

STATE OF CONNECTICUT  
AGENCY PREVENTION REPORT

November 2006



A REPORT TO THE CHILD POVERTY AND PREVENTION  
COUNCIL

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## **I. Background**

### **State Prevention Council**

The State Prevention Council was created under Public Act 01-121, An Act Concerning Crime Prevention and a State Prevention Council to evaluate and promote prevention work in the State of Connecticut. In essence, the mandate was to establish a prevention framework for the state, develop a comprehensive state-wide prevention plan, offer recommendations to better coordinate existing and future prevention expenditures across state agencies and increase fiscal accountability.

The Council met regularly to ensure that the requirements of the public act were implemented in a comprehensive manner. The membership of the Council included representatives from the Office of Policy and Management, the Chief Court Administrator, and the Commissioners of the departments of Children and Families, Education, Mental Health and Addiction Services, Mental Retardation, Public Health and Social Services.

One of the main tasks of the Prevention Council was the development of a statewide prevention plan. The Council conducted research, analysis and deliberated extensively during the planning and development phase of the plan. The plan included four major recommendations that served to advance formation of comprehensive approaches for prevention within the state. The recommendations were to:

- increase public awareness of the value of prevention
- strengthen state and local networks involved in prevention
- improve data collection on prevention programs
- share and implement best practices

The Council strongly felt that these recommendations when implemented would provide the Council with the information and tools necessary to effectively evaluate and analyze prevention initiatives in the state and set priorities for future prevention programming. The State Prevention Plan was submitted to the General Assembly in 2003.

As stipulated in the public act, the Governor's 2003-2005 Biennium Budget packet included a prevention report with recommendations for appropriations for primary prevention services administered by state agencies that served on the State Prevention Council. The report was released in February 2003.

In 2003, the legislature enacted Public Act 03-145, An Act Concerning the State Prevention Council and Investment Priorities, which required the Council to continue its work to implement its recommendations to foster the development and implementation of a comprehensive and coordinated statewide system of prevention in Connecticut. Implementation of these recommendations served to increase the awareness of the value of prevention. In January 2004, the Prevention Council's progress report was submitted to the General Assembly. This report highlighted statewide prevention initiatives within the policy domains of Early Childhood Development and Youth Development and its relationship to the four recommendations.

In accordance with the stipulations set forth in the public act, the Council submitted its final prevention report in March 2004. The report highlighted the accomplishments and outcomes for statewide prevention initiatives.

### **Child Poverty Council**

In the Spring of 2004, the Connecticut legislature enacted Public Act 04-238, An Act Concerning Child Poverty establishing a Child Poverty Council. The Council was charged with recommending strategies to reduce child poverty in the State of Connecticut by fifty percent (50%) within ten years.

The legislation required that the Council consist of the following members or their designees: the Secretary of the Office of Policy and Management, the President Pro Tempore of the Senate, the Speaker of the House of Representative, the Minority Leader of the Senate and the Minority Leader of the House of Representatives, Commissioners of the Department of Children and Families, Education, Higher Education, Labor, Mental Health and Addiction Services, Mental Retardation, Public Health, Social Services, Corrections, Transportation, Economic and Community Development, Health Care Access, and Child Advocate, chairperson of the State Prevention Council, Executive Director of the Children's Trust Fund, the Executive Director of the Commission on Children, and the Commission on Human Rights and Opportunities.

The Council engaged in numerous strategies to gather the appropriate data to assist in the formation of its recommendations. To that end, the Council presented its first report to the Legislature in January 2004. The report contained 67 recommendations to reduce child poverty in Connecticut by fifty percent over a ten year period. The recommendations were organized under six major objectives:

- enhance families' income and income-earning potential;
- help low income families build assets;
- enhance affordable health care, housing, child care and early childhood education;
- support safety net programs for families with multiple barriers;
- enhance family structure stability; and
- further study child poverty issues and solutions.

In July 2005, the legislature enacted Public Act 05-244, An Act Concerning the Implementation of the Recommendations of the Child Poverty Council. This public act made the executive director of the Commission on Human Rights and Opportunities a member of the Child Poverty Council and required the Council to meet at least twice a year to review and coordinate state agency efforts to meet the goal of reducing child poverty by 50% by June 30, 2014. The Council's annual implementation reports to the legislative committees included progress made toward meeting this goal. The Council continued its work to develop strategies to implement, monitor and report on the implementation of the recommendations.

It is important to note that a number of the Council's recommendations were proposed by Governor Rell and enacted by the legislature in FY 2006-07.

In January 2006, the Child Poverty Council submitted a report on progress made towards the implementation of the plan to meet the child poverty reduction goal and the extent to which state actions were in conformity with the plan.

### **Child Poverty and Prevention Council**

In June 2006, the Connecticut legislature enacted Public Act 06-179, An Act Concerning State Investments in Prevention and Child Poverty Reduction and the Merger of the State Prevention and Child Poverty Councils.

This public act requires the newly formed Child Poverty and Prevention Council (CPPC) to adhere to provisions of the previous councils and imposes additional responsibilities relating to prevention services. The CPPC is comprised of members from both the Child Poverty and State Prevention Councils. In 2006, the Chief Administrator was added to the Council.

The public act directs the Child Poverty and Prevention Council to:

- Establish prevention goals, recommendations and measure prevention service outcomes to promote the health and well-being of children and their families.
- Report to the Governor and various legislative committees on the state's progress in prioritizing expenditures for prevention services in budgeted state agencies with membership on the council including:
  - Summarizing measurable gains made toward the child poverty and prevention goals established by the CPPC.
  - Providing examples of successful interagency collaborations to meet the child poverty and prevention goals established by the CPPC.
  - Recommending prevention investment and budget priorities.

The public act also requires each state agency with membership on the council that provides prevention services to children and families to submit an agency prevention report to the CPPC by November 1, 2006 and November 1, 2007 and must be included in the Council's report to the Governor and legislature. Each agency report must include at least two prevention programs.

This report represents the first State Agency Prevention Report in response to the legislative reporting requirement cited above.

## **II. Development of State Agency Prevention Reports**

In July 2006, OPM convened a subcommittee meeting with representation from each of the state agencies represented on the CPPC. The purpose of the meeting was to discuss reporting requirements, responsibilities of subcommittee members and the process for submission of the state agency prevention reports. Agencies participating were: the Office of Policy and Management, Departments of Children and Families, Education, Higher Education, Labor, Mental Health and Addiction Services, Mental Retardation, Public Health, Social Services, Corrections, Transportation, Economic and Community Development, Office of Workforce Competitiveness, Children's Trust Fund, Judicial Branch, and the Office of Health Care Access.

At the initial subcommittee meeting, OPM proposed an overall approach for the development of the state agency prevention report, which was adopted by subcommittee members. Each agency represented on the Council designated one staff person to serve as the single point of contact for their agency. The contact person distributed all requests for information from OPM to the appropriate division within their agency and forwarded the responses to OPM.

For the purpose of this report, the subcommittee agreed to use the definition of prevention found in the public act:

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

This definition spans multiple fields and encompasses many types of prevention services. In an effort to focus the scope of the agency's prevention report, the subcommittee agreed to refine this broad definition and report on primary prevention programs that serve children 0-18 and their families. Primary prevention refers to programs designed to prevent or eliminate at risk behavior before a problem occurs and promotes the health and well-being of children.

OPM developed and distributed to the state agencies a report form to capture all relevant prevention data needed to complete the prevention report.

## **III. State Agency Reports**

This section of the report represents an array of primary prevention services that provide intensive, comprehensive and family-centered resources and support that reduces or eliminates high risk behavior and promotes the health and well-being of children and families. Each state agency was given the option to select and report on two or more primary prevention programs that positively impact children aged 0-18 and their families.

Each report includes the following:

- a brief description of the purpose of prevention programs
- the number of children and families served

- long-term goals, strategies and outcomes to promote the health and well being of children
- a statement on the overall effectiveness of prevention within the agency
- methods used to reduce disparities in child performance and outcomes by race, income level and gender

The departments of Corrections, Labor, Higher Education, Economic and Community Development, Office of Health Care Access, Office of Workforce Competitiveness, and the Judicial Branch, determined that their prevention programs did not meet the definition of primary prevention, and therefore, no reports from these agencies are included in this report.

