which is generally filled through internal promotion, 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. In the past year, the State of Connecticut has experienced reductions in force that have resulted in laid off staff from all agencies within the state having priority rights for reemployment in any classification for which they qualify. This has created a situation where a significant number of new hires by the Department have "related" degrees, therefore qualifying for the Social Worker Trainee position and have priority over any new hires with degrees in Social Work or experience in CPS or Child Welfare. 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. To

address the needs of new hires from the reemployment of laid off State employees, the Academy for Workforce Development, along with local managers, reviewed the skills and experience of those staff who needed individualized training, guidance and mentoring above and beyond what was offered in the pre-service curriculum in order to succeed.

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 Case Workforce as of 2/28/17

	Statewide										
	Total	Total Male	Total Female	White Male	White Female	Black Male	Black Female	Hispanic Male	Hispanic Female	Other Male	Other Female
C& F Admin	10	2	8	2	5	0	3	0	0	0	0
Area Dir. 2	6	2	4	1	3	1	1	0	0	0	0
Prog. Direc	32	7	25	3	16	0	5	4	4	0	0
Prog. MGR	99	29	70	18	40	3	16	6	13	2	1
Soc Wrk Supv	344	85	259	47	136	25	76	11	41	2	6
Soc. Wrkr	1190	272	918	136	403	87	304	42	193	7	18
S/W Trainee	166	37	129	14	53	19	39	2	30	2	7
S/W Case Aide	103	38	65	10	25	16	18	12	21	0	1
Grand Total	**1950**	**472**	**1478**	**231**	**681**	**151**	**462**	**77**	**302**	**13**	**33**

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%
Last amended March, 2012						

Juvenile Justice Transfers

According to the Department of Children and Families' SACWIS system, during calendar year 2016 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.

Sources of Data on Child Maltreatment Deaths:

DCF & CT Medical Examiner Partnership

The Director of the Office of the Ombudsman is a member of the Child Fatality Review Panel. On a monthly basis, he attends a meeting, co-chaired by the Office of the Child Advocate and a Pediatrician from Yale New Haven Hospital, to review all deaths of children in the State of Connecticut. That meeting is held at the Office of the Chief Medical Examiner and a Medical Examiner is also a standing member of the Fatality Review Panel.

The Director of the Office of the Ombudsman is in charge of the Department's Special Qualitative Review (SQR) process in which child fatalities are reviewed and reports are submitted documenting the Department's action in families where a fatality or near fatality has occurred. The SQR report documents case practice, policies and procedures, systems issues and key points to build upon after reviewing the case and discussing it with applicable Department and community providers who were involved with the family.

On a consistent basis, the Director of the Office of the Ombudsman has contact with the Office of the Chief Medical Examiner to receive updates on the cause and manner of death of children and to ensure that the Medical Examiner who conducted the autopsy on a child, and who will subsequently produce a report on that child's death, has any required Departmental records so a full assessment can be made of the circumstances leading up to the child's death.

Child Fatalities and SACWIS

Introduction

The purpose of this document is to describe how an employee of DCF with appropriate permissions to the SACWIS system will enter the information into SACWIS to indicate a maltreatment death due to abuse or neglect has occurred and subsequently how the data is extracted and submitted in the NCANDS reports.

The CT definition of a "Maltreatment Death" is so defined as: when at least one allegation of abuse or neglect related to the death has been substantiated by DCF against a caregiver. NCANDS defines a maltreatment fatality "as a child dying from abuse or neglect, because either (a) the injury from the abuse or neglect was the cause of death, or (b) the abuse and /or neglect was a contributing factor to the cause of death.

The following DCF Policies are used in the process:

34-2-7 – Operational Definitions of Child Abuse and Neglect

34-2-2 – Investigation Process

34-2-6 – Critical Questions to Answer

34-3-6 – Determination and Conclusion

The definition of Substantiated is "Reasonable cause to believe that child abuse or neglect has occurred".

Data Entry Process

From a data entry perspective the process starts when a user enters a CPS report into LINK **(Fig 1).**

The next relevant data entry point is reflected in **(Fig 2)** when an investigation worker enters the allegation such as physical abuse with a description of death and marks the outcome as substantiated. There is also a confirmation process that asks if the victim is deceased when death is chosen **(Fig 2b)**

The other two areas where a death recording can initiate is in the placement ending /discharge reason screen **(Fig 3)** and in the inactivation of case participants in the case maintenance screens **(Fig 4).**

In an effort to ensure that the LINK case record is consistent, edits have been applied to areas of LINK where a child's death may be recorded that prompt the worker to also record the actual date of death on the Person Management window.

When the death of a child is recorded in either Investigation **Allegations**, **Placement End/Discharge Reason**, or **Case Participant Deactivation**, that action or approval will not be allowed until a Date of Death is entered in the Person Management window **(Fig 5).**

NCANDS Reporting Process

On an annual basis the federal reporting team lead will run automated jobs run programs to extract data from the agency's SACWIS system "LINK". The lead will then provide the data to the LINK Program and Customer Support Team (PCSU) for review and validation.

The NCANDS logic is program to extract the following as a fatality any child where the following conditions are met:

- A CPS Report alleging child maltreatment was received and accepted,
- An investigation resulting from that report was conducted and concluded that year,
- Allegations of maltreatment were substantiated,
- The child died, the proximate cause of death determined to be the maltreatment the child sustained

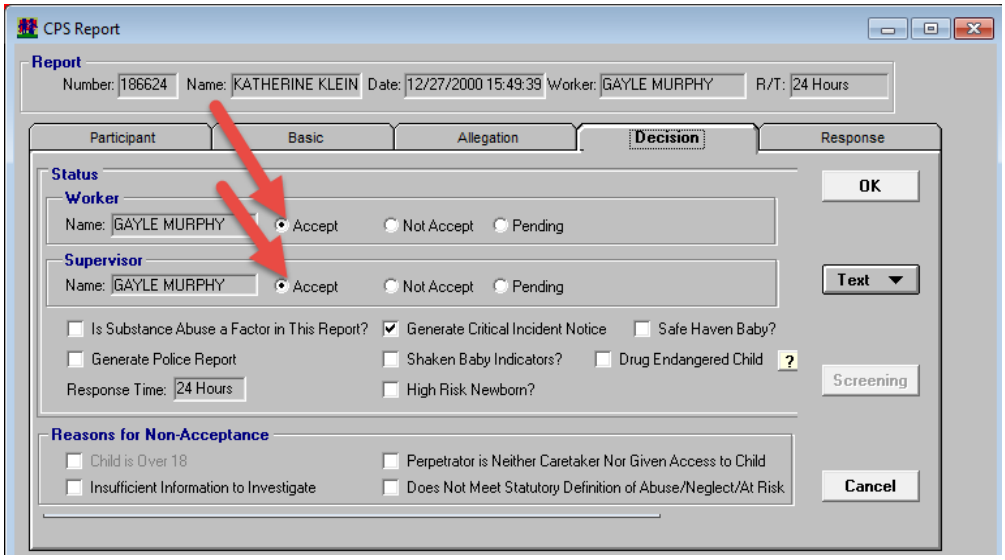
The NCANDS job uses COBOL and SQL to extract data from the ALLEGATION and PERSON tables in the SACWIS DB2 Database.

The NCANDS extraction batch will only transmit data when there is a substantiated allegation of death due to maltreatment. It will not transmit if the death data was entered but there is no corresponding substantiation. Also noteworthy is that the data is only transmitted for the FFY where the investigation has concluded and not the date of death which can have an effect on the date the death is reported.

Recording the Death of a Child

CPS Reports

Fig 1



Investigation Allegations

Investigations with an allegation of Death (i.e. Physical Abuse - Death, or Physical Neglect - Action/Inaction resulting in Death). Upon clicking Approve, a pop up asks if the victim is actually dead ("An allegation of death has been selected. Is the victim actually dead?"). If answered Yes, the investigation cannot be approved until a date of death is entered into **Person Management**.

Fig 2.

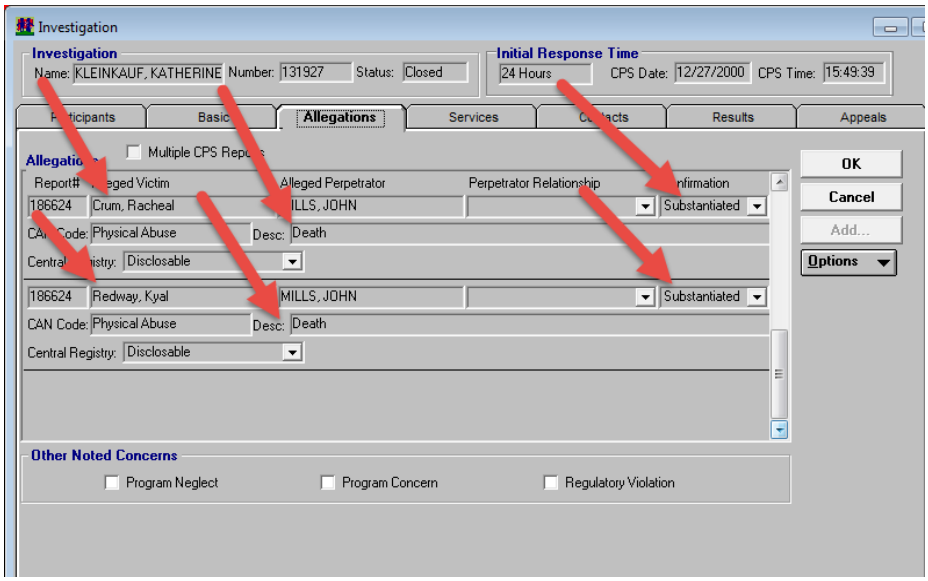
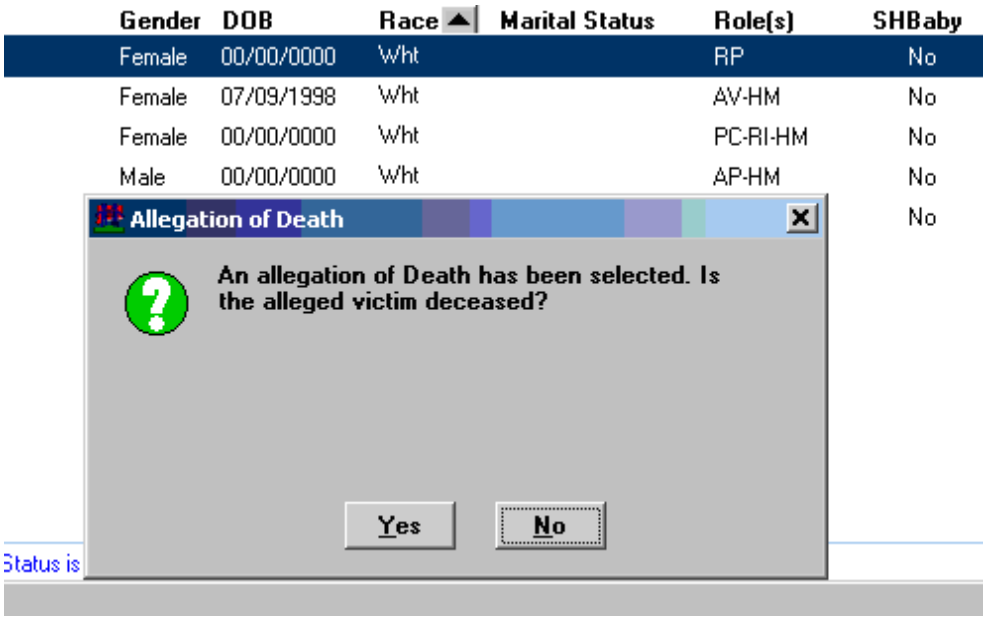


Fig 2b.



Placement End/Discharge Reason

Ending a Placement for Reason of **Death of Child.** If a placement is ended for reason of Death of Child, the placement ending cannot be approved until a date of death is entered in person management.

Fig 3.

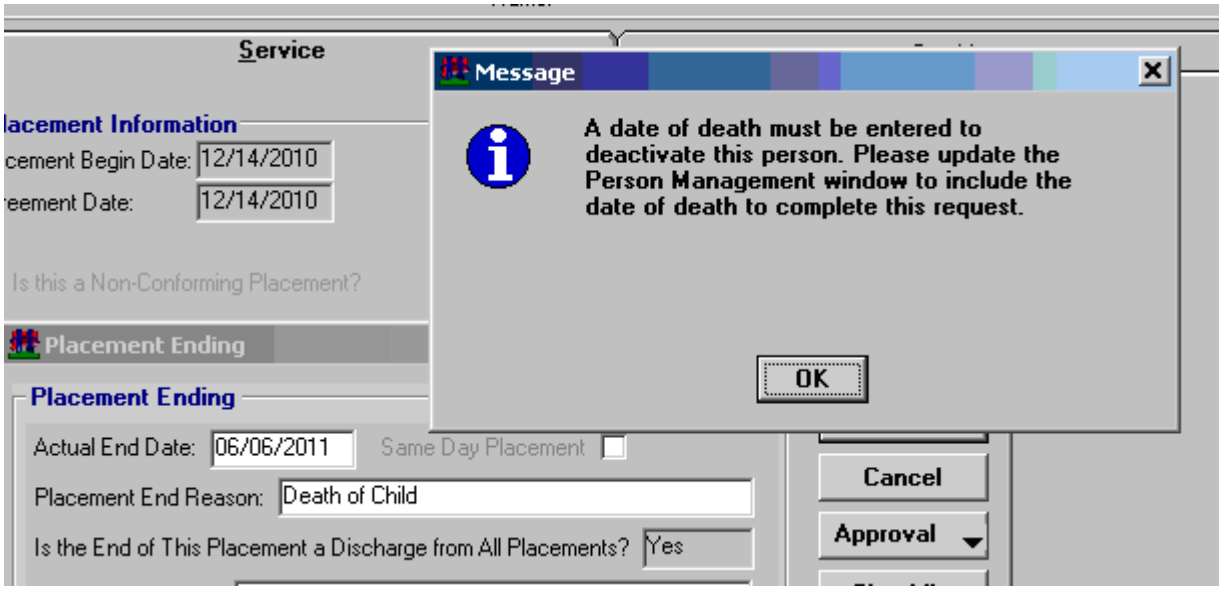


Fig 4.

Inactive Case Participants

In the Case Maintenance window, there is a change to the **Inactive/Removed Participant** list - the **Legal Status** label has been changed to **Reason** and will display the most recent reason for deactivation. If the participant is reactivated, the current Legal Status will again display.

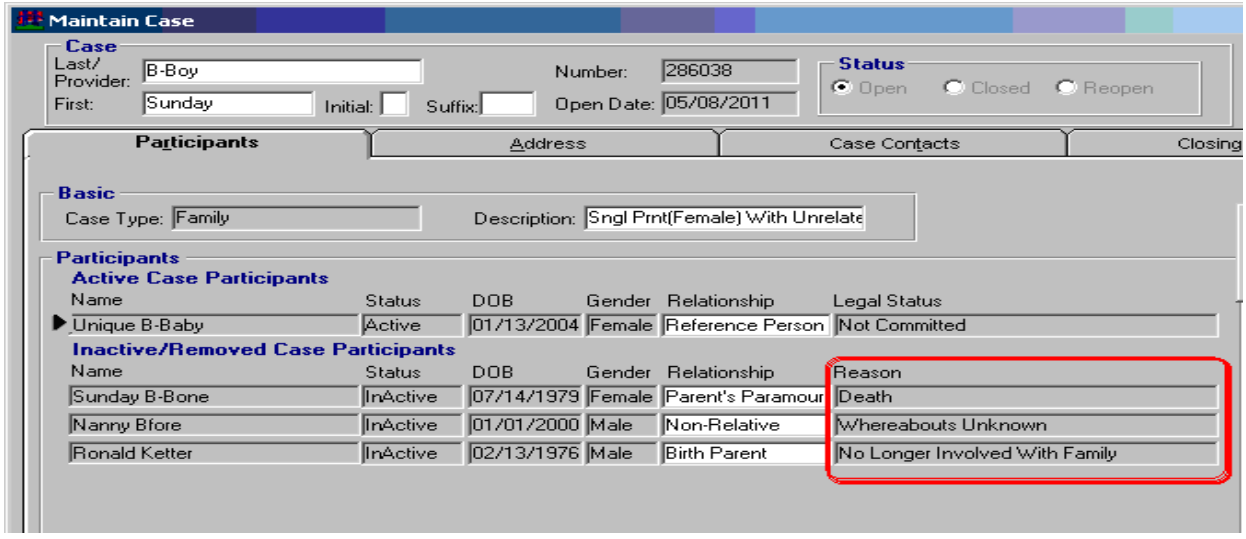


Fig 4 b.

Deactivation of a Case Participant

If a Participant is deactivated due to Death, a date of death must be entered in the person management window.

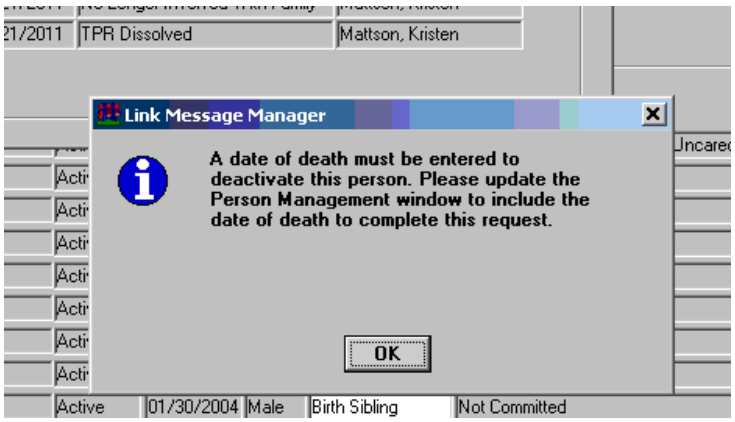
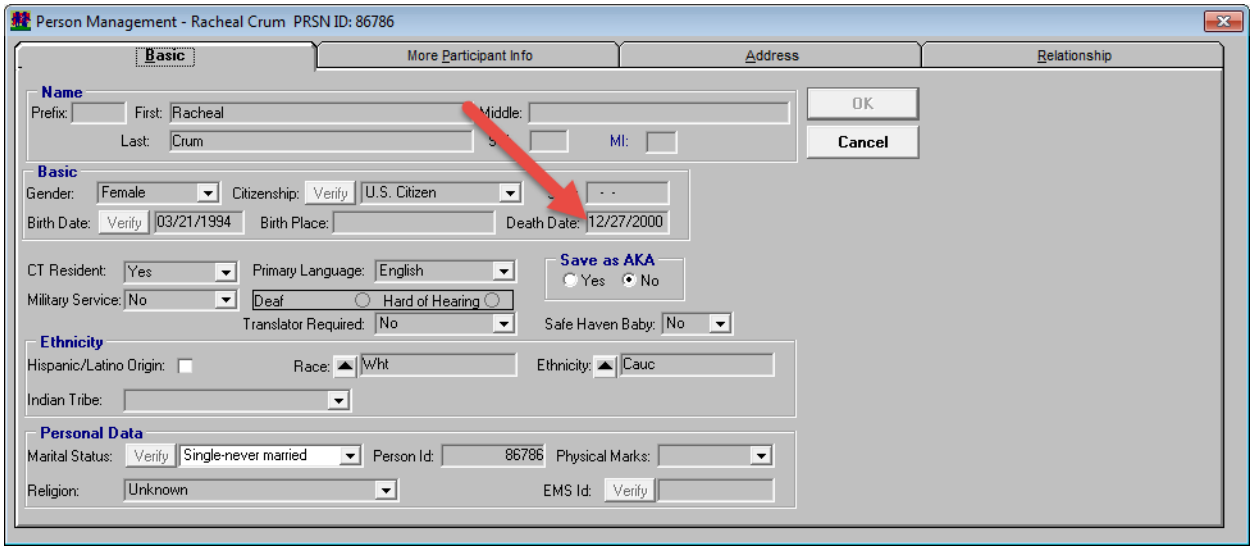


Fig 5.



3. Education and Training Vouchers: See Section E

4. Inter-Country Adoptions

At this time, the Department is not able to identify the number of Children who were Adopted from other Countries and have entered State custody.

5. Monthly Caseworker Visit Data

The Department will submit our monthly caseworker visitation data by 12/15/17 as required.

Payment Limitations - Title IV-B, Subpart 1:

- The Department did not expend Federal Title IV-B, Subpart I funds for child care, foster care maintenance, and adoption assistance payments in either FY 2005 or 2017.

- Therefore, no non-Federal funds expended for foster care maintenance were applied as a match for the Title IV-B, Subpart I program in FY 2005.

Payment Limitations - Title IV-B, Subpart 2:

State of Connecticut - Department of Children and Families

Maintenance of Effort

Child and Family Services Plan for June 30, 2017 submission

	FY 2015	**FY 1992**
Program Type	**State Expenditures**	**State Baseline**
Family Preservation	73,695446	12,983,241
Family Support	84,980,129	5,278,088
Totals	**158,675,575**	**18,261,329**

State share of Title IV-B, subpart 2 expenditures for comparison to 1992 base as required for evidence of compliance with non-supplantation requirements in Section 432 (a) (7) (A) of the Social Security Act

Category Protective Services	Population Description	Geographical Area Served
Reunification & TFT Services	Families with children in OOH care	Statewide
Multidisciplinary Teams	Children/youth, age 0-18, who are victims of serious physical/sexual abuse	Statewide
FAVOR	Parents who have a child under age 18 with a diagnosable behavioral health condition.	Statewide
CT Association for Infant Mental Health	DCF staff and Community Providers working with young children and their families.	Statewide
Triple P America	Contracted Triple P Providers	Statewide
ABH-MST	CPS workforce involved with Individuals affected by Intimate Partner Violence	Statewide
Office Assistant Positions	Support for Area Office Staff	Norwalk & Meriden
JRA Consulting – Racism	Agency Staff and Community Partners	Statewide
Joyce James	Agency Staff and Community Partners	Statewide
CCMC	Children/ Youth for whom serious physical abuse/neglect is suspected.	Statewide
Central Office	Provides Contract Support to Area Offices	Statewide
Solnit North Positions	Provides support to children requiring psychiatric hospitalization	Statewide
The Connection	DCF involved families in need of supportive housing	Statewide
KJMB Solutions	DCF Staff & contracted community-based services providers	Statewide
CT-AIMH Membership	Agency Staff	Statewide
CT Parents with Cognitive Limitations	Agency and Community Providers	Statewide