The state agency prevention programs included in this report are as follows:

**Children’s Trust Fund**

Sex Abuse Project  
 Family Empowerment Initiative  
 The Help Me Grow Program  
 The Kinship and Grandparent Respite Fund  
 Nurturing Families Network  
 The Parent Trust Fund  
 Shaken Baby Syndrome Prevention Project

**Department of Children and Families**

Positive Youth Development Initiative  
 Youth Suicide Prevention  
 Shaken Baby Syndrome Prevention Project

**Department of Education**

Even Start  
 Family Resource Centers  
 Early Childhood Programs/School Readiness  
 Head Start Services & Enhancement

**Department of Mental Health and Addiction Services**

Best Practices Initiative  
 Local Prevention Council Programs

**Department of Mental Retardation**

Family Supports  
 Birth to Three

**Department of Public Health**

Captain 5 Day Nutrition Education  
 Immunization Program

**Department of Social Services**

Fatherhood Initiative  
 Family Supportive Housing

**Office of Policy & Management**

Norwich Reintegration Education  
 Neighborhood Youth Center

## Children's Trust Fund

**Program Name:** Sexual Abuse Project

**Program Description:** This pilot program trained teachers in every school in East Hartford and spoke with hundreds of parents and others interested in preventing childhood sexual abuse. The Child Sexual Abuse Prevention Project at ChildPlan, Inc. grew out of the work of the Trust Fund's Childhood Sexual Abuse Prevention Coalition in 2003. The project builds upon the work of the coalition by developing strategies to prevent child sexual abuse by focusing on involving adults throughout the community in these efforts.

**Number of children and families served:** 425 professionals and 400 parents were served during 2005- 2006.

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**Program Name:** Family Empowerment Initiatives

**Program Description:** Family Empowerment Initiatives include 8 prevention programs that assist high-risk groups of parents with children of various ages. The programs are co-located in various settings including a school, a substance abuse center, a prison, a domestic violence shelter, a child guidance center and a public housing project where families may be addressing other issues.

These programs help families to address a whole range of issues including parenting and family relationships.

**Number of children and families served:** 647 children and families were served during 2005 – 2006.

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**Program Name:** The Help Me Grow Program

**Program Description:** The Help Me Grow Program is a prevention initiative that identifies and refers young children with behavioral health, development and psychosocial needs to community-based services. The program bridges the gap between children with early signs of developmental problems and the services designed to address them. The program serves children who may not be eligible for the state's Birth to Three or preschool special education programs, yet are still at risk for developmental problems.

**Number of children and families served:** 9,345 children and families served since January 1, 2000.



**Program Name:** The Kinship and Grandparents Respite Fund

**Program Description:** The Kinship and Grandparents Respite Fund awards small grants to orphaned or abandoned children and the court-appointed relative guardians they live with. The Trust Fund provides funding to eight probate courts to administer the program. The grants provide for a range of activities including tutoring, camp, fees for a variety of programs and extra-curricular experiences, clothing, eyeglasses and other basic necessities and respite for the caregivers.

**Number of children and families served:** 2,018 children and families serviced from July 5, 2005 through June 6, 2006.

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**Program Name:** Nurturing Families Network (NFN)

**Program Description:** This program operates out of 25 of the twenty-nine birthing hospitals in the state and in 10 community centers in the city of Hartford. NFN provides education and support for all interested new parents and intensive home visiting services for parents identified as most at risk. The NFN reaches more than 4,000 first time families each year and has offered home visiting services to approximately 3,243 vulnerable families at risk of abusing, neglecting or abandoning their children. The program is expanding to eight neighborhood service areas in the City of New Haven and is expecting to reach an additional 250 vulnerable families through its home visiting services. The home visitors become involved during the mother's pregnancy and continue working with the family, on average, for nineteen months. The home visitors teach child development and help the family to bond with and take hold of their responsibility to their child. Seventy percent (70%) of the time fathers are involved. Home visitors support the parent to finish school, to secure a job, and to find and utilize the services of a pediatrician. They connect families to WIC, and to counselors and others in the community who can help. The Network also offers intensive group support to parents and extended family members. The program teaches the family appropriate expectations for their children and fosters empathetic understanding and strategies for enhancing the well being of children. Approximately 600 families have participated in the Nurturing Program each year.

**Number of children and families served:** 24,155 children and families served since the program began.

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**Program Name:** The Parent Trust Fund

**Program Description:** The Parent Trust Fund provided 29 grants to offer classes to parents to help improve the health, safety and education of children by training parents in leadership skills and by supporting the involvement of parents in community affairs.

**Number of children and families served:** 577 parents were served during 2005 – 2006.

**Program Name:** Shaken Baby Syndrome

**Program Description:** The Shaken Baby Prevention project trained hospital based medical professionals and community service providers throughout Connecticut on integrating a national model of prevention into their practice. The training program has been widely accepted into many local high schools' health and well-being curriculum. Three regional trainers provide outreach, education and support to the community on preventing shaken baby syndrome.

**Number of children and families served:** 550 participants have attended presentations during 2005-2006.

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**Long-Term Agency Goals:** The goal of the Children's Trust Fund is to prevent child abuse and neglect and to ensure the positive development of children.

The funds appropriated to the Children's Trust Fund are used to support community efforts that assist families. The community programs are designed to engage families before a crisis occurs – to actually keep abuse and neglect from happening.

This strategy is working. The programs supported by the Children's Trust Fund are making a difference in the lives of children and their parents while reducing the number of families that enter the state child welfare system.

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

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

**Outcomes:**

- Reduced rate and severity of child abuse and neglect
- Improved parent –child interaction and parenting skills
- Connection to health care providers, high immunization rates
- Gains in household stability, education, employment

- Less financial hardship, access to more resources
- Enhanced family relationship and parent well-being
- Increases in developmental monitoring and access to services
- Enhanced child well being over time.

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

- The incidence and severity of child abuse and neglect in the high-risk families served by the Trust Fund is much less than expected.
- The evaluation on its Nurturing Families Network (NFN) shows the incidence of abuse and neglect to be well below that of high-risk families not participating in this type of program; 3% compared to 19%.
- The immunization rate for two-year old children whose families are involved in the program is 93% compared to 73% for two years olds with similar demographic background on Medicaid.
- A significant percentage of the parents are completing high school, becoming employed and moving out of financial hardship.
- The percentage of mothers establishing independent households increased from 53% to 93% in the second year of program involvement. This is a significant outcome, likely to ensure the future safety of children, given the high number of mothers who were living in abusive or violent or potentially violent households at the start of their program involvement.
- Families are also improving parent-child relationships as well as parenting capacity, attitudes and behavior.

Other research on home visiting shows that the early intervention reduces rates of tobacco and alcohol use, episodes of running away, behavioral problems, arrests, convictions, and sexual promiscuity among teenagers whose families had been reached in this way.

Research on other Trust Fund efforts have found that health care providers have increased their use of developmental surveillance and referrals of at risk youth following training.

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

**Intensive multi-focused home visiting:**

Several studies have found that home visiting services reduce disparities in child performances and outcomes by race and income level.

One study, conducted by the Missouri Department of Elementary and Secondary Education, found that children enrolled in preschool - whose families participated in a home visiting program - scored significantly higher on all measures of intelligence, achievement, and language ability than children in the comparison group whose families did not receive home visiting services.

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

How does Help Me Grow reduce disparities by race, income level and gender...?

The National Research Council's report *Neurons to Neighborhoods* (Shonkoff and Phillips, 2000) and RAND's analysis of early childhood interventions, *Investing in Children*, (Karoely et al, 1998) indicate that high quality early intervention programs can have very positive results for those children receiving services. These included increases in short and long term academic achievement, reduction in grade retention rates, and reductions in special education referrals and reduction in teenage pregnancy.

The Help Me Grow program offers universal access to anyone in Connecticut who has concerns about their child's learning, behavior or development. Thousands of families have been connected to critical early intervention programs. Help Me Grow provides training to child health providers on developmental screening and connection to services. The Help Me Grow staff has visited over 50% of Connecticut's pediatric and family practices. Based on this research project, funded through the Commonwealth Fund, referrals for early intervention have doubled. In addition, Connecticut is the only state that provides universal access to an on-going child development monitoring system called *Ages & Stages*. Anyone in the state can access this free service.

**Other:** Child abuse and neglect is at the root of many of the problems children face. Children who are abused or neglected are at high risk for developmental and behavioral problems, health issues, learning disabilities and cognitive delays.

Abused or neglected children are more likely to become involved with the child protection and juvenile justice systems and to become involved with the departments of Social Services, Corrections and Mental Health as adults.

Children fare best when they are nurtured by parents who provide for their needs and help through difficult times growing up. And yet we find that most of the families who participate in

Trust Fund programs are ripe for a crisis. More than half of the parents served were abused themselves as children, most are poor and have a limited education and more than half are teenagers – who are just growing up themselves.

As a result, many of the mothers are having difficulty bonding with their babies and meeting the needs of their infants. In Connecticut there are thousands more families who struggle with the demands of parenting and who are in the high range for abuse potential.

It is critical that families are reached before a crisis occurs. Child abuse and neglect must be prevented.

While prevention is a relatively new field, research demonstrates that the strategies employed by the Children's Trust Fund can help more families and more children have a better life. By preventing child abuse and neglect we have a better chance of keeping children safe in their homes, able to perform well in school and have a productive future.

## Department of Children and Families

**Program Name:** Positive Youth Development Initiative

**Program Description:** The Department funds 6 agencies, all using evidence-based or best practice models, to provide positive youth development and family strengthening programs. The Bureau staffs bimonthly technical assistance meetings. An independent evaluator is assisting the Department, in partnership with the providers, to develop common outcomes for this initiative, gather data and monitor effectiveness.

**Number of children and families served:** Approximately 803 children and their families were served in SFY 2005-2006.

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### **Long-Term Agency Goals:**

- An increase in the social-emotional skills of children through a universal prevention program/strategy;
- An increase in support and opportunities for young people through enrichment and/or recreation;
- An increase in bonding of children to their parents, school and peers; and
- An increase in the engagement of/and communication with families.

**Strategies:** The Positive Youth Development Initiative promotes approaches that help young people grow into competent, healthy adults by providing them with opportunities to build skills, help their communities, and form healthy relationships with others. The youth development approach defines goals or outcomes, based on the capacities, strengths, and developmental needs of youth. Therefore youth must be included in any planning sessions, committees or coalitions that are going to make decisions directly affecting them. Similarly the diversity of gender, culture, ethnicity, religion, economic status, etc. in the target group must be recognized and represented in the planning process.

**Outcomes:** Increase student and parental life skills thereby reducing risk level and increasing the probability of youth success in school and future endeavors through the sustained implementation of universal and indicated evidence-based prevention programs for youth and families statewide. This is a new initiative and possible outcomes are yet to be determined.

The possible outcomes under discussion within the agency include the following:

- Completion/graduation from program
- Decrease in drug use / delayed initiation of use
- Decrease in aggression/ violence
- Increase in positive peer network

- Increase in internal locus of control for youth and parents
- Increase in knowledge of & ability to identify and control moods including anger
- Increase in young persons' self-efficacy
- Increase in school bonding
- Improvement in attendance
- Improvement in graduation rate
- Improvement in grades
- Decrease in DCF involvement
- Increase in youth involvement in their "passion"
- Increase in parental skills (e.g., coping, monitoring, communication, discipline) and their application
- Increase in parental involvement with school
- Increase in help-seeking behavior by youth and parents
- Decrease in perceived isolation by families

**Measure of Effectiveness:** One measure is the integration of prevention throughout the Department. DCF Prevention Liaisons have been established in all Area Offices and facilities and meetings are held monthly.

**Methods:** All services must be provided in a context that is child centered, family-focused, strength based and culturally competent.

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**Program Name:** Suicide Prevention

**Program Description:** CT Youth Advisory Board was legislatively established in 1989 within the Department of Children & Families. The membership is comprised of volunteers, community and state agency representatives with the goal of preventing suicide among children & youth. This goal is accomplished through statewide awareness campaigns and training.

**Number of children and families served:** 271 people were trained in SFY 2005-2006.

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**Long-Term Agency Goals:**

- Increase public awareness of the existence of youth suicide and means of prevention;
- Make recommendations to the Commissioner of the Department of Children and Families for the development of state-wide training in the prevention of youth suicide;

- Develop a strategic youth suicide prevention plan;
- Recommend interagency policies and procedures for the coordination of services for youth and families in the area of suicide prevention;
- Make recommendations for the establishment and implementation of suicide prevention procedures in schools and communities;
- Establish a coordinated system for the utilization of data for the prevention of youth suicide;
- Make recommendations concerning the integration of suicide prevention and intervention strategies into other youth focused prevention and intervention programs

### **Strategies:**

#### **Promote Awareness That Suicide Is Preventable and That Mental Health Is Important To Overall Health**

- Promote a public awareness campaign that promotes the adult role in facilitating the mental health of children and youth
- Use non-traditional service providers and community partners to develop appropriate messages and strategies to reach diverse populations
- Enhance and facilitate training for children and youth, parents and caregivers, professionals on child development, substance abuse, coping skills, life skills, mental health issues, conflict resolution, competition and stress relieving strategies
- Promote awareness among adults of key male and female methods of suicide attempts and completions among children and youth
- Promote awareness of issues specific to children and youth who may be victimized by their peers because they are perceived to be not acceptable.

#### **Promote, Develop and Implement Effective Prevention Strategies**

- Facilitate more early mental health prevention and intervention such as early childhood services and specialized nursery schools
- Encourage providers to discuss firearm safety with caregivers and include in client assessment
- Promote participation of schools and local agencies in local systems of care
- Expand after school and other positive youth activities
- Increase awareness of the significance of self-mutilating and cutting behaviors among children and youth.

#### **Promote Improved Access to Behavioral Health Care**

- Conduct rapid assessment and planning of care for children, youth and their caregivers
- Ensure that clinical care is provided in the least restrictive environment
- Ensure timely access to behavioral health care
- Provide increased community-based services
- Reduce over-utilization of out of home care
- Promote system changes to expand the scope of services in schools



- Assess utilization of school-based mental health and substance abuse services
- Ensure that caregivers and gatekeepers are educated about Husky and Medicaid coverage for children and youth

**Promote the Provision of Quality Behavioral Health Care**

- Promote support of the appropriate use of clinical behavioral health interventions prior to the use of psychotropic medications
- Increase knowledge of the efficacy of the use of multiple psychotropic medications in children
- Increase collaboration between state agencies- education, public health, mental health and addiction services, judicial, children and families, mental retardation and social services
- Maintain and implement measures to ensure family/caregiver input is solicited, respected and heeded at the treatment, planning and evaluation level
- Develop and implement effective transition plans with participation of parents/caregivers and community service providers.

**Outcomes:** Through the work of the Interagency Suicide Prevention Network, the state now has a five-year plan in place. We are now entering the implementation stage. Of the above referenced strategies, the Board has identified four to be the focus for the coming year and outcomes measures will be aligned with these. These four are:

- Enhance and facilitate training for children and youth, parents and caregivers, professionals on child development, substance abuse, coping skills, life skills, mental health issues, conflict resolution, competition and stress relieving strategies
- Promote participation of schools and local agencies in local systems of care
- Ensure timely access to behavioral health care
- Increase collaboration between state agencies- education, public health, mental health and addiction services, judicial, children and families, mental retardation and social services

**Measure of Effectiveness:** One measure is the integration of prevention throughout the Department. DCF Prevention Liaisons have been established in all Area Offices and facilities and meetings are held monthly.

**Methods:** Cultural competency is incorporated into the designing and implementation of all training and awareness campaigns. Target populations for training include high risk groups such as Gay, Lesbian, Bisexual and Transgender youth.

**Program Name:** Public Awareness Campaign; Training of DCF workers and providers on strategies to calm crying babies and stop toddlers’ temper tantrums and educate young people in the Department’s facilities about the dangers of shaken baby syndrome.

**Number of children and families served:** Training was provided on baby calming strategies to over 400 providers and 100 parents. Technical assistance was provided and audio-visual

materials were provided to the Department's four facilities in order to develop prevention education for young people in the Department's care.

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**Long-Term Agency Goals:**

- Reduce the incidence of shaken baby syndrome
- Increase the bonding of parents and young children.

**Strategies:** Since crying is a known trigger for shaken baby syndrome, the Department is working to disseminate baby calming strategies to the general population, and in particular to parents who may be at greater risk for the perpetration of shaken baby syndrome.

**Methods:** In partnership with the Department's Research Scientist feasible outcomes are being developed.

**Measures of Effectiveness:** Resources were unavailable to conduct a formal evaluation of the series of trainings conducted in the Spring of 2005. However, very positive anecdotal information has been received from both DCF staff and community providers regarding the use of these strategies with their clients after attending the training.

**Methods:** Simultaneous translation in Spanish was available for the parents' training

## Department of Education

**Program Name:** Even Start Family Literacy Program

**Program Description:** Even Start provides intensive “family literacy services” to help break the cycle of poverty and illiteracy by improving the educational opportunities of low-income families by integrating early childhood education, adult literacy or adult basic education and parenting education into a unified family literacy program.

Even Start is contained as part of Title I, Part B Subpart 3 of the Elementary and Secondary Education Act (ESEA) reauthorized as the “No Child Left Behind Act of 2001” Public Law 107-110.

**Number of children and families served:** 238 Children and 194 Families for fiscal year 2005-2006.

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**Program Name:** Family Resource Centers

**Program Description:** Family Resource Centers are based on the "Schools of the 21st Century" concept, as developed by Dr. Edward Zigler, Director of the Zigler Center in Child Development and Social Policy at Yale University. This concept envisions comprehensive, integrated, community-based systems of family support and child development services located in public school buildings. By strengthening effective family management practices and establishing a continuum of childcare and support services for parents and children in need, Family Resource Centers work to provide the best possible start for all children and families regardless of race, ethnicity, and socio-economic status. Centers provide a common location for families to take advantage of a range of services, which can be tailored to meet the unique needs of families from diverse backgrounds and cultures.

**Number of children and families served:** 18,416 (average number of families enrolled monthly)

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**Program Name:** Early Childhood Program (School Readiness)

**Program Description:**

- To significantly increase the number of accredited and/or approved spaces for young children in order to provide greater access to high-quality programs for all children;
- To significantly increase the number of spaces for young children to receive full-day, full-year child care services to meet family needs and to enable parents to become employed;

- To establish a shared cost for such early care and education programs among the state and its various agencies, the communities and families and;
- To enhance the quality of programs providing school readiness or child day care services.