Family Preservation –Services	Description of Population Served	Geographical Area(s)Served
Triple P America	Contracted Triple P Providers	Statewide
Reunification & TFT Services	Families with children in OOH care	Statewide
FAVOR	Parents who have a child under age 18 with a diagnosable behavioral health condition.	Statewide
CCMC	Children/ Youth for whom serious physical abuse/neglect is suspected.	Statewide
The Connection	DCF involved families in need of supportive housing.	Statewide
KJMB Solutions	DCF Staff & contracted community-based services providers	Statewide
CT-AIMH Membership	Agency Staff	Statewide
CCMC	Children/ Youth for whom serious physical abuse/neglect is suspected.	Statewide
CT Association Infant MH	Agency staff & Community Partners	Statewide
CT Parents with Cognitive Limitations	Agency and Community Provides	Statewide
ABH – MST IPV Admin Costs	CPS workforce involved with Individuals affected by Intimate Partner Violence	Statewide

One on One Mentoring	Youth, ages 14 -21, who are committed to the Department and residing in foster care.	Statewide
Community Based Life Skills	DCF committed youth placed in community settings.	Statewide
Family Support –Services	Description of Population Served	Geographical Area(s)Served
Triple P America	Contracted Triple P Providers	Statewide
FAVOR	Parents who have a child under age 18 with a diagnosable behavioral health condition.	Statewide
CCMC	Children/ Youth for whom serious physical abuse/neglect is suspected.	Statewide
The Connection	DCF involved families in need of supportive housing.	Statewide
ABH – MST IPV Admin Costs	Child protective workforce involved with Individuals affected by Intimate Partner Violence.	Statewide
KJMB Solutions	DCF Staff & contracted community-based services providers	Statewide
CT-AIMH Membership	Agency Staff	Statewide
CT Parents with Cognitive Limitations	Agency and Community Providers	Statewide
One on One Mentoring	Youth, ages 14 -21, who are committed to the Department and residing in foster care.	Statewide
Community Based Life Skills	DCF committed youth placed in community settings.	Statewide
One on One Mentoring	Youth, ages 14 -21, who are committed to the Department and residing in foster care.	Statewide
Work to Learn	Committed youths ages 16 to 21.	Statewide
Youth Advisory Board Stipends	Youths involved with the Department that are working in one of our Youth Advisory Boards.	Statewide
Reunification & TFT Services	Families with children in Out of home Care	Statewide
UCONN -Adoption enhancements	Families who have adopted children from DCF's custody or the state's subsidized guardianship program.	Statewide
Adopt a SW program	Children and families (birth, foster and adoptive) that are DCF involved.	Statewide
Child First	Families with children ages 0-6	Statewide
Time-Limited Family Reunification Services	Description of Population Served	Geographical Area(s)Served
FAVOR	Parents who have a child under age 18 with a diagnosable behavioral health condition.	Statewide
The Connection	DCF involved families in need of supportive housing.	Statewide
KJMB Solutions	DCF Staff & contracted community-based services providers	Statewide
CT-AIMH Membership	Agency Staff	Statewide
CT Parents with Cognitive Limitations	Agency and Community Providers	Statewide
One on One Mentoring	Youth, ages 14 -21, who are committed to the Department and residing in foster care.	Statewide

Community Based Life Skills	DCF committed youth placed in community settings.	Statewide
Reunification & TFT Services	Families with children in OOH Care	Statewide
Adopt a SW program	Children and families (birth, foster and adoptive) that are DCF involved.	Statewide
The Connection	DCF involved families in need of supportive housing.	Statewide
CT Association for Infant Mental Health	DCF staff and Community Providers working with young children and their families.	Statewide
Adoption-Promotion and Support Services	Description of Population Served	Geographical Area(s)Served
UCONN -Adoption enhancements	Families who have adopted children from DCF's custody or the state's subsidized guardianship program.	Statewide
FAVOR	Parents who have a child under age 18 with a diagnosable behavioral health condition.	Statewide
CT-AIMH Membership	Agency Staff	Statewide
KJMB Solutions	DCF Staff & contracted community-based services providers	Statewide
Community Collaboratives	Families and Individuals wanting to be a foster and or adoptive resource.	Statewide
Adopt a SW program	Children and families (birth, foster and adoptive) that are DCF involved.	Statewide
Easter Seals Support Group	Families that have adopted children with special needs	Statewide
Other Services Related Services	Description of Population Served	Geographical Area(s)Served
	N/A	

Foster Care Maintenance	Description of Population Served	Geographical Area(s)Served
A) Foster Family & Relative Foster Care	Children (ages 0-21) Placed in OOH care	Statewide
B) Group/Institutional Care	Children (ages 0-18) requiring OOH with 24 hour supervision	Statewide
Adoption-Subsidy Payments	Description of Population Served	Geographical Area(s)Served
	Families who have adopted children from DCF's custody.	Statewide
Guardianship Assistance Payments	Description of Population Served	Geographical Area(s)Served
	Families who have been granted legal guardianship of children from DCF's custody.	Statewide

Independent Living Services	Description of Population Served	Geographical Area(s)Served

Independent Living Services	Youth making a transition from foster care to self-sufficiency	Statewide
Education & Training Vouchers	Description of Population Served	Geographical Area(s) Served
	Youth through the age of 21 pursuing secondary education and or vocational training.	Statewide

Child Care Related to Employment Training	Population Served	Geographical Area(s) Served
	Adolescent parents and expecting adolescent parents.	Statewide

CFS-101, Part III: 10/1/14-9/30/16 - Title IV-B, subpart 1

Description	**Description of Population Served**	**Geographical Area(s)Served**
Triple P America	Contracted Triple P Providers	Statewide
Office Assistant Positions	Area Office Staff	Norwalk/Meriden
JRA Consulting – Racism	Agency Staff and Community Partners	Statewide
Joyce James - Racial Justice	Agency Staff and Community Partners	Statewide
CCMC	Children/ Youth for whom serious physical abuse/neglect is suspected.	Statewide
Central Office - Contract Management	Provides Contract Support to Area Offices	Statewide
Solnit North Positions	Provides support to children requiring psychiatric hospitalization	Statewide
The Connection	DCF involved families in need of supportive housing	Statewide
KJMB Solutions	DCF Staff & contracted community-based services providers	Statewide
CT-AIMH Membership	Agency staff	Statewide
CT Parents with Cognitive Limitations	Agency and Community Providers	Statewide

Descriptions	Population Served	Geographic Area
Reunification & TFT Services	Families with children in Out of home Care	Statewide
Community Collaboratives	Families and Individuals wanting to be a foster and or adoptive resource.	Statewide
FAVOR	Families with children involved in the mental health system.	Statewide
UCONN -Adoption enhancements	Families who have adopted children from DCF's custody or the state's subsidized guardianship program.	Statewide
Easter Seals Support Group	Families that have adopted children with special needs.	Waterbury
Adopt a SW program	Children and families (birth, foster and adoptive) that are DCF involved.	Statewide
UCONN SSW PIC	Families and Community Partners that have been involved in a Family Assessment Response	Statewide
CT Association for Infant Mental Health	Agency staff and Community Partners	Statewide
Child First	Families with children 0-6	Statewide

Attachments:

Appendix 1: Training Plan

Appendix F: Human Trafficking Assurance

Appendix: CAPTA – Addiction and Recovery Assurance

DCF Classes
Given July 1, 2016 – May 31, 2017

In Service Classes: Audience- All Staff

Appendix 1 DCF Staff = DCF Employees / Subject Matter Experts
Academy Staff = DCF Employees in the DCF Academy division
Consultants = University and/or Paid Consultants

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
Adolescent Training Series This ten-day training series is for staff working with the adolescent population in the care of the Department. This series is being offered to Social Workers and Social Work Supervisors with youth ages 12 and up. This training series is mandatory for staff in specialized adolescent services units and Juvenile Justice social workers. This training focuses on the evolution in philosophy of adolescent services from independent living to inter-dependent living as well as policy and legislation that supports and gives momentum to this transition. Adolescent development in the context of trauma informed practice and risk taking will be a focus. Other topics will include normative adolescent experiences such as educational planning and support, sexuality and relationships. Additionally, adolescent parenting, human trafficking, legal and criminal issues, life skills, and planning for adolescents transition from services with supports will be included.	Yes	Held in house	Academy Staff and DCF Staff	60	All Staff
Assessing and Teaching Life Skills – Facilities The LIST training prepares providers who are working with DCF youth in a congregate care, community based, or activity themed environment to complete a life skills assessment, identify and prioritize learning needs and consider strategies for implementing life skills learning. Focus is placed on the importance of assessing demonstrable skills, determining learning styles, and identifying individual needs relative to skill development. Participants in the group will receive an over view of the department's expectation for teaching life skills, practicing using the L.I.S.T and complete the data reports. Participants will • Delineate the different components of the LIST tool • Describe how to perform a LIST assessment • Strategize techniques for assessing and teaching life skills in formal and informal settings • Define methods to measure and track progress towards life skill achievement • Identify process to access and utilize a compendium of curricula and outcome measures for skill building	Yes	Held in house	Academy Staff	6	Facility Staff

• Detail expectations regarding documentation and updates of LIST assessment and life skills learning					
BAFA' BAFA': A Cross Cultural Simulation In this simulation, participants are assigned to two artificial cultures. Each group is introduced to a different set of cultural values and allowed to practice these values and subsequently engage the other culture. This simulation is designed to foster cross-cultural awareness through experiencing the development and impact of stereotypes. Participants come to appreciate the negative impact of stereotypes and of the need to foster greater tolerance and understanding of others in all spheres of life	Yes	Held in house	Consultants	3	All Staff
Beginner Excel 2013 This hands-on one-day course will give you the skills needed to do so! Participants will learn about the distinct parts of a spreadsheet; tips to navigate and search through an existing workbook; as well as the tools needed to create a simple workbook with data, formulas and basic functions. Time will be allotted during the class for participants to work on their own Excel documents with the support of the instructor.	Yes	Held in house	Consultants	6	All Staff
Car Seat Refresher This half-day course provides social workers with a refresher of the regulations regarding car seats, and hands on training for the proper installation of car seats.	Yes	Held in house	Consultants	3	Social Work Staff
Case Planning: Boosting Your Understanding Of The Practice The goal of this two-day refresher course is to familiarize participants with case planning policy, the Case Plan document, components of case practice directly related to the planning process, and the role and process of the Administrative Case Review (ACR) and ACR Supervisor. This course includes an overview of expectations regarding the development of both a Family and CIP Case Plan and the ACRI. The impact of Fostering Connections and the Child and Family Service Review (CFSR) on the Case Plan will also be discussed. Through this course, participants will be able to identify and describe the elements of the Family Case Plan/Child in Placement Plan and participate in a case plan writing exercise. Focus will be placed on the important impact of engaging and including the voices of the family, kin and family supports in case planning and supporting clients in achieving success. Throughout the course, representatives from the Administrative Case Review Unit will highlight the federal mandates addressed in the ACR process, identify the requirements for notification of participants, and familiarize staff with the ACR LINK process.	Yes	Held in house	Academy Staff	12	Social Work Staff