**Number of children and families served:** The number of children served in priority and competitive districts combined for the 2005/2006-grant year is 7,525 children. It is unknown how many families were served.

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**Program Name:** Head Start Services and Enhancements

**Program Description:** Head Start is a federally funded program that is supplemented by the state. It is a comprehensive program that serves children 3-5 and their families. It is a child focused and family centered program that has the overall goal of increasing the social competence of young children in low-income families. Social competence means the child's everyday effectiveness in dealing with his or her present environment and later responsibilities in school and life. Head Start offers opportunities and support for families to grow and change based on their strengths, needs and interests. State funding provides more parents opportunities to work, attend education and/or job training programs to help them attain self-sufficiency. The state supplement increases the number of children who attend Head Start programs, the number of children who have the opportunity to attend full-day and full-year programs and extended-day and extended-year programs. It provides increased opportunities for children to enhance their language, literacy and mathematical skills.

**Number of children and families served:** 6,628 children (and their families which are not counted in this number)

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### **Long-Term Agency Goal**

*The narrative below represents draft language developed by The Connecticut State Board of Education for a five-year (2006 – 2011) comprehensive plan for education. Included is the “implementation plan with appropriate goals and strategies to achieve resource equity and equality of opportunity, increase student achievement, reduce racial, ethnic and economic isolation, improve effective instruction, and encourage greater parent and community involvement in all public schools of the state.” The vision is to create “a superior education for Connecticut’s 21<sup>st</sup> century learners.” Final approval of this draft plan is expected in the fall 2006. The narrative language below reflects the proposed wording.*

Working with the education community, the State Board of Education has put forth a vision and a mission for public education in Connecticut, and has identified seven core values that reflect its beliefs and form the basis for an organizational structure and culture that will strengthen State Department of Education employees' interactions and relationships with all internal and external colleagues. The seven core values listed below are embedded in the Board's vision and mission

and will guide the entire education community as it works to achieve the Board's goals and objectives:

*Collaboration:* We work in meaningful partnerships to learn, to make decisions, and to share information, talents and energy to achieve our goals.

*Diversity:* We value, actively pursue and are strengthened by diverse perspectives. Our varied cultural backgrounds, beliefs and points of view are essential to achieve our mission.

*Innovation:* We generate and support new ideas and approaches that achieve individual and organizational excellence.

*Integrity:* We are honest, ethical and respectful.

*Leadership:* We advocate for and advance our vision. We inspire and empower our colleagues to achieve it.

*Responsibility:* We are dedicated to individual and organizational performance that builds and maintains public trust and confidence. We are accountable for fulfilling our commitments and expectations.

*Responsiveness:* We are timely, thorough and accurate.

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## **Long-Term Agency Goal # 1**

Goal: Increase student achievement.

Student achievement is directly related to high quality instruction. The student achievement gaps in Connecticut are unacceptable. There are gaps between genders, racial, ethnic and socioeconomic groups, as well as gaps in expectations for students from differing backgrounds. We must expect all students to achieve at high levels and make certain that expectations for students and rigor of curriculum are equal in urban, suburban and rural schools. We will increase student achievement by working with our state, federal and local partners. We must ensure in Connecticut that our definition of achievement extends beyond core subject areas so students can be successful in the 21<sup>st</sup> century.

### **Strategy and Methods**

- Develop and provide model curriculum.
- Review curriculum in low performing districts for rigor and alignment to state standards; require state-approved revisions.

- Provide training on implementation of standards-based model curriculum and monitor implementation of curriculum in low-performing districts.
- Increase training for educators in curriculum and teaching strategies that emphasize contributions and perspectives of different ethnic and cultural groups.
- Increase collaboration/communication with preparation programs to align preparation and pre-service training with research-based standards.
- Provide training on effective instruction to meet needs of all students, including English Language Learners (ELLs) and students with special needs.
- Provide training on the use of technology to meet the needs of all students.
- Develop partnerships with higher education and local entities to recruit and retain diverse educator workforce.
- Promote use of formative assessments as part of all instruction and course offerings.
- Expand alternative routes to certification.
- Explore use of technology to expand access to high quality educators.
- Accelerate recruitment of minority candidates into teaching.
- Convene leadership committee with representative stakeholders to recommend design and content of program.
- Use data from pilot sites at Cooperative Educational Services (CES) and Connecticut Association of Schools (CAS) to provide input for design and content.
- Create repository of test items and electronic delivery systems and analysis system.
- Align test items with model curriculum.
- Provide a data warehouse and tools for analysis.
- Provide technical assistance on analyzing data and using results to improve student achievement.
- Use State Education Resource Center to identify and publicize best practices.
- Collaborate with higher education, high school credential programs and business to define PK-16 student competencies.

- Align Connecticut college placement tests with defined student competencies.
- Incorporate 21<sup>st</sup> century skills and content into curriculum and instruction in middle and high schools.
- Provide guidelines on modifying middle and high schools to meet the needs of students, such as smaller learning communities, alternative schedules, and access to online learning opportunities.

## **Outcomes**

- Provide quality, standards-based, culturally responsive and relevant curriculum for all.
- Ensure educators (teachers and administrators) provide relevant, meaningful and engaging instruction to meet needs of all students.
- Develop and support nontraditional pathways to meet anticipated educator shortages.
- Develop and implement statewide induction program to attract, support and retain high-quality administrators.
- Develop and implement a formative assessment system.
- Assist district and school personnel to collect and analyze data to inform decision-making.
- Implement Vanguard School Improvement Model.
- Ensure students are well-prepared for higher education and the workforce.

## **Measure of Effectiveness**

- Significant increase in number of students in low-performing districts scoring at or above proficiency and goal in reading, writing, math and science.
- Increased proportion of students scoring at or above proficiency and goal on Connecticut Mastery Test and Connecticut Academic Performance Test; decreased gap between subgroup performance.
- Decreased drop-out, expulsion and suspension rates among all subgroups of students.
- Increased graduate rates among all subgroups of students.
- Increased diversity in educator workforce.

- More high quality teachers in every classroom.
- Sufficient numbers of educators to meet shortage areas.
- All new leaders have access to induction program.
- All educators use formative assessments to evaluate students' progress frequently throughout school year.
- All districts have access to and knowledge of resources to analyze formative and summative assessment results and other data to improve instruction.
- All educators have access to repository of best practices.
- More Vanguard Schools.
- More students demonstrate competencies that enable them to successfully transition to higher education or work.
- More students taking science, technology, engineering, math, world language, and advanced courses.
- Increased participation and successful completion of a higher education degree.
- Increased student achievement.

### **Long-Term Agency Goal # 2 and # 3**

Goal: Achieve resource equity and equality of opportunity; reduce racial, ethnic and economic isolation.

These two goals are closely linked. All students should have the same opportunities and access to human, material, and fiscal resources regardless of where they attend school. In addition, each student should have the opportunity to learn from and connect with others of different racial, ethnic and economic backgrounds. The State Board of Education will facilitate greater access to resources and choices; address issues of over-identification of subgroups in special education; foster culturally responsive learning environments; continue magnet school, charter school, and Open Choice programs; and seek expanded funding to fully support these initiatives.

### **Strategy and Methods**

- Increase resources to provide full-day kindergarten, and focus initial efforts to increase capacity in high-need districts.
- Focus initial efforts to serve neediest 3- and 4-year-olds.



- Recruit, prepare and certify high-quality preschool teachers.
- Increase physical space to accommodate additional preschool programs.
- Expand existing student data collection system to include data for all students in public and private preschool programs.
- Develop kindergarten assessment to determine school readiness.
- Evaluate effectiveness of preschool programs.
- Advocate for extended school year and extended school day programs for students who need additional assistance.
- Advocate for before- and after-school programs where extended day programs not available.
- Advocate for summer programs that offer academic and cultural enrichment where extended year not available.
- Provide models for reducing “out-of-school” suspension programs.
- Use state-of-the-art technologies as part of all instructional and course offerings.
- Provide on-line learning opportunities.
- Provide teaching and learning opportunities through Connecticut Education Network (CEN).
- Provide guidance and technical support to districts on components of physically safe and healthy learning environments.
- Promote implementation of Healthy and Balanced Living Curriculum Framework.
- Promote implementation of nutrition, health and behavioral guidelines.
- Provide guidance and technical support to districts on prevention of substance abuse, sexually transmitted diseases and related concerns.
- Provide guidance and technical support to districts on components of emotionally safe and healthy learning environments.
- Promote efforts to provide information and technical support on positive school climate to pre-service and in-service educators.

- Assist districts in increasing and fostering strong personal connections among school community members, especially between adults and students.
- Provide legal guidance to educators and students surrounding Connecticut anti-bullying and sexual harassment legislation.
- Increase number of courses offered and number of schools offering courses.
- Increase funding to pay fees associated with these programs.
- Increase awareness of opportunities for participation and funding.
- Increase program and course offerings, such as Advanced Placement, honors, dual/concurrent enrollment such as UConn, International Baccalaureate.
- Provide information, technical assistance, and professional development.
- Develop relationships with other countries to increase teacher exchange programs.
- Integrate international awareness in subject areas and career development.
- Provide resources through general funding of all educational programs (revised Education Cost Sharing funding formula).

## **Outcomes**

- Provide full-day kindergarten to all.
- Provide quality preschool programs to all.
- Extend opportunities for learning in PK-12 for students in high-needs districts.
- Explore alternatives to meet the needs of underperforming student groups.
- Provide physically safe and healthy learning environments for all.
- Provide emotionally/socially safe and healthy learning environments for all.
- Expand access to all forms of advanced course/program offerings.
- Expand world language and international awareness education instruction across all Connecticut schools to begin in early elementary grades.
- Expand magnet, charter and Open Choice programs.

## Measure of Effectiveness

- More high-quality, full-day kindergartens offered in state.
- Increased school readiness.
- Decreased suspension and expulsion rates.
- More students attend preschool; all high-poverty students attend preschool.
- More certified/qualified teachers in preschool settings.
- Comprehensive student database used to track students from preschool through high school.
- More students ready for kindergarten.
- Kindergarten curriculum aligned to Connecticut preschool curriculum framework.
- Decreased preschool expulsion rates.
- More high-needs districts on extended-day and/or extended-year schedule.
- Increased enrollments in summer school programs where extended year not available.
- More students exposed to and engaged in new academic and cultural experiences.
- Increased graduate rates.
- Decreased drop-out, suspension and expulsion rates.
- Increased achievement of *all* students.
- More teachers use effective strategies to meet needs of diverse student population.
- More diverse perspectives that represent multiple points of view emphasized in the curriculum.
- Decreased number of black and Hispanic students identified as special education.
- Increased accommodation of students with diverse learning styles.

- More school communities fully-informed about and protected from physical hazards and allergens.
- More school communities fully-informed about violence prevention (physical).
- More school communities fully-informed about making healthy choices with respect to exercise, nutrition, and life choices about risky and healthy behaviors.
- More school communities fully-informed about strategies to diminish substance abuse and other related risky behaviors.
- More school communities fully-informed and protected from all forms of peer cruelty (male and female bullying behaviors in verbal, emotional, social, intellectual, physical and cyber arenas) and violence prevention.
- More training provided to educators for creating positive and respectful school culture and climate; comprehensive violence prevention and intervention.
- All students have at least one significant adult in school as their advocate.
- More school communities fully-informed about letter and spirit of anti-bullying and sexual/racial harassment legislation.
- Reduction in incidents of bullying and sexual/racial harassment.
- Increased participation of needy students in various forms of advanced courses and programs.
- More students earn “3+” on Advanced Placement examinations.
- More schools offer world languages.
- Increased enrollments in world languages.
- Increased sequence lengths in world languages.
- International competition integrated in career development design.
- Students in all districts to have access to choice programs.

#### **Long-Term Agency Goal # 4**

Goal: Encourage greater parental and community involvement in all public schools in the state.

The State Board of Education recognizes that education is a shared responsibility throughout a student's life. Schools, families and communities all contribute to student success, and the best results come when all three work together. School-family-community partnerships are formed to support student success and help adults coordinate their efforts to promote learning. The State Board of Education will provide leadership in developing and promoting school-family-community partnership programs that contribute to success for all students. Partnerships must engage multiple community stakeholders and recognize, respect and address families' diverse interests, needs and talents, as well as economic and cultural differences.

### **Strategy and Methods**

- Align pre-service training with National Council for Accreditation of Teacher Education (NCATE) standards on partnering with families and communities.
- Provide professional development to school and district staff in developing effective school-family-community partnerships based on the State Board of Education standards.
- Provide incentives to schools and districts to establish a permanent infrastructure to support Action Teams for Partnerships, which include community organizations, business sector and faith-based groups.
- Provide training and technical assistance for development and implementation of district parent involvement policies.
- Disaggregate data in adult education reporting system to determine number of adult learners who are parents of school-age children and provide access to programs and services.
- Increase capacity of adult education system and Family Resource Centers to meet literacy needs of parents.
- Increase resources to establish parent reading clubs in sites that receive School Readiness funds.

### **Outcomes**

- Engage families and communities meaningfully in success of all students.
- Develop literacy skills of parents; help parents support children's literacy development.

### **Measure of Effectiveness**

- School and district action teams trained for school-family-community partnerships with outcome-oriented action plans.

- Increased parent participation in the planning and improvement of school programs.
- Increased support to parents for supporting children's learning at home.
- Improved district policies and consistent implementation.
- Improved student attendance.
- Increased homework completion.
- Increased attendance at parent-teacher conferences.
- Increased number of parents of children in School Readiness programs that support children's learning and development.
- Increased number of parents with improved literacy skills and high school credentials.

## Department of Mental Health & Addiction Services

**Program Name:** Best Practices Initiative

**Program Description:** 13 statewide funded projects that apply science and research-based programs to populations across the life cycle. These science-based community prevention programs are designed to enhance the lives of adults and children and encourage family, peers, neighbors and others to become involved.

Program components usually include education and information, opportunities to develop life and professional skills and individualized service plans. The programs target services to meet the needs or concerns of the population being served and vary in length, intensity, approach and content.

**Number of children and families served:** 6,847

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**Program Name:** Local Prevention Council Programs

**Program Description:** Increase public awareness of Alcohol Tobacco and Other Drugs (ATOD) prevention and stimulate the development and implementation of local prevention activities primarily focused on youth through 120 local municipal and town councils serving the 169 towns and cities in Connecticut.

**Number of children and families served:** 460,376 (this number includes professionals and community members as we are unable to break out the children and families separately).

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### **Long-Term Agency Goals:**

- Provide cost-effective, research based, developmentally appropriate prevention services that promote the health & well-being of children and families
- Increase partnerships with state and local agencies to develop, implement, evaluate and diffuse effective prevention programs and strategies that focus on youth and families
- Increase the cultural ability of prevention program providers to work effectively with youth and parents from culturally, economically and geographically diverse populations

### **Strategies:**

- Fund programs based on needs identified by communities
- Implement program standards to monitor the service system
- Develop partnerships with state and local agencies by participating committees and advisory boards

- Increase funding of evidence-based programs that focus on families, early childhood and youth development
- Assess the prevention needs for youth and families across the state
- Provide training and technical assistance to the DMHAS prevention providers on cultural competency

**Outcomes:**

- Increased number of evidence-based programs that focus on youth and families
- A more refined quality assurance process that assesses effectiveness and fidelity of implementation of prevention programs
- An integrated state plan that supports families and communities in youth and early childhood development
- Increased partnerships with state and local agencies
- Increased number of providers trained and receiving technical assistance on cultural competency

**Measure of Effectiveness:** In the last 3 years the DMHAS Prevention unit has increased by 50% the number of evidence-based programs that focus on youth and their families. With the increase in staff, there were also increases in the number of Prevention partnerships between DMHAS and other state and local agencies. Several plans have emerged from these partnerships, most notably the Early Childhood Partners, Strategic Prevention Framework and a policy recommendation to align substance abuse prevention and social and academic development through school community and family partnerships. The DMHAS Prevention Training Collaborative has also increased the number of courses offered to providers.

**Methods:** DMHAS provides Prevention services aimed at increasing the health & wellness of children and their families through funding and assessing its pool of over 160 non-profit providers statewide. To address disparities, DMHAS contracts with the Multicultural Leadership Institute (MLI), a statewide resource in the provision of cultural competent mental health and substance abuse prevention services to assure that all products, activities and services are culturally competent.

**Other:** Where possible, the DMHAS Prevention unit shares lessons learned and program outcomes and accomplishments with the field at national meetings and conferences.



## Department of Mental Retardation

**Program Name:** Birth to Three

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

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

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

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

The federal law requires that two groups of children receive services 1) those with developmental delays and 2) those with diagnosed conditions expected to lead to a developmental delay without the benefit of early intervention. The state is given quite a bit of latitude in defining both of those groups. The federal law also allows states to serve children who are at environmental risk for delay, although Connecticut has not chosen to include those children yet.

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

**Number of children and families served:** In FY 2006, 7,971 children were newly referred for evaluation. 8,586 eligible children and their families received services during some portion of the fiscal year which equated to approximately 4,000 on any given day. The one-day count represents 3.1% of all Connecticut children under the age of three.

**Long-Term Agency Goals:** To ensure that children with developmental delays or who are at-risk of developmental delays are ready for Kindergarten.

**Strategies:** Family-centered early intervention services are delivered in natural environments as early as possible to as many Connecticut infants and toddlers who have disabilities or developmental delays or who are at risk for developmental delays.