Child Sexual Abuse By Women: A Discussion On Female Sexual Offenders This course will provide participants with an overview of the research on women who sexually abuse children. It is designed to teach participants the common characteristics of female child molesters, including their similarities and differences from male child molesters. A review of the sociocultural factors that can make it difficult to view women as sexual predators will also be provided during the course.	Yes	Held in house	Consultants	3	All Staff
Collect National Criminal Inquiry Check (NCIC) - Full Access This class will allow users full access to in-state COLLECT files as well as providing access to other state systems and files such as Department of Motor Vehicles (DMV), Sex Offender Registry (SOR), Protective Order Registry (POR), Department of Corrections (DOC), State Police Criminal History (CCH), Weapons, Offender Based Tracking System (OBTS), Paperless Re-Arrest Warrant Network (PRAWN), and more. The COLLECT system provides access to two national systems: National Crime Information Center (NCIC) and International Justice and Public Safety Information Sharing Network (NLETS).	Yes	Off Site	Consultants	4	Designated Staff who perform background checks
Collect National Criminal Inquiry Check (NCIC) and SPRC Recertification Training This class will recertify users to in-state COLLECT files as well as providing access to other state systems and files such as Department of Motor Vehicles (DMV), Sex Offender Registry (SOR), Protective Order Registry (POR), Department of Corrections (DOC), State Police Criminal History (CCH), Weapons, Offender Based Tracking System (OBTS), Paperless Re-Arrest Warrant Network (PRAWN), and more. The COLLECT system provides access to two national systems: National Crime Information Center (NCIC) and International Justice and Public Safety Information Sharing Network (NLETS).	Yes	Off Site	Consultants	4	Designated Staff who perform background checks
Considered Removal Teaming Facilitator Training Through this three-day course, attendees will learn the skills necessary to facilitate a Considered Removal Child and Family Team Meeting. Facilitators will learn the skillful balance of authority and how the appropriate or inappropriate use of it can affect removal-related decision making and interactions between child protective staff and families. Facilitators will review some of the components of strength-based facilitation: self-awareness and cultural responsiveness; using family strengths in the development of safety plans; and how to manage emotions, disagreements and conflict. The course will teach to the key elements of purposeful pre-, during- and post- debriefings. Facilitators will be able to identify how domestic violence impacts the	Yes	Held In House	DCF Staff and Academy Staff	18	Considered Removal Facilitators

process and demonstrate several in-the-moment strategies. Facilitators will become familiar with their roles and responsibilities, and with the Considered Removal Child and Family Team model, policy, procedures and documentation.					
Differential Response System (DRS) Training This nine day training series is for newly assigned DRS Unit staff, as well as those staff interested in pursuing positions in a DRS unit / workgroup. Best practice principles are discussed for both Intake and Family Assessment Response, along with strategies for assessing safety, safety planning, critical thinking, involving families in the assessment of their own needs, and numerous other areas.	Yes	Held in house	Academy Staff	51	Investigation Social Work Staff
Early Childhood Development Training This five day training is designed for DCF staff currently working with Infants, Toddlers, and Preschoolers in order to enhance and further their knowledge in this area. As a result of this training, participants will increase their competence and skill level around Early Childhood Development in order to better serve children between the ages of 0-5, as well as work effectively with the parents/caregivers caring for children in this age range.	Yes	Held in house	Academy Staff and DCF Staff	30	Social Work Staff
Essential Training For Trainers This course is designed to build training techniques and skills in presentation, transfer of learning, technical aides, and practical aides on any subject matter, lecture, and discussion. Trained by an experienced trainer, numerous interactive exercises and demonstrations of classroom tools will be utilized. This workshop is short on lecture and long on discussion, demonstration and interactive exercise. It is an introduction to some basic training adult learning theory quickly transitioning into providing some of the best quick tips.	Yes	Held in House	Consultants	6	Trainers
Exploring Outlook 2013 In this half-day class, you will explore the new interface and features of Outlook 2013. The purpose of the training is to provide hands on experience using the program. Specifically, participants will • Gain an understanding of the new interface of this version of Outlook 2013 • Develop an understanding of common Outlook tasks, and how to accomplish them in Outlook 2013 • Learn about some of the new functionality now available in the program, including Quick Steps, Insert Calendar, Insert Screen Shot, Contact Groups, Calendar Overlay and Calendar Groups.	Yes	Held in House	Consultants	3	All Staff

Exploring Solutions in Engagement and Workforce Development: Understanding Challenges and Opportunities for Bilingual Clinicians This workshop was co-sponsored and the audience was primarily Region 5 service providers. The effort was to help support our providers in finding and maintaining bilingual staff to services our families since it is commonly been expressed that this a huge barrier for them.	Yes	University of St. Joseph	Consultants	3	All Staff
Family Stability This course consists of 5 modules • Participants will watch an interview with Dr. Nora Volkow, director of the National Institute on Drug Abuse, focused on addiction as a disease of the brain. Participants will be lead in a facilitated discussion throughout to underscore important components of the interview. • Second module will focus on the use of motivational interviewing as a strategy to encourage change on the part of individuals struggling with addiction. Participants will view the on-line Motivational Interviewing training and participate in a quiz." • Another module focuses on defining recovery and recovery capital, protective factors, and how DCF staff can support individuals struggling with addiction to achieve and maintain recovery. • The fourth module is a review and explanation of the service array specific to the region in which the training is occurring. • The last module is an explanation of the Family Stability Project, including overview of Pay for Success programs, identification of roles and responsibilities of the FSP, and questions and answers.	Yes	Area Office	Academy Staff and DCF Staff	6	DCF Staff
Foster & Adoptive Services (FASU) Training Series The Foster and Adoptive Services Unit (FASU) Training Series is a three-day course designed to provide FASU staff with a foundational understanding of foster care, and to provide a local and global perspective on its history and evolution. Throughout the course, emphasis will be placed on the important role FASU staff play in achieving placement stability for children in care. Strategies such as the increased use of kin and relative homes; teaming; and creative recruitment will be explored. The course will include discussion on the significant needs of children in care, ranging in age from early childhood to adolescence; and how the prior traumatic experiences of children in care shape their emotional, behavioral, and social challenges while in placement. Support for foster parents, internal to DCF and external to the	Yes	Held in House	Academy Staff and DCF Staff	18	FASU Staff

agency, will be reviewed in some detail; and throughout the three days, the importance of achieving permanency for all children in DCF care will be underscored					
From Cultural Competence To Cultural Humility: Identifying Key Skills In Addressing Racial Bias In Child Welfare Practice This workshop reviews definitions of cultural competence and provides a review of related concepts that address critiques of cultural competence. The concepts include Intersectionality, Implicit Bias and Cultural Humility. Considerations for child welfare practice are addressed. Participants will become familiar with definitions of cultural competence and a number of related concepts such as Intersectionality, Implicit Bias and Cultural Humility. Participants will become familiar with practice principals and skills for culturally responsive child welfare practice.	Yes	Held in house	Consultants	3	All Staff
Gambling Awareness 101 The normative and pervasive nature of gambling behaviors in the United States can desensitize us to the problems that can occur when a person's view of gambling shifts from entertainment to fixation. Recently reassigned in the DSM 5 from an impulse control disorder to a behavioral addiction, disordered and problem gambling affects 2-5% of adults and twice as many young people. Confounding the issues of problem identification, referral, and treatment is a lack of awareness on the part of service providers, clients, family members and the general public that, for some people, gambling can become an addiction even more devastating than alcohol or other drugs. As state governments turn more to legalized gambling as a source of revenue, studies indicate that vulnerable populations: the poor, disenfranchised, and people in recovery from mental health and substance use disorders, are disproportionally impacted in harmful ways. This training will address the social and environmental factors which influence gambling; gender and race considerations; and how our biology creates conditions conducive to the pursuit of risk and reward. Training will include lecture, large and small group discussion, activities and media.	Yes	Held in house	Consultants	6	All Staff
Human Trafficking Day 1 - Understanding Commercial Sexual Exploitation Of Children And Domestic Minor Sex Trafficking This course provides a framework for understanding the complex issue of Commercial Sexual Exploitation of Children/ Domestic Minor Sex Trafficking (CSEC/ DMST). Youth involved in Child Welfare are at a higher risk for being targeted for exploitation than the general population. This course provides essential information to assist with recognizing the risk factors and red flags for youth and children and a framework for responding in a well-prepared and collaborative way. The significant impact CSEC/ DMST can have on children/youth will be	Yes	Held in house	Academy Staff	6	All Staff

discussed as well as interventions and resources available. Tactics of exploiters will also be reviewed to assist with understanding of dynamics of the exploitation. This course explores the prevalence of these cases in Connecticut and nationally. Information provided will include State and Federal laws as well as protocols and supports within the Department.					
Human Trafficking Day 2 - Working With Youth At Risk Of Human Trafficking (Commercial Sexual Exploitation Of Children (CSEC), Domestic Minor Sex Trafficking (DMST) and Labor Trafficking): Helping Staff Understand And Engage With Child Victims. This course is designed to further participants' knowledge of Commercial Sexual Exploitation of Children / Domestic Minor Sex Trafficking (CSEC/DMST). This course will look at youth's risk factors, conditions that increase risk, and how to determine the level of risk as it pertains to CSEC/DMST. Utilizing the stages of change model when determining interventions and next steps for youth and providers will be explored. In addition, the roles of the Department, providers, law enforcement, as well as other systems in addressing the problem will be examined. This course will conclude with strategies and interventions that have been implemented in efforts to service the CSEC/DMST population	Yes	Held in House	Academy Staff	6	All Staff
Identifying and Working With Parents With Cognitive Limitations This one day course is designed to provide participants with an overview of challenges and strategies to effectively work with parents with cognitive limitations. The training team is made up of professionals with direct working experience with these parents, within child welfare as well as in community programs and clinical settings. Through this training, participants will increase their ability to identify an individual who may have cognitive limitations. The training will encourage participants to reassess case practice and develop new interventions to enhance service delivery to these individuals and ultimately improve outcomes for families and children	Yes	Held in House	Consultants	6	All Staff
Implicit Bias Training This session includes interactive learning and both group and individual processing exercises e.g. case studies, videos and personal testimony that can be used to better understand implicit bias and its impact. These activities can aid participants in developing and implementing practices that will help in reducing subjective decision-making as a result of implicit bias	Yes	Held in House	Academy Staff and Consultants	3	All Staff
Intermediate Excel 2013 This hands-on one-day course is a unique opportunity for participants to be provided with a	Yes	Held in House	Consultants	3	All Staff

detailed overview of a wide range of Microsoft Excel functions, while allowing them to complete their own projects, data reports, or other with the support of the instructor. Participants in this course are required to bring materials to work on while the course is provided. Participants will learn everyday shortcuts in navigation and data entry, enhance their ability to analyze data with filtering, sorting, quick analysis' and charts, learn to use Printing and Copy/Paste features to enhance presentation of data, increase their ability to retrieve and use data from LINK and ROM reports and enhance their ability to use data entry sheets via drop down lists, conditional formatting and removing duplicate data.					
Intermediate Outlook 2013 During this hands-on one-day course, participants will expand their knowledge of Microsoft Outlook and learn "tips and tricks" that will allow them to work more effectively and efficiently. During this training participants will develop an understanding of functionality available beyond basic emailing, develop an understanding of common Outlook features, and how to utilize them in Outlook 2013, Learn to find specific messages quickly using various methods (i.e. search, categories, flag), and become more familiar with the Calendar feature to be proficient in adding/sharing/planning.	Yes	Held in house	Consultants	3	All Staff
Intermediate Word 2013 During this hands-on one-day course, participants will expand their knowledge of Microsoft Word 2013 and learn "tips and tricks" that will allow them to work more effectively and efficiently with word documents. The training will be a combination of hands-on instruction and "open time," where participants spend time on their own Word document projects with the support of the instructor. The creation of tables and numbered lists, as well as the use of track changes and mail merge, will be specific areas of focus in this course.	Yes	Held in house	Consultants	3	All Staff
Introduction To Fetal Alcohol Spectrum Disorders (FASD) In this course participants will be introduced to Fetal Alcohol Spectrum Disorders as a leading cause of preventable intellectual disabilities. This course is designed to improve prevention, identification, and management of fetal alcohol spectrum disorders (FASDs). FASD refers to the range of physical, mental, behavioral and learning disabilities that an individual may acquire as a result of maternal alcohol consumption. Areas of focus will include an overview of diagnostic terminology and criteria, facts about FASDs and alcohol use among pregnant women, the cause of FASDs, typical disabilities and strengths of individuals with diagnosis under this umbrella term, prevention strategies and resources as well as the role of child protection and educational professionals.	Yes	Held in House	Academy Staff	6	All Staff