**Outcomes:**

- Children receive early intervention services as early as possible
- Children’s development is improved
- Families feel more confident and competent to facilitate their children’s development
- Fewer children need special education services by Kindergarten

**Measure of Effectiveness:**

- percent of children under the age of three served (currently 3.1% - 11<sup>th</sup> nationally compared to all other states)
- percent of children under the age of 12 months served (23<sup>rd</sup> nationally compared to all other states)
- percent of infants and toddlers served who demonstrate: 1) improved social-emotional skills, 2) acquisition and use of knowledge and skills, and 3) use of appropriate behaviors to meet their needs (data not yet available)
- percent of families served who report that early intervention services have helped the family help their children develop and learn (data under analysis, not yet available)
- percent of children served who have exited the program and who do not need to receive special education services in Kindergarten (49%)

**Methods:** All children that meet the eligibility criteria are eligible – irrespective of race, income level, gender, or town of residence. The program does not specifically target groups of children for services. However, by including all children with significant developmental delays, Birth to Three is working to teach families and other caregivers to facilitate the child’s development so that they can “catch up” to their typical peers by Kindergarten. Therefore, we are actually concentrating on reducing disparities between children with developmental delays and their typically developing peers.

The focus of services is in teaching the family and caregiver(s) ways to facilitate the child’s development during naturally-occurring routines and activities. Birth to Three uses a coaching process to help the caregiver feel more confident and competent in assisting the child’s development. Since each child’s Individualized Family Service Plan is individualized for that child and that family, and since the focus of the plan is on the family’s priorities for their child and themselves, the family’s ethnicity and income level will be addressed because it affects that family’s priorities and need for services.

As services begin, children are assessed using any one of three curriculum-based assessments. This allows the Birth to Three provider to summarize the child’s development at entry which is

then compared to the development at exit to track developmental progress. Use of this type of assessment also helps the family track their child's development.

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**Program Name:** Family Supports

**Program Description:** The Department of Mental Retardation (DMR) provides Family Supports which assist families to care for their children who have mental retardation. Most families who have children with mental retardation need extra support to help them to care for their children at home. Family supports include goods, services, resources, and other forms of assistance that help families to successfully parent their children who have mental retardation. Family Supports help families to stay together and to maintain their children in the family home. When children grow up in a nurturing family home, they are more likely to live healthy, safe and productive lives.

**The department provides two primary Family Support programs, Individual and Family Grants and Respite at DMR Respite Centers.**

#### **Individual and Family Grants**

Individual and Family Grants are cash subsidies provided for the purpose of assisting individuals and families to defray extraordinary disability-related expenses. The provision of Individual and Family Grants acknowledges the extra effort and commitment of families who have children with disabilities that have an extraordinary financial impact on the family. The provision of Individual and Family Grants assists families to purchase items and services that are not otherwise reimbursable through insurance or available from other sources. The cash subsidies may be used to purchase supports that include, but are not limited to, in-home supports, behavioral supports, nursing, medical or clinical supports, temporary assistance, crisis support, skill training, family training, leisure services, transportation, support coordination, respite and assistance to access community supports. The maximum grant amount is \$5,000 per individual or family per fiscal year. For families who have children with mental retardation, Individual and Family Grants support the child to remain in the family home and help to prevent out of home placement. A total of 3,463 families received Individual and Family Grants in FY 2006. This number includes 1,587 families of children under age 18.

#### **Respite Services**

Respite is the temporary care of a person with mental retardation for the purpose of offering relief to the family. It is a service that allows the family to have time to reenergize, deal with emergency situations, or engage in personal, social, or routine activities and tasks that otherwise may be neglected, postponed, or curtailed due to the demands of caring for a child who has mental retardation. The goal of respite services is to support the continued presence and participation of individuals who have mental retardation within the family homes and to prevent out of home placement.

The Department of Mental Retardation provides respite through ten regional Respite Centers. DMR Respite Centers are specifically designed to provide planned and scheduled relief to families. The three DMR regions provide overnight respite throughout the year from Thursdays through Tuesdays and are open twenty-four hours a day, seven days a week for up to eight weeks

during the year, including summer months or school vacations. Respite Centers are operated by DMR staff who have skills needed to work with children and adults who have mental retardation and their families.

In total, DMR Respite Centers served 1,133 persons who have mental retardation in FY 2006, including both children and adults. There were a total of 484 children served in DMR Respite Centers in FY 2006.

**Number of children and families served:** 1,617 served in fiscal year 2006.  
(Most children who received Respite Services also received Individual and Family Grants)

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**Long-Term Agency Goals:** The Department of Mental Retardation serves over 15,000 individuals who have mental retardation including 3,055 children under the age of 18. This number does not include children who do not have mental retardation and are served in the Birth to Three System. While most children live with their families, about 252 or eight percent of children served by DMR live in other residential settings. The department's long term prevention goal is to support families to care for their children in the family home and to prevent out of home placement.

**Strategies:** Most families who have children with mental retardation need extra support to help them to care for their children at home. DMR provides Family Support to assist families to care for their children at home. Family Supports include goods, services, resources, and other forms of assistance that help families to successfully parent their children who have mental retardation. The Department of Mental Retardation plans to continue to provide Family Supports, including Individual and Family Grants and Respite. Within available resources, the department will expand the number of families served with Family Supports.

In addition to the Family Support services offered by the department, DMR continues to pursue the development and implementation of Home and Community Based Services Waivers which offer services in the community as an alternative to institutional care. The department continues to expand the range and amount of services available under the waivers that assist families to care for their children within the family home. These services include personal services, respite, home and vehicle modifications, family training and consultative services.

In FY 2006, the department established a position of Lifespan Coordinator within the Central Office to coordinate children's services, as well as services to elderly individuals who are served by DMR. The initial focus of this position is on children's service, including expanding the availability and ensuring the quality of supports provided to children and their families.

**Outcomes:** Specific outcomes to measure the success or effectiveness of the Family Supports provided by DMR include the number and percentage of children who live in family homes rather than in out of home placements.

**Measure of Effectiveness:** The percentage of children served by DMR who lived in their family homes has remained consistent over the last six years. The percentage of out of home placements has not increased since October 2000 and has remained at eight percent.

**Methods:** DMR Family Support services are available to children and their families regardless of race, income level or gender, however families with significant income levels may be liable for a portion of the cost of the respite stay.

**Other:** The Department of Mental Retardation's vision and guiding principles for children with mental retardation are as follows:

**Vision:** All children with mental retardation grow up with the love and nurturing of their families. Families identify and receive the individually designed supports they need to raise their children in their local communities. Communities embrace children with mental retardation and their families and include them in all aspects of community life.

**Guiding Principles:** The following guiding principles were identified by focus team members as critical ingredients in providing supports to children and their families.

- **Children Grow Best in Families**

A "whatever it takes" approach should be adopted to keep children with their families. Families should receive the support they need to raise their children at home. When a family is not able to provide full time care for their child, arrangements should be made to share the care of their child with others who will provide a nurturing family home. When a child is unable to live with his or her family, even part-time, a permanent home should be provided for the child that balances the family's wishes with the best interests of the child. It is essential that children maintain strong relationships with their families. Families' bonds with their children should be maintained whenever possible.

- **Families Know their Children Best**

Families have primary responsibility for the well being of their children. Families should have information about available options, services, and resources that will enhance their abilities to make informed choices. Support staff should listen to families and respect their decisions.

- **Supports Are Responsive to the Needs of the Entire Family**

Families are the constant in their children's lives. Children should be supported in the context of their families with services that are tailored to the unique family circumstance.

- **Supports Are Family-Directed**

Families should drive the planning process and have a strong voice in designing, selecting, and evaluating the supports and services they and their children receive. Families should have the tools and resources they need to be successful in directing their supports.

- **Supports Are Delivered in a Culturally Competent Manner**

The culture of the family influences the choices they make and will accept. Supports should be delivered in the family's language and in ways that are consistent with a family's cultural

preferences. Supports should be provided by a culturally competent workforce that understands the diverse needs of families.

- **Services and Supports Are Individualized, Flexible, Far-reaching, and Responsive to Changing Needs**

No two families are alike in their strengths, challenges, or aspirations. Families should have access to a full range of options including in-home and community supports that are uniquely tailored to their needs. Supports should be easily accessible and sufficiently available to make a difference. Supports should be available before a crisis arises, but if an emergency does arise, families want some sense of security that help will be there when they need it. Supports should be flexible to meet the changing needs of families in a timely way.

- **Families and Children Receive Supports and Services in Their Community of Choice**

Families want their children to be welcome participants in their own communities. They want their children to be able to access the same formal and informal supports available to children who do not have disabilities. Assistance should be available to help families to use and strengthen their natural supports, connect with their communities, and develop new resources. Families should be assisted to reach out to other families for networking, and to work on community building and workforce development issues. Supports should promote the integration and inclusion of children with mental retardation in the daily life of the community.

- **Supports Are Designed to Maximize Families' Competencies**

Families should be supported to make decisions about needed supports and services and to direct the provision of those services. Professionals and others should promote the competencies of families and provide any tools necessary to assist families including leadership, networking, and advocacy skill development that will prepare families to advocate for new or enhanced supports.

## Department of Public Health

**Program Name:** Captain 5 A Day Nutrition Education Program

**Program Description:** This program targets parents, pre-school children, and teachers in Head Start and School Readiness (SR) programs. Workshops are provided to teachers to enable teachers to integrate nutrition education into their lesson plans and curriculum. Workshops are provided to parents to assist parents' success in feeding healthy food to their children. Developmentally appropriate activities and strategies are used to maximize the program's impact on children

**Number of children and families served:** 3,800 preschool and 7,000 high school children and their caregivers in fiscal year 2005.

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**Program Name:** Immunization Program

**Program Description:** The State of Connecticut Immunization Program's mission is to prevent disease, disability and death from vaccine preventable diseases in infants, children, adolescents, and adults through surveillance, case investigation and outbreak control, vaccination, monitoring of immunization levels, provision of vaccine, and professional and public education.

- **Number of children and families served:** According to the latest National Immunization Survey (fiscal year 2005) 84.8 % of the states' two year olds were up to date on their immunizations comprised of a series of 4 doses of DTP, 3 doses of Polio, 1 dose of MMR, 3 doses of HiB, 3 doses of Hepatitis B, and 1 dose of varicella vaccines (4:3:1:3:3:1). This rate is the highest in the country. Connecticut's childhood immunization has remained among the top five nationally since the 1990's, was ranked third in 2005, and has a projected rate of 92.8 for 2006
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**Long Term Agency Goals:** The Department of Public Health (DPH) works proactively to protect the health and safety of the people of Connecticut and to prevent disease and promote wellness through education and programs such as prenatal care, newborn screenings, immunizations, nutrition and supplemental foods, AIDS and sexually transmitted disease awareness. Reducing health disparities in maternal and child health remains one of the agency's highest priorities. DPH selected its prevention programs for inclusion in this report based on a focus on children birth to age eighteen. These initiatives also impact the families of these children, either directly or indirectly. The selected programs are preventive in nature, provide education and information to families that promote healthy behaviors, attempt to reduce crime and violence, promote academic success, and discourage socially destructive behaviors.

**Strategies:**

- Implement disease prevention and health promotion of women, infants and children including children with special health care needs

- Identify and nurture community-based health and prevention initiatives through public and private partnerships
- Provide funding to community-based providers to implement prevention programs at the local level, including school-based and community health centers
- Through Community-Based Health Centers, assure the availability and accessibility of comprehensive primary and preventative health care and other essential public health services for low-income uninsured and vulnerable children and families in underserved areas
- Conduct surveillance activities to continuously monitor the effectiveness of the agency's prevention initiatives
- Collaborate with other state agencies to cut across agency boundaries and combine programmatic and funding efforts to improve outcomes
- Establish and coordinate the DPH's Virtual Children's Health Bureau to capture the overarching programs and initiatives throughout the agency
- Provide community-based abstinence-only education to 9-14 year old youths, including parental/guardian involvement whenever possible
- Promote the use of asthma management plans by health care providers and parents of asthmatic children, address the early identification of children with asthma and work to develop a state asthma plan and enhance asthma surveillance activities
- Provide nutrition education to parents, pre-school children, and teachers in Head Start and School Readiness programs, and provide workshops to enable teachers to integrate nutrition education into their lesson plans and curriculum, and to educate parents on feeding healthy food to their children
- License and regulate child day care facilities and offer resources and technical assistance to providers
- Improve the quality of care children receive in licensed child day care programs by revising Connecticut's licensing standards to be more in line with national standards and provide technical assistance to licensed programs
- Work with organizations such as the Child Day Care Council and the CT After School Network to develop draft regulations, staff training, and assure inspection goals are met in accordance with state statutes
- Ensure that state-of-the-art emergency medical care is available for all ill or injured children or adolescents, and that pediatric services are well integrated into an emergency medical service system
- Prevent disease, disability and death from vaccine preventable diseases in infants, children and adolescents through surveillance, case investigation and outbreak control, vaccination, monitoring of immunization levels, provision of vaccine, and professional and public education
- Conduct comprehensive lead poisoning prevention programs to reduce the risk of lead exposure
- Screen all newborns for genetic and hearing disorders prior to hospital discharge or within seven days of birth to help prevent severe health and developmental consequences
- Through Oral Health initiatives, increase entry into long-term comprehensive dental services for Medicaid, SCHIP, and other underserved children and develop a best practice model for sealant programs



- Make available to sexual assault victims and their families free and confidential services such as crisis intervention, support and advocacy, survivor groups, 24-hour hotline, and emergency transportation
- Through collaborative effort between Injury Prevention Program and CT Safe Kids, provide child passenger safety workshops to health care and childcare professionals to increase provider capacity as effective educators on child passenger safety
- Provide a variety of services to adolescents to reduce the transmission and incidence of selected sexually transmitted diseases
- Address all risks associated with the use of tobacco products focusing on youth, pregnant women, disparate populations and environmental tobacco smoke
- Provide nutrition education and supplemental food to eligible women, infants, and children through the WIC and Nutrition Programs
- Provide professional education, technical assistance and program development targeted toward youth violence prevention

The role of DPH is to address prioritized needs and gaps in services for the target populations. Services provided by community-based programs include case management, outreach, disease prevention, education, and the empowering of MCH populations about health and health-related issues. The combination of ongoing assessments, quarterly reporting data, technical assistance meetings and site visits assist DPH in determining priorities.

#### **Outcomes:**

- 1.8 million newborns have been screened prior to hospital discharge and 941 identified with genetic disorders to allow treatment to be promptly initiated to avert complications and prevent irreversible problems
- Inception of newborn hearing screenings at birth in 2000 has identified 360 babies with hearing loss, with the average age of diagnosis dropping from 2 ½ years to 2 months, and in 2005, Connecticut conducted hearing screenings on 99% of newborns
- Coordinated prevention and intervention efforts with parents and health professionals as partners lead to improved health and school readiness
- Revision of child day care regulations with improved health and safety standards, staff training opportunities, number of technical assistance opportunities conducted, and the number of inspections and investigations completed
- Every child, their parents, and all pregnant women in Connecticut will have access to comprehensive, preventive, continuous health care
- All children will have access to affordable, healthy, safe, and developmentally-appropriate early care and education with comprehensive support services that facilitate effective transitions from birth to Kindergarten
- All families will have access to the information and resources they need to raise healthy children, and parents will be involved as partners in the planning of early childhood services
- Effective local or regional early childhood collaborative structures will ensure the provision of integrated services

- A state level infrastructure with community representation will guide, support, and monitor implementation of a comprehensive, integrated system of services for children and families
- Data integration among agency programs will allow for seamless retrieval of information

**Measure of Effectiveness:** Infant Mortality – programming within DPH to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods.

- From 1981 to 2003, Connecticut’s infant death rate fell from 12.0 to 5.3 deaths per 1,000 live births

Births to Teens – State programs serve pregnant and parenting teens and provide intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding.

- In Connecticut from 1993-2003, the birth rate for teens dropped from 38.8 to 25.8 infants born per 1,000 female teens

Prenatal Care – DPH strives to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics.

- In Connecticut in 2004, 87.5% of infants were born to women who began receiving prenatal care in the first trimester

Title V programs Comadrona, Healthy Start, Healthy Choices for Women and Children, Fetal Infant Mortality Review and Right From the Start provided outreach to and identification of pregnant women to promote early entry into prenatal care

Breastfeeding – DPH promotes breastfeeding as a social norm in the state due to the positive maternal and infant health effects

- The estimated rate for breastfeeding in Connecticut has improved from 68.7% to 69.3%

**Methods to Reduce Health Disparities:** Reducing disparities in maternal and child health indicators remains one of the major challenges facing the public health community, and DPH utilizes multi-level strategies that include:

- Addressing health disparities by targeting low-income families and encouraging them to participate in screenings, prevention activities such as immunizations and oral health, and HUSKY
- Improving the number and capacity of providers in underserved communities by functioning as liaison in the recruitment and retention of primary health care professionals through a collaboration with the DPH Primary Care Office and the Connecticut Primary Care Association

- Increasing the knowledge base on causes and intervention to reduce disparities by analyzing data on health care practices and use across racial and ethnic groups
- Utilizing the DPH Office of Multicultural Health to raise public and provider awareness of racial/ethnic disparities in health care
- As resources permit, consider addressing the recommendations of the Connecticut Health Foundation's Policy Panel on Racial and Ethnic Disparities which include:
  - Collect and integrate racial and ethnic data to its statewide planning efforts and publish a report on the key findings
  - The Office of Health Care Access and DPH should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve
  - Establish a certification program for all medical interpreters to ensure cultural competence and quality service
  - Establish a system for monitoring and enforcing PA 00-119 regarding linguistic access in acute care hospitals

## Department of Social Services

**Program Name:** Fatherhood Initiative

**Program Description:** The purpose of the Fatherhood Initiative Program is to promote and facilitate positive interaction between fathers and their children thereby increasing the parent child bond that contributes to optimal growth and development for children. The Initiative also facilitates and supports social and emotional connections between fathers and their children, which has been shown to increase financial support for children of non-custodial, separated, and divorced fathers.