Introduction To Pivot Tables A Pivot Table report is an interactive table that quickly combines and compares large amounts of data. This hand-on course will introduce participants to this useful tool, and create an opportunity for practice using Pivot Tables. Participants will discover how Pivot Tables can be created and used with data from existing DCF reporting areas (ROM/LINK/ETC), as well as how to choose the fields to be included. Participants will understand how to select from the Functions that are available to summarize results in a Pivot Table, and how this tool can be used to enhance their use of data.	Yes	Held in House	Consultants	3	All Staff
Justice-Involved Mothers And Child Welfare This training will discuss the unintended consequences of mass incarceration, including disparities among marginalized families and communities. Implications for best practice will be explored for working with children and families before, during and after incarceration. The unique challenges facing justice-involved parents and their children will be explored and identified. Strategies to support families of incarcerated parents and the limitations of current policies and practice will be discussed. Best practices with children and justice-involved parents will be examined.	Yes	Held in House	Consultants	3	All Staff
Link Training for the Legal Team This three hour computer training is designed to provide the legal team with in overview of the CCWIS/LINK system. The content includes the following: 1) Link searching; 2) CMS searching; 3) the entering of information into the appeals tab; 4) entering narratives (	Yes	Held in House	Academy Staff	3	Legal Staff
LIST: Assessing and Teaching Life Skills Participants will gain knowledge and understanding of • The importance of Life Skills • Details on how the LIST was chosen • Expectations of Youth in the LIST process • Factors in determining who is eligible for the LIST and how referrals should be prioritized • The different roles of Providers, DCF, and Caregivers in the LIST and Life Skills process • Ongoing assessment of life skills progress • Ongoing documentation of the Life Skills process • Components of the LIST assessment and supporting website • The role of the Permanency Team in assessing and building life skills	Yes	Various Locations in CT	Academy Staff	3	All Staff

• Practice introducing LIST to youth and their permanency team					
Loss, Grief & Bereavement In Young Children From Birth To Age Five This training will explore the process of grief in young children as a result of the death of a parent, sibling, family member and/or caregiver, focusing on Birth to 5 years of age. Grief will be defined as the intense sadness, confusion, and sorrow that accompanies the death of a loved one. This training will provide social workers with the tools to identify symptoms and behaviors that children birth to 5 may experience and display as a result of their grieving process. Social workers will also learn about the "common" emotional reactions to death for young children and how young children "understand" death related to their current stage of development. The training will provide social workers with resources and strategies to help support caregivers of young children, as they support the children they care for, during this process.	Yes	Held in house	Consultants	6	All Staff
Mandated Reporter Train the Trainer (MR-TOT) The "Mandated Reporter Train-the-Trainer" certification course is a unique opportunity for staff with current or prior child protective services experience to develop their presentation and training skills; and to become certified to provide an important service to mandated reporters throughout the state. This two-day course will develop and enhance participants' presentation and training skills, and includes a detailed review of the current Mandated Reporter Training curriculum. In this course, participants are provided the opportunity to "teach-back" a component of the curriculum on the second day, and receive immediate feedback from other participants as well as the instructors. Upon successful completion of the two-day course, and a demonstrated ability to present the Mandated Reporter Training curriculum, participants will receive certification to conduct the training.	Yes	Held in House	Academy Staff	12	Social Work Staff
Medical Marijuana And Harm Reduction, Addiction And Opiate Overdose Responses During this three-hour course, representatives from the Department of Consumer Protection will orient participants to the laws, policy, and procedures in the state of Connecticut regarding the use of medical marijuana. During the second half of the course, participants will learn about the principles of harm reduction; information about addiction including language and the impact of stigma; overdose risks and recognizing and responding to an opiate overdose, including administration of Narcan	Yes	Held in house	Consultants	3	All Staff
Mental Health First Aid Mental Health First Aid is an 8-hour course that teaches participants how to help someone who is developing a mental health problem or	Yes	Held in house	Consultants	8	All Staff

experiencing a mental health crisis. It provides a basic understanding of what different mental illnesses and addictions are, how they can affect a person's daily life, and what helps individuals experiencing these challenges get well. The course helps participants identify, understand, and respond to signs of addictions and mental illnesses. Mental Health First Aid teaches about recovery and resiliency – the belief that individuals experiencing these challenges can and do get better, and use their strengths to stay well. The course trains participants to help people who may be experiencing a mental health problem or crisis, and participants that successfully complete the training receive a three year certification as a "Mental Health First Aider."					
Minimal Facts For 1st Responders Child sexual abuse is disturbing, complex and extremely difficult to investigate. How professionals react and respond to a suspected child sexual abuse allegation will have a direct impact on the child's recovery from the traumatic act and on the integrity of the subsequent investigation. This training is designed to give child protective service workers and law enforcement professionals the tools needed to optimally respond when a child discloses a sexual abuse or there is an indication that he or she may be a victim of sexual abuse.	Yes	Held in house	DCF Staff	6	DCF Social Work Staff
More Advanced Features of Outlook 2013 Are you very comfortable using Outlook? This course will go beyond the basics, and focus on some of the more advance features this program has to offer.	Yes	Held in House	Consultants	3	All Staff
NRCT Handcuffing and Field Safety Annual Refresher Training The NRCT Handcuffing training lasts a full day and covers important aspects of using our mechanical restraints. The class covers proper care and maintenance of state issued mechanical restraints. The proper nomenclature is reviewed, along with handcuffing techniques and considerations. During the training each individual gets to practice verbal de-escalation skills and demonstrate the ability to properly apply and remove mechanical restraints	Yes	Court Support Service Division (CSSD)	Consultants	6	Juvenile Justice Staff
Office 2013 Learning Lab This "open lab" training is designed for participants to bring their own work materials to accomplish a task on a specific project or presentation with the support of the DCF Academy IT Consultant.	Yes	Held in house	Consultants	2	All Staff
Outlook 2013 For Support Staff This hands-on one-day course will allow DCF Support Staff the opportunity to expand their knowledge of Microsoft Outlook and learn "tips and tricks" to work more effectively and efficiently. During this training participants will develop an understanding of functionality available beyond	Yes	Held in house	Consultants	3	All Staff

basic emailing; develop an understanding of common Outlook features and how to utilize them in Outlook 2013; learn to find specific messages quickly using various methods (i.e. search, categories, flag); and become more familiar with the Calendar feature to be proficient in adding/sharing/planning.					
Power Simulation Participants will be assigned to roles in a simulated organization and through interaction will have an opportunity to understand their responses to different members of the organization and their statuses. Participants will develop insight into their own perceptions of others and how they are perceived by others in the workplace. Themes of group dynamics and power will be explored.	Yes	Held in house	Consultants	3	All Staff
Regional Intake Training Series The training will increase the knowledge base for Intake staff with respect to cornerstone elements of our Investigation/FAR practice. The definitions of Safety, Risk, Engagement, Assessment, Commencement, and Completion will be explored. Large and Small group discussions will be facilitated to generate Critical Thinking centered on our practice within each of these elements. The training will focus on our functional practice within Intake. Purposeful visitation, meeting with children alone, documentation elements, and barriers for engagement with children and Families will be at the forefront of the discussion. Large and Small group discussions with respect to excellent work and work where room for improvements are present will be reviewed. The training will increase the knowledge base of staff regarding the importance of using critical thinking skills during the Investigation/FAR process. Having an open mind and avoiding Confirmation Bias with respect to assessments and practice will be discussed. The utilization of Protective Factors to assess Protective Capacity for parents and caregivers will be reviewed. Significant attention will be paid to the important role supervision and consultation play in the development of intake worker skill set. Group Supervision will occur where Supervisors will facilitate discussions on current cases within the Region.	Yes	Area Office	Academy Staff	18	All Staff
Sexual Harassment and Diversity Training Presented by the Office of Diversity and Equity (ODE), this interactive three (3) hour sexual harassment training will introduce you to the two types of sexual harassment, how you can prevent sexual harassment in the workplace, what to do if you encounter sexual harassment in the workplace, and what is the DCF's policy regarding sexual harassment in the workplace. This interactive training will also reinforce your understanding of the importance of embracing and respecting diversity among your peers and clients.	Yes	Area office and in house	DCF Staff	3	Non-Supervisory Staff

This training is mandatory for all non-managerial and all non-supervisory staff in order for the DCF to fulfill its obligation to the Commission on Human Rights and Opportunities (CHRO).					
Social Worker Case Aide (SWCA) Training Series These classes will give an overview of the role of the Social Worker Case Aide in the department of children and Families. Learn to understand the importance of assisting parents in developing activities that will meet the developmental needs of their children and increase the parent's ability to interact with their children, develop skills to facilitate meaningful visits between children and their families, including the importance of developing a visitation plan and will develop skills in developing such a plan. Participants will also explore LINK and learn how to locate case information. Participants will also learn the components of a good narrative as it pertains to supervised visits and will be able to record facts, not an evaluation of the facts, and learn the fundamentals of the court process.	Yes	Held in House	Academy Staff	18	Newly Hired Social Worker Case Aides
Stop Spinning Your Wheels: Using A Results-Based Approach To Get The Outcomes You Want This half-day course introduces participants to the concepts of outcome-focused work, with a heavy emphasis on Results-Based Accountability (RBA). Participants will learn the concepts, language, and operating framework of the RBA approach. RBA is a straightforward approach to planning and evaluating the work of government and nonprofit agencies. It rejects jargon and empowers participants to move from talk to action to: create change; improve outcomes; and work effectively with partners to make a difference in their work and in our communities.	Yes	Held in house	DCF Staff	3	All Staff
Structured Decision Making (SDM) Refresher This one day refresher course provides an overview of Structured Decision Making (SDM). The SDM model provides evidence based data to guide the decisions regarding safety, permanency and well-being for the families and children served by DCF. The training provides a hands-on application approach to reinforce the implementation and use of the tools at critical points during the life of a DCF case. Timeframes for completion and the integration of SDM with the case planning process are also covered.	Yes	Held in house	Academy Staff	6	All Staff
Supporting Diverse Families When Their Child Comes Out A family response to their child's coming out is the single most important predictor of outcomes for LGBTQ youth. Research also demonstrates that a family's initial response is rarely their final response. With family preservation as a core value for DCF, it is critically important that Social Workers have the tools to help families negotiate their journey to acceptance of their child. This	Yes	Held in house	Consultants	3	All Staff

interactive half day workshop will: *Explore the concerns that families typically raise, *Consider the potential impact of race, ethnicity, religiosity, gender norms and other family attributes or identities on family acceptance,*Identify and practice strategies for intervention					
Team Building And Permanency Teaming Coaching This is a full day training course integrating Permanency Teaming Coaching/consultation and team building. In order for the day to be most effective, area office units must sign up as a group. Supervisor must register the entire unit. This training will be arranged and held at an offsite location in close proximity to the regional office. This program explores the essentials that team members and leaders need to understand for team success. Included in the session is discussion around the four stages of team development and how to understand and deal with different personalities on the team. Additionally, small group work identifies strengths and needs of the team. The results are developed into a plan of action and commitment based on personal ownership. The Permanency Teaming coaching/consultation portion of this training is based on the Casey Model. This model focuses on transfer of learning from training room to the field. We will practice skill development and identify next steps to implement Permanency Teaming on a presented case. This day will provide an opportunity for peer-to-peer learning and support. Additionally, this formalized process of consultation between three or more professionals provides support for the supervisee(s) in order to promote self- awareness, development and growth within the context of their professional environment as well as enhance permanency for the children in the case presented.	Yes	Held in house	Academy Staff	6	All Staff
The Child and Family Services Reviewer Training The Child and Family Service Reviews (CFSR) are conducted to help provide an overall comprehensive assessment of state standards in relation to safety, permanency and well-being outcomes. The training will provide an in-depth look into the CFSR process, and the monitoring tool. Staff will become familiar with the 7 Outcomes and 7 Systemic Factors upon which the CFSR is built. This training will provide staff with the knowledge and skill necessary to complete a review within the state of Connecticut.	Yes	Held in House	DCF Staff and Academy Staff	12	CFSR Reviewers
The Effects Of Parental Incarceration On Young Children This training will explore the effects and long- term impact of parental incarceration in young children. Discussions will include supporting children before, during and after visits. Using a variety of media, attendees will gain insight and be given strategies to use for effective planning around visitation. This topic is relevant for Social Workers, Foster Care	Yes	Held in house	Consultants	6	All Staff

families, Childcare providers and Parents/ guardians. At the close of this training you will be able to: 1. Identify the correlation between challenging behaviors and the visitation process. 2. Describe the short and long term impact that parental separation may have on young children. 3. Describe how the use of developmentally appropriate child specific strategies can reduce children's stress and anxiety.					
The Legal Work Of Permanency: Revisiting The Role Of Case Work In The Legal Process This one-day refresher course, co-trained with a DCF Staff Attorney, is designed to assist CPS workers in understanding the different phases of concurrent planning and post dispositional proceedings, including Motions to Review Permanency Plans and Motions to Change Disposition. This course reviews the underlying concepts of legal work done in the department, explores the various permanency plans for children in DCF care, as well as the importance of meeting the court's expectations regarding Reasonable Efforts. Discussion focuses on the role Specific Steps and rehabilitative efforts play in both the court process and case practice. Participants are provided hands on experience in writing components of a Study in Support of Permanency Plan. In addition, participants are introduced to the implications of terminating parental rights, including an in-depth discussion of the grounds for filing a TPR.	Yes	Held in house	Academy Staff	6	All Staff
The Next Step: Exploring The Transition Toward Supervisor While Enhancing Your Leadership This in-service training will discuss the roles, responsibilities, and competencies of being a supervisor. You will have the opportunity to explore your learning and leadership style, as well as discuss the roles they play. The process toward becoming a supervisor will be examined to include exam preparation, interviewing, and what qualities and experience are valued in the process. The class will include a mock interview in the classroom as well as an opportunity for an individual mock interview at a later scheduled date for participants interested.	Yes	Held in house	Academy Staff	6	All Staff
Train the Trainer – Racial Justice Case Consultation Process Participants will review the case consultation model developed by the University of St. Joseph by preparing and presenting cases that will be examined for content related to racial justice in decision making. Participants will also be trained to implement the case consultation model in their region and or offices.	Yes	Held in House	Consultants and DCF Staff	6	All Staff
Trauma And Resiliency In Young Children From Birth To Age Five And Its Effects On Providers	Yes	Held in house	Consultants	6	All Staff

This training will explore trauma in the lives of young children, focusing on Birth- Age 5. Trauma will be defined as it relates to young children and how it may affect typical child development. Resiliency will be also defined, exploring different resiliency factors in young children and the role they play in children's responses to traumatic events. This training will also provide social worker's with the tools to know when to make a referral for a child on their case load, and what type of referrals to make. Social workers will also learn about the "red flags" to be aware of when working with traumatized children, and how to respond appropriately to them. Social workers will be prepared to discuss the effects of trauma on young children with biological, foster and adoptive families, and provide them with some tips and strategies to support these children in their homes. This training will also explore vicarious traumatization from the perspective of the social worker, and how to draw on their own resiliency factors when working with young children who have been traumatized.					
Understanding Diversity and Racial Justice The goal of this training is that participants will be able to recognize, appreciate, and understand families within the context of their own family rules, traditions, history and culture, and explore ways to address culturally sensitive issues in the field and in the workplace. New staff will also be introduced and gain an understanding the policies and roles of the Division of Diversity and Equity, the various complaint procedures, and the impact and importance of Affirmative Action/Civil Rights in the workplace.	Yes	Held in House	Academy Staff	3	Newly Hired Non Social Work Staff
Understanding The Numbers To Enhance Case Practice The goal of this training is for participants to gain an understanding of the various types and applications of data created within the department and an understanding of how to use that data in their everyday work. This one day course will provide participants with an overview of the various data reporting systems used within the department, the various organizational tools available, and options for developing systems to prioritize and manage case work demands and enhance case work practice. Using both lecture and direct computer application, students will be provided information regarding the data collected by LINK and the resulting ROM, LINK Reports, ACR Reports, and other SharePoint reports that stem from their input. Specific focus will be placed on reports that can be used by staff to assist in managing case work. Participants will be guided through the process of setting default settings and moving between the summary and detail views. An introduction to EXCEL will be provided, to include exporting data from ROM and LINK SharePoint,	Yes	Held in house	Academy Staff	6	All Staff

filtering and sorting data, freezing panes, and creating formulas.					
Working Smarter, Not Harder: Effective Time Management & Organizational Skills Training Participants will be engaged in exploring their own organizational styles and helped to identify areas of their own personal practice which may create barriers to the successful and timely completion of their work. Focus will be placed on techniques for prioritizing tasks, effective planning of efforts and work space, and the development of filing and tracking systems. An overview of the basic functions of Outlook will be provided, including creating tasks and appointments, setting reminders, and organizing emails, as a tool to help maintain organization. In this training staff will understand the importance of organizing yourself and your work, learn ways to reduce anxiety and feelings of being overwhelmed; and increase self-confidence, recognize strategies for effective scheduling of work, identify the elements of effectively work and work place planning,	Yes	Held in house	Academy Staff	6	All Staff
Working With Military Connected Families Through A Culturally Competent Lens This course will enhance participants' understanding of the unique needs of working with military and veteran families. This course will inform participants how military culture colors the civilian lives of post-9/11 veterans, and how military culture impacts military connected families. Participants will gain an understanding of how adjustment to civilian life can present as sub-clinical and clinical symptoms and the impact this has on the military couples, children and the family system. It examine the impact of deployments, impacts on children, domestic violence, Post-Traumatic Stress Disorder, and Acquired Brain Injury / Traumatic Brain Injury. The course will include case examples and provide the opportunity to process risk assessment scenarios specific to military connected families in small groups, and as a collective group, through role play. In addition it will provide information on accessing veterans' services and benefits in Connecticut.	Yes	Held in house	Consultants	6	All Staff

Audience: Supervisors

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
AHA Mastering The Art Of Child Welfare The American Humane Association Mastering the Art of Child Welfare curriculum is a four module core training program for new supervisors. This training program is available to supervisors who have satisfied the requirement of completing the Yale Supervision Training Model. AHA training builds off of the agency's supervision model and allows staff to explore their development as a supervisor through the use of various tools. In addition, this training content also serves as a compliment to the Leadership Academy for Supervisors (LAS) in setting the foundation for understanding the theory behind supervision. Participants will be required to attend all five days of the training program in its entirety.	Yes	Held In House	DCF Staff	3	Supervisors
Group Supervision Coaching The Group Supervision Coaching course is designed to support supervisory staff and their direct reports in understanding, implementing, and utilizing Group Supervision. This unique coaching experience involves five hours of coaching, occurring over the course of two days at the participants' work location. The course involves both modeling of the facilitation of Group Supervision by an Academy Trainer, as well as an opportunity for the supervisor to facilitate a session and receive feedback. The course involves individual meetings between the Academy Trainer and the supervisor; and written materials regarding Group Supervision are provided. It is important to note the course utilizes current cases of the participants for the Group Supervision sessions, and therefore some advanced planning is necessary.	Yes	Held in house	Academy Staff	12	Supervisors
Leadership Academy For Supervisors (LAS) The Leadership Academy for Supervisor (LAS) is a blended learning program for experienced child welfare supervisors based on the National Child Welfare Workforce Institute (NCWWI) Leadership Model. The core curriculum consists of six online modules each followed by a face-to-face facilitated classroom experience. Additionally, each LAS participant is paired with a coach, who will meet with the participant 1:1 throughout the Academy to provide support, guidance, and structure. The LAS provides 30 contact hours of training over a 9-month period and includes a Personal Learning Plan to develop leadership skills and a Change Initiative Project to contribute to a systems change within the agency	Yes	Held in house	Academy Staff and DCF Staff	30	Supervisors
Results Based Facilitation (RBF) For Supervisors This in-service training will provide supervisors with an understanding of RBF, and the foundational skills necessary to effectively plan a meeting that results in a commitment to action. Participants will leave the training with concrete RBF tools which can be put into practice.	Yes	Held in house	Academy Staff and DCF Staff	3	Supervisors

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
Strengthening Supervision for Supervisors Over the course of this two-day learning experience, participants will explore a number of supervision topics. These include: • An informed consent approach to establishing supervisory relationships, setting forth roles and responsibilities. • Practical strategies for achieving the four core supervisory functions: quality of service, administration, professional development, and support. • Approaches to "managing from the middle" of organizations: serving as a link between agency leadership and front line staff; communicating administration's goals to staff and providing feedback from staff and clients to administration; translating agency goals into practical guidance for staff; and leading from the middle of the agency in a time of change. • Group supervision techniques. • A problem solving model for assessing difficulties in supervision and crafting an intervention plan. • Constructive supervisory responses when "bad things happen". • Self-care for supervisors.	Yes	Held in House	Consultants	12	Supervisors
Supervising Trainees This one day course is designed to provide DCF supervisors with knowledge needed to perform the duties of a training unit supervisor. The class will explore how meeting the unique needs of newly hired social work staff fits into the Department's existing supervision model, specifically coaching and communication. We will define the various processes and responsibilities surrounding preservice training including; academy policy, training curriculum, role of liaison, pre & post testing, trainee observations and transfer of learning activities. The afternoon will also include a presentation from Human Resources followed by question and answer.	Yes	Held in house	Academy Staff	6	Supervisors
Team Building And Group Supervision This is a full day training course integrating group supervision and team building. In order for the day to be most effective, area office units must sign up as a group. Supervisor must register the entire unit. This training will be arranged and held at an off-site location in close proximity to the regional office. This program explores the essentials that team members and leaders need to understand for team success. Included in the session is discussion around the four stages of team development and how to understand and deal with different personalities on the team. Additionally, small group work identifies strengths and needs of the team. The results are developed into a plan of action and commitment based on personal ownership. The group supervision portion of this training is based on the Yale Supervision Model. This program explores a formalized process of meeting between unit members within regional offices. It's focus is on the professional growth and practice improvement of the supervisee, through examining the supervisee's case work Included in this session is a negotiated process whereby members come together in an agreed format to reflect on their work by pooling their skills, experience and knowledge to improve both individual and group capacities. Additionally, this formalized process of consultation between three or more professionals to provide support for the	Yes	Held in house	Academy Staff	6	Supervisors

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
supervisee(s) in order to promote self- awareness, development and growth within the context of their professional environment.					

Audience: Managers

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
A Refresher On Education: A Training For Supervisors & Managers This course is designed to update participants' practical knowledge and application related to meeting students' educational needs. This half-day session addresses the new notification process for the DCF Form 603; identifying the responsible LEA; DCF's role in early childhood development & education; preliminary post-secondary education planning; DCF/CSDE & LEA data sharing; accessing on-going educational records required to outline statutory educational case planning requirements; as well as changes and trends in public school educational practice and statutes specific to general education, inclusive of Section 504 and special education. Case specific education related questions / scenarios can also be explored during the course.	Yes	Held in house	DCF Staff	3	Supervisors and Managers
Data Leadership This two-day management course is an introduction to managing with data, with a focus on quantitative and qualitative analysis. Managers will be oriented to the data resources available within the Department, approaches to exploring and analyzing the available data, and how Excel may be used to organize their data. The course will include hands on exercises using data and various reports in the computer lab. Participants will leave Day 1 prepared to explore and analyze data reflective of the work being done in their workgroup/office relative to the Performance Expectations. The second day will be offered as a half-day. Individuals will report out on their research and findings. Time will be allotted for participants to receive guidance and peer coaching. Fundamental knowledge of working with Excel, ROM, Share Point and Link Reports is required.	Yes	Held in house	Academy Staff	12	Managers
Leadership Academy For Middle Managers (LAMM) This six day training will allow managers to be able to apply the components and dynamics of the Child Welfare Leadership Model to the work of a Child Welfare Manager. They will also be able to assess one's own strengths and challenges and model authentic behavior as a manager; establish, communicate and implement an organizational vision in a continuously changing environment based on a personal vision that guides practice and professional development. Be able to orchestrate conflict as well as to integrate and defuse opposition to create partnerships. They will also be able to demonstrate commitment to continuous learning as a leader and address systems change issues. It will also allow managers the distribution of decision-making & leadership responsibilities; manages human, cultural, social & economic capital and encourages purposeful action.	Yes	Held in House	Academy Staff and DCF Staff	42	Middle Managers
Managing The Money This training covers the techniques, practices, and organization of the financial functions in governmental administration. Some topics include: understanding budgets; analysis of financial	Yes	Held in House	DCF Staff	6	Managers

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
statements; the state budget cycle; understanding the roles of OPM and the legislature in fiscal matters; managing wrap expenses; managing overtime expenses; and applied budgeting exercises					
Public Sector Management This one-day course explores the foundational aspects of being a public sector manager and the basic skills one needs to be successful. Based on Harvard Kennedy School Michael Moore's publications on "Creating Public Value," this course will focus on ways in which leaders of public agencies like DCF can engage communities in supporting and legitimatizing their work. The day will explore how managers envision what is valuable to produce, and how they witness dilemmas faced by a cross-section of public managers. The course will also include concrete strategies to change manager's individual practice that will lead to a more successful and rewarding career.	Yes	Held in House	DCF Staff	6	Managers
STEP - Striving Toward Excellent Practice - Data Leaders This new professional development opportunity, offered in collaboration with Casey Family Programs, is a 9-month blended learning program focused on data-driven decision-making and Continuous Quality Improvement (CQI). STEP is designed for DCF leaders who seek to strengthen their skills in using data through a racial justice lens; to identify problems; research solutions; and collaborate with colleagues and partners. Components of STEP include interactive classroom experiences; coaching focused on local challenges; web-based lessons and links to resources; and support for change initiatives	Yes	Held in House	Consultants and DCF Staff	96	Managers

Online Trainings

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
Early Childhood Practice Guide On-Line Training The CT Department of Children and Families "Early Childhood Practice Guide" was issued in April 2016 and designed to build on the many strengths of child welfare practice. The Guide provides clear and concrete guidance and information to further support comprehensive assessments and engagement with families and partners when working with children in the 0-5 population. This on-line course supports the information contained in the Guide; and upon completion, participants will be better prepared to articulate the evolution of early childhood practice at DCF; explain the importance of fostering a supportive and nurturing environment for children age 0-5; describe the impact trauma has on brain development, attachment, and physical, social, and emotional development; explain the factors needed to assess safety and risk for this population; describe the standards associated with CAPTA; articulate the importance of securing quality education and care for this population; and articulate the importance of supervision, consultation, and connecting families/children to appropriate services	No	Online Training	Academy Staff	30 min	All Staff
Mandated Reporter On-Line Training Any employee of the Department of Children and Families is designated as a Mandated Reporter per Connecticut General	No	Online Training	Academy Staff	30 mins	All Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
Statute 17a-101. During this interactive on-line course, participants will learn what their roles and responsibilities are relative to this designation, and how to make a report to the DCF Careline or law enforcement. Participants will be provided information on what constitutes child abuse and neglect, as well as what occurs after a report of child maltreatment is made. Legal protections, as well as consequences for not fulfilling the obligation of mandated reporting, will be reviewed. The course involves an interactive quiz, and a certificate of completion is electronically provided to the participant.					
Motivational Interviewing Motivational Interviewing (MI) is a collaborative approach to helping people who are ambivalent about making decisions or changes in some area of their lives. During this interactive on-line course, participants will learn how to use MI to help move clients along a continuum of positive change. Additionally, participants will understand the difficulties associated with changing behaviors; as well as the relationship between the "Stages of Change" and MI. By the end of the training, participants will be able to develop strategies, questions, and the language associated with Motivational Interviewing.	No	Online Training	Academy Staff	30 mins	All Staff
Reasonable Prudent Parent Standard (RPPS) On-Line Training Research has consistently shown that children who are engaged in normal, developmentally appropriate activities are less likely to engage in negative behaviors. Public Act 15-199 establishes the Reasonable Prudent Parent Standard (RPPS) which caregivers (e.g. foster parents, congregate care providers) are expected to adhere to when making decisions around a child's ability to participate in normal childhood activities. This brief on-line training provides participants with clear definitions of the RPPS; explanation of all parties impacted by the standard; clear description of expectations related to caregivers; and explanation of the implications the standard will have on case planning.	No	Online Training	Academy Staff	30 min	All Staff

Pre Service Classes

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
An Introduction to Child Welfare: A Family Centered Approach During this course participants introduce themselves thru a group activity noting their past experiences, educational background and reasons for choosing employment with the Department of Children and Families (DCF). The Trainer reviews the Juan F. Exit Plan, Positive Outcomes for Children, (POC) and the Children and Family Services Reviews (CFSR). The Trainer also introduces the participants to Child Welfare legislation and evidenced based tools utilized by the Department. In the afternoon, the participants will take a multiple-choice test to determine their baseline knowledge of child protective services issues and practice.	Yes	Held in house	Academy Staff	6	New Social Worker Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
Foundations for Best Case Practice Through this course, participants learn to identify personal values and explore how those values impact service delivery to children and families. Participants connect personal values to a professional code of ethics that govern the field of social work and the Department of Children and Families standards for state employee conduct. Participants learn the proper use of authority and how the appropriate or inappropriate use of it can affect positive case management services and interactions between social worker and families. Participants become familiar with the functions of the Child Protective Careline, the investigation process and possible outcomes associated with each process. By the end of the training participants will be able to connect how their values, ethics, and beliefs on authority will impact these processes.	Yes	Held in house	Academy Staff	6	New Social Worker Staff
Health and Wellness Practice Standards The goal of this training is to provide participants with the knowledge necessary to recognize and identify the health and well-being issues associated with children in the child welfare system; and to also promote and help families and caretakers sustain the health and well-being of children in their care. This training will also orient participants to the Health & Wellness Division within DCF.	Yes	Held in house	DCF Staff	6	New Social Worker Staff
Trauma Toolkit This two day course provides participants with an overview of trauma exposure experienced by the children with whom they work and how those experiences impact workers ability to ensure children's safety, permanency, and well-being. Using the seven Essential Elements of trauma-informed welfare practice model, participants in this training will learn ways to address and best respond to the needs of children who have been maltreated and traumatized.	Yes	Held in house	Academy Staff	12	New Social Worker Staff
Promoting Racial Justice within Child Welfare Organization This full day course that provides the opportunity for participants to recognize and understand the diversity of cultures in the children and families served by the Department of Children and Families. This course allows participants opportunities to self-reflect their own values, beliefs and attitudes, biases (explicit and implicit), and worldviews and examine how these impact their assessments of children and families and their own decision making processes. Participants will also have the opportunity to have courageous conversations regarding race and racism and the impact on the work we do with our children and families at DCF, community partners, as well as internally as the Department moves towards becoming a Racial Justice Organization. This course will feature individual and interactive activities to not only invoke courageous conversations, but also develop skills and knowledge necessary to effectively work and provide services to children and families from diverse populations.	Yes	Held in house	Academy Staff	6	New Social Worker Staff
Car Seat Safety This course provides participants with the knowledge of the regulations regarding car seats. Training is provided	Yes	Held in house	Consultants	3	New Social Worker Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
through the use of lectures, video, written exam and hands on training for installing car seats while observed by a certified instructor.					
LINK for CPS - (DCF's Computer Data Base System) During this course, participants will develop a baseline understanding of the Department's Comprehensive Child Welfare Information System (CCWIS) (LINK) role and function, their responsibility for entering information, to search information from the system. Participants will learn the general functions of LINK, including search functions, general tab functions, saving material, printing, and the nature of each case icon. Participants will be oriented to and provided opportunity to practice: searching cases, individuals, placements, legal status, and providers; entering narratives utilizing codes to accurately reflect visitation bench-marks and other elements of data reports; reviewing investigations materials, entering and ending placements (including temporary placements and runaway episodes) and payments. Focus will also be placed on entering educational and medical profiles for children; overview of the Structured Decision Making (SDM) tools; case plans; and an introduction to data collection systems. In addition, representatives from the Revenue Enhancement Division provide participants an overview of the purpose of completing 'Random Moment Time Study' icons that are generated randomly in LINK.	Yes	Held in house	Academy Staff	6	New Social Worker Staff
Worker Safety: A Physical and Psychological Approach for Child Welfare Staff This course focuses on identifying risks and protective factors as it pertains to worker safety. A heavy emphasis is put on prevention and awareness, including self-awareness, client awareness and environmental awareness. The day includes a discussion on crisis formation and suggestions for de-escalating a client that is presenting as anxious or defensive. Techniques to avoid canine attacks are explored. A portion of the day is dedicated to self-care, which includes an overview of the special review process and a framework for preventing/addressing trauma exposure response.	Yes	Held in house	Academy Staff	6	New Social Worker Staff
Structured Decision Making (SDM) This one day course provides an overview of Structured Decision Making (SDM). The SDM model provides evidence based data to guide the decisions regarding safety, permanency and well-being for the families and children served by DCF. The training provides a hands-on application approach to reinforce the implementation and use of the tools at critical points during the life of a DCF case. Timeframes for completion and the integration of SDM with the case planning process are also covered.	Yes	Held in house	Academy Staff	6	New Social Worker Staff
Legal I – Introduction to Legal , Legal II-Neglect Petitions, How to Write an Order of Temporary Custody and Mock Trial Services and Legal III – The Legal Work of Permanency This one day course starts off the legal training series for participants and provides a foundational framework for understanding the legal context of child welfare work. Participants are provided an overview of the court system	Yes	Held in house	Academy Staff and DCF Staff	18	New Social Worker Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
in Connecticut, legal terminology, statutory, regulatory and policy related limitations on decision-making as well as strategies to assist workers in information collection and presentation to the AAG's. Neglect petitions are the primary focus of the afternoon portion of the training, and includes exploration of the petition document, jurisdictional facts, and the summary of facts. This two-day course, co-trained with representatives from the legal division, is designed to assist CPS workers in becoming familiar with the unique authority and responsibility the Department has when addressing safety concerns for children. Legal 2 Day 1 is an exploration of immanency relative to a child's safety will occur using scenarios and classroom discussion. Additionally, participants will learn the legal forms that are used when filing an order of temporary custody, the difference between a social work affidavit and a summary of facts, and the role of trials (including testifying) in the legal process. Legal 2 Day 2 continues with a mock trial utilizing an actual case assigned to one of the course participants, with that participant serving as the witness in the mock trial. Trainers assist in portraying the various roles associated with a trial. Legal 3 is a one-day course, co-trained with a DCF Staff Attorney, is designed to assist CPS workers in understanding the different phases of concurrent planning and the post dispositional proceedings including Motions to Review Permanency Plans and Motions to Change Disposition. This course reviews the concepts taught in Legal I and Legal II, and explores the various Permanency Plans for children in DCF care. Discussion focuses on the role Specific Steps and rehabilitative roles they play in the court process as well as case practice. Participants are provided hands on experience in writing components of a Study in Support of Permanency Plan. In addition, participants are introduced to the implications of terminating parental rights, including an in-depth discussion of the grounds for filing a TPR. The Expectations of the court regarding the department making reasonable efforts, and the steps which need to be taken to meet those expectations, is also presented.					
Case Plan for Pre-Service - Days 1 & 2 The goal of this two day course is to familiarize participants with the Case Plan document, policy, components of case practice directly related to its development and functionality, and the role and process of the Administrative Case Review (ACR) and ACR Supervisor. This course specifically covers the requirements for when a Family Case Plan and/or a Child in Placement Case Plan are to be written. Fostering Connections and the Child and Family Service Review (CFSR) and their impact to the Case Plan are discussed as well as Case Activity Narrative and its role in the development of the case plan and ongoing assessment. Participants will be able to describe and identify the elements of the Family Case Plan/Child in Placement Plan and participate in a writing exercise in order to demonstrate skills learned to complete the case plan requirements.	Yes	Held in house	Academy Staff	12	New Social Worker Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
Focus will be placed on the important impact of engaging and including the family, kin and family supports voices in case planning and assisting clients in achieving success. Throughout the course, representatives from the Administrative Case Review Unit connect material being covered to the federal mandates addressed in the ACR process, identifies the requirements for notification of participants; familiarize staff with the ACR LINK process, and its role in achieving successful outcomes for children.					
Engaging Families: In the Home and In Care – Days 1 & 2 Through this course participants will be introduced to essential components of family centered practice and solution focused case work. Participants will deepen their knowledge of protective capacities and protective factors through small group activities. In addition to reviewing the stages of change, participants will apply the concept to a family. Models for purposeful visitation are reviewed. Participants will develop genograms for the purpose of understanding family dynamics. The difference between contracted services and credentialed services is delineated as is the importance of collaborating with service providers to ensure the right fit for children and families. Expectations of assessing secondary caretakers and home environment is clarified. Finally, participants put into practice the skills they have learned through role play.	Yes	Held in house	Academy Staff	12	New Social Worker Staff
Intimate Partner Violence (IPV) – Days 1 & 2 Day 1 provides participants with an introduction to Intimate Partner Violence (IPV). Through group activity, lecture, and supplemental video clips, participants explore and discuss commonly held myths pertaining to IPV; gain an understanding of the various terms being used within the field; and discuss the numerous warning signs and types of abusive behavior that are present in relationships characterized by IPV. A significant discussion regarding the implications of culture with respect to IPV is also conducted during this course. Also explored is the impact of IPV on children. Day 2 builds on the introductory material covered in "Intimate Partner Violence, Day 1;" and is designed to provide participants with an opportunity to build their knowledge base and skills relative to working with offenders and survivors in IPV cases. Strategies for engaging and interviewing children, survivors, and offenders in the case planning process is covered. Significant time is devoted to safety planning and the identification of local and statewide IPV services and resources.	Yes	Held in house	Academy Staff and DCF Staff	12	New Social Worker Staff
Behavioral Health This one day course orients participants to the topic of behavioral health as it relates to substance abuse and mental/ emotional diagnosis. This course will provide a base understanding of the signs, symptoms, and behaviors specific to the parents and/or caregivers that are struggling with or living with mental health concerns. Participants will explore, within their role as a CPS social worker, how to discuss mental health concerns and their impact on child safety. Focus will be placed on the importance and obligation of CPS social workers in not only recognizing	Yes	Held in house	Academy Staff	6	New Social Worker Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
concerns, but also in facilitating and supporting access to timely services. Discussion includes the impact of culture within the assessment and treatment process as well as the role stigma can play in the arena of behavioral health concerns.					
Permanency Teaming - Days 1 & 2 This two-day course provides an in-depth exploration of the needs of youth in care to secure permanency, maintain relationships with their biological family and other important people in their lives, as well as an exploration of the agencies Permanency Child and Family Team Meetings. Day 1 establishes the basic framework of the Permanency Teaming process, including the importance of family, search and engagement. Through lecture, small group activity, DVDs and role-play, participants will explore the core values of child welfare practice in the permanency teaming process and the role of the child welfare social worker. Focus will include balancing safety and connection, initiating permanency conversations with children and youth, as well as provide tools to organize and represent the youth's voice. Day 2 continues the exploration of the permanency teaming process using lecture, small group activity, DVDs and role-play. Participants explore the process and content of individual conversations with adults in preparation for team meetings, the role of joint or small group conversations and large team meetings, with focus placed on including the child and youth's voice. The training culminates in the importance of and steps toward establishing a culture of permanency in the reframing of casework practice.	Yes	Held in house	Academy Staff	12	New Social Worker Staff
Partnering with Caregivers and Families to Better Serve Children in Foster Care The goal of this training is to have participants enhance their skills to support partnership among CPS, FASU, Foster Parents and Biological family to meet the safety, permanency and well-being needs of children in foster care. Topics covered in this training include: a review of the Reasonable and Prudent Parent Standard; Commissioner's waiver process for kinship foster parents; purposeful child in placement visitation and parent/sibling visitation; conducting thorough assessments of potential relative/kinship foster parents; meeting children's cultural needs while in care; and an introduction to the LIST tool and collaborating with caregivers and service providers to complete the LIST for adolescents in DCF care.	Yes	Held in house	Academy Staff	6	New Social Worker Staff
Introduction to Substance Use Disorders - Days 1 & 2 Participants will be exposed to the nature of addiction, relapse, and recovery, as well as an overview of the drugs most prevalent in child protective service cases. The primary goal of this course is to develop a knowledge base as it pertains to addiction. Participants will be encouraged to question their own beliefs and biases, and confront their perceptions. Within the course, the strong relation between substance use and child maltreatment will be highlighted. Participants will be exposed to several models of dependence and options relative to recovery. Clips from the HBO Series "Addiction" will be utilized to assist in the	Yes	Held in house	Academy Staff	12	New Social Worker Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
understanding of the process of addiction and the difficult aspects of recovery. Throughout the course the information presented will be weighed against the necessary practices of child protective services, the court system, and child development. Day 1 Introduction to substance abuse from a historical perceptive as it affects the families we serve will be explored. Day one focuses on the impact of addiction, the diagnostic criteria and the behaviors associated with the disease. Day two introduces participants to harm reduction therapies and issues relevant to relapse and recovery. The DCF Policy and referral process is reviewed and participants are educated on the signs, symptoms, and physical evidence associated with five different substances. The impact of the addiction on the family system is explored throughout the course.					
Introduction to Sexual Abuse - Days 1 & 2 Sexual Abuse Day 1 is designed to give participants an overview of child sexual abuse. The day covers dynamics of sexual abuse, indicators of child sexual abuse and a review of what a child sexual abuse medical and clinical evaluation entails. This course introduces participants to the topic of "Minimal facts" and Connecticut's multi-disciplined approach to sexual abuse. The focus of the course is around understanding the victim. Day 2 is a continuation of Sexual Abuse Day 1 the focus of the course introduces participants to the role of the sexual offenders, the non-offending parent(s), and their impact on family dynamics and the ability to adequately safety plan for children. Topics include characteristics of offenders, treatment options for offenders, and the impact the non-offender has on the disclosure, safety planning and treatment, and safety planning with the non-offending parent, offenders, and children. A pre-selected participant presents a case involving sexual abuse, which is explored using the group supervision model.	Yes	Held in house	Academy Staff	12	New Social Worker Staff
Understanding the Numbers to Enhance Case Practice This one day course will provide participants with an overview of the various data reporting systems used within the department, the organizational tools available, and options for developing systems to prioritize and manage case work demands and enhance case work practice. This will include an overview of information regarding the data collected by LINK and the resulting ROM, LINK Reports, ACR Reports, and other SharePoint reports that stem from their input. Participants will be guided through the process of setting default settings and moving between summary and detail views. An introduction to EXCEL will be provided, to include exporting data from ROM and LINK SharePoint, filtering and sorting data, freezing panes, and creating formulas.	Yes	Held in house	Academy Staff	12	New Social Worker Staff
Educational Issues This course is taught by the representatives in the educational division. Course content covers special education, planning and placement teams (PPT's), Individual Educational Plans (IEP's) and the role of	Yes	Held in house	DCF Staff	12	New Social Worker Staff

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
surrogate parents. The role of the DCF worker in the education setting is also discussed.					
Test and Written Assessment This course is comprised of a computer based posttest, an oral presentation and exploration of a case from their caseload utilizing a truncated version of the department's group supervision model, and the writing of assessment components of a case plan based on an investigation protocol and narrative for a sample case. The final tests provide insight on the retention of knowledge from the classroom and field experiences as well as a demonstration of their individual skills. The results of and feedback stemming from the final test day is provided to and can be used by supervisors and participants to identify further training needs and areas that need increased proficiency for successful completion of the job.	Yes	Held in house	Academy Staff	12	New Social Worker Staff

Mandated Reporter Training

Training	IV-E Eligible	Venue	Trainers	Hours	Target Audience
Mandated Reporter Training This training is for those professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect. Section 17a-101 through 17a-03a inclusive of the Connecticut General Statues.	No	Held in various locations throughout Connecticut OR Available as an online training module	DCF Staff	60 – 90 mins	School Employees Community Partners Others deemed Mandated Reporters by state statue

Attachment F

Child Abuse Prevention and Treatment Act (CAPTA)
Grant to States for Child Abuse or Neglect Prevention and Treatment Programs

State Plan Assurances added by P.L. 114-22,
the Justice for Victims of Trafficking Act of 2015

(These amendments to CAPTA are effective May 29, 2017)

***Governor's* Assurance Statement for**
The Child Abuse and Neglect State Plan

As **Governor** of the State of Connecticut, I certify that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes:

1. Provisions and procedures requiring identification and assessment of all reports involving children known or suspected to be victims of sex trafficking (as defined in section 103(10) of the Trafficking Victims Protection Act of 2000 (TVPA) (22 U.S.C. 7102)); (section 106(b)(2)(B)(xxiv) of CAPTA)

2. Provisions and procedures for training CPS workers about identifying, assessing, and providing comprehensive services to children who are sex trafficking victims, including efforts to coordinate with State law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters to serve this population; (section 106(b)(2)(B)(xxv) of CAPTA).

Signature of **Governor**:

Date: 5-24-17

Reviewed by: _____

(CB Regional Child Welfare Program Manager)

Dated: _____

Child Abuse Prevention and Treatment Act (CAPTA)
Grant to States for Child Abuse or Neglect Prevention and Treatment Programs
State Plan Assurances amended by Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016

(These amendments to CAPTA were effective July 22, 2016)

Governor's Assurance Statement for
The Child Abuse and Neglect State Plan

As **Governor** of the State of Connecticut, I certify that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes:

(ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to –

(I) establish a definition under Federal law of what constitutes child abuse or neglect; or

(II) require prosecution for any illegal action;

(iii) the development of a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –

(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

Signature of **Governor**: _____

Date: _____

Reviewed by: _____ Date: _____

(CB Regional Child Welfare Program Manager)