This Initiative is operationalized through contracts with five geographically dispersed agencies. Intervention strategies and tactics used by Fatherhood Initiative providers aim to prevent child poverty, child abuse and neglect, absentee fathers, intergenerational poverty, and youth violence among children of program participants. The agencies provide a range of services including preparation for employment, job search, life skills training, case management, parenting skills and education for parenting. Program participants are multi-ethnic, multicultural, working income, no income, and marginal income men, many of whom have had some involvement with the criminal justice system, DCF, and DSS.

In October 2006, the Fatherhood Initiative was awarded a competitive grant of one million dollars per year, for five years, by the Department of Health and Human Services, Administration on Children and Families, Office of Family Assistance.

The program receives oversight from a multi-agency, multi-disciplinary steering committee.

**Number of children and families served:** Approximately 400 fathers will be served annually.

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### Specific long term goals for the Department are:

- To provide structured ongoing programs and activities that support the development and retention of parenting (fathering) skills among non-custodial, divorced, and fathers with shared custody;
- To reduce the level of poverty among children living in households in which the father is absent;
- To support and facilitate healthy child development by providing programs and services for Fatherhood Initiative program participants that contribute to healthy father-child relationships;
- To promote and support co-parenting, regardless of marital status;
- To foster and facilitate, through various community based programs and services, economic self-sufficiency for Fatherhood program participants and their children;
- To provide programs and services that increase the vocational skills and employability of program participants; and
- To provide community based programs and services that sustain co-parenting and successful father-child relationships.

**Specific intended outcomes of DSS' prevention efforts include but are not limited to:**

- Among Fatherhood program participants, a decrease in the number of unemployed and underemployed program participants;
- Increase in the number of children who have healthy relationships with their fathers;
- Increase in the number of gainfully employed non-custodial fathers who contribute to the financial support of their children;
- Decrease in the number of single female headed households who are totally dependent on entitlements;
- Among non-custodial fathers and single mothers, increased awareness of the pivotal role that men play in normal healthy child development and positive psycho-social/educational outcomes for children;
- Increase in voluntary child support payments; and
- Increase in the number and rate of voluntary paternity acknowledgement by unmarried fathers

**Strategies:** Strategies developed to achieve the goals and intended outcomes are:

Contract with five geographically dispersed agencies with expertise and knowledge about fatherhood, non-custodial parenting, co-parenting, cultural and ethnic factors in parenting, and proven ability to work with low/no income men;

- In collaboration and partnership with contracted agencies, identify best practices for developing, supporting, and/or improving father-child relationships and parent to parent relationships;
- Provide non-custodial fathers and other Fatherhood program participants with life skills training;
- Provide non-custodial fathers and other Fatherhood program participants with employment training and job placement;
- In partnership with contracted agencies, support and facilitate job development and job retention among Fatherhood program participants;
- Develop and provide knowledge and skill driven father-child activities that foster and support healthy father-child relationships;
- Educate fathers and mothers about the importance of male parent involvement in the lives of children; and
- Develop strategies and practices that, whenever possible, connect unmarried fathers to the gestation/birth process, parenting roles and responsibilities prior to the birth of the child.

**Outcomes:** Specific outcomes that may be used to measure the success or strategic effectiveness of the Fatherhood Initiative may consist of:

- Longitudinal comparison of changes in parent-child relationships, rate and extent of co-parenting (regardless of marital status), and rate of job retention among Fatherhood program participants from ethnic/cultural minority communities;
- Increase in the actual number of early pre-post birth paternity acknowledgements; and

- Positive changes in the rate of voluntary child support payments.

**Measure of Effectiveness:**

- Rate and extent of voluntary and involuntary child support payments among program participants;
- Consistent ongoing employment;
- Reduction in the rate of unemployment and underemployment among program participants;
- Reported rate of co-parenting among program participants;
- Rate of voluntary paternity establishment and acknowledgement among unmarried fathers;
- Actual rate of pre-post birth involvement of unmarried fathers;
- Changes in pay rates/income among program participants; and
- Number of households evidencing an increase in income, resulting in a reduction in child poverty, as a result of the receipt of financial support from non-custodial, divorced, separated, and/or co-parenting fathers.
- Other measures of effectiveness will result from the completion of the grant related evaluation, currently under development.

**Methods:** In progress, however, greater emphasis is being placed on addressing the impact of ethnicity, income, and gender on performance outcomes.

**Program Name:** Family Supportive Housing

**Program Description:** The DSS Family Supportive Housing Program is composed of two separate components. The overall purpose of the program is to prevent future homelessness among families and to secure and maintain family stability. The newest initiative or component is the Family Supportive Housing Program. It is designed to create permanent and affordable housing opportunities for adults and families who are homeless or at risk of becoming homeless, especially those families evidencing a history of consistent and persistent homelessness due to mental illness, substance abuse, and/or family violence. In order to address some of these systemic, personal, and interpersonal causes of homelessness, this initiative offers supportive services to program participants. DSS provides housing subsidies from its Section 8 or State Rental Assistance (RAP) program for the housing component and funds the supportive services component through an appropriation.

The second initiative is a joint collaboration between DSS and the Department of Children and Families (DCF). The Department provides Section 8 and RAP housing subsidies to DCF families who are participants in the Recovering Families Program. This DCF program supports the reunification and maintenance of stability within these families. DCF provides program oversight and the funding for the contracted supportive services.

**Number of children and families served:** The Family Supportive Housing Initiative aims to have 500 supportive housing units in use within the next five years. The 500 units will include 25 units of supportive housing for families during the current biennial budget period and a proposed increase to 75 family units during the next biennial budget. The department has provided Section 8 and State RAP housing subsidies for over 400 DCF families; the budget provides another 100 subsidies this fiscal year.

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**Specific long-term goals for the Department are:**

- To provide structurally sound, habitable, safe, affordable apartments combined with health care, social service support, and employment services;
- To develop strategies and tactics that support the reintegration of families with chronic health challenges into the community by addressing their basic needs for housing and ongoing support;
- To prevent or reduce the rate of homelessness among families with children; and
- To support and facilitate family stability and reunification in order to increase self-reliance and self-sufficiency among at-risk families and their children.

**Outcomes:** Specific intended outcomes of DSS' prevention efforts include but are not limited to:

- Decrease in the number of families who are homeless or housed in shelters
- Reduction in number of emergency room visits and hospital inpatient stays.
- Increase in the number of families who become self-reliant and less dependant on public entitlements.
- Reduction in the rate and incidence of relapse within those families with substance abuse issues.

- Increase in the number of employed heads of households currently receiving support from DSS.
- Improve the health, employability, earning capacity, self-sufficiency, and other social-economic outcomes for families experiencing homelessness.
- Improve developmental and educational outcomes for the children of such families through connections to early childhood education and child care programs as well as more stable involvement in K-12 educational programs.

**Strategies:** Strategies developed to achieve the goals and intended outcomes are:

- In collaboration with shelter providers and community based social service agencies, identify families who are consistently and persistently homeless.
- Develop guidelines for programs and services.
- Create an RFP, review proposals and select service providers for the supportive services component.
- Develop and maintain a multi-media outreach campaign designed to educate the community.
- Identify opportunities and create services, including day care/early care, that can be delivered on site or in close proximity to the housing units.
- Encourage sponsors of family projects to establish relationships early on in the project planning with child care and early childhood education providers within the community to secure designated “slots” for children from the supportive housing project.

**Measure of Effectiveness:**

- Housing occupancy – rate and duration.
- Number of episodes or incidence of repeat homelessness among program participants;
- The degree or extent to which the person’s mental health status remains stable as evidenced by cooperating with treatment plans, in-patient care, number of emergency room visits, observation of social service staff, etc.
- The degree or extent to which the person remains drug/substance free as evidenced by self-report, hospitalization, observable signs of substance use.
- Consistent ongoing employment
- Changes in Income and changes in job or work status. Average monthly income; receipt of SSI/SSDI or other public benefits;
- Severity of existing chronic health conditions (pre and post housing occupancy service receipt), evidence of well child care, preventive health care visits, hospitalizations (pre-post assessment)
- Incidence or rate of involvement with the criminal justice system including arrests, number of days incarcerated, etc.
- Evidence of connections/networking within the community
- Client-participant feedback via an objective data collection instrument.
- Using the individualized care or service plan, measurable improvements based on the client contract for needed services.



- Reported changes in parent-child or family relationships.

The current data collection system used by DSS and its partner agencies indicates that primary prevention programs are meeting stated goals and objectives.

**Methods:** In progress, however, greater emphasis is being placed on addressing the impact of ethnicity, income, and gender on performance outcomes.

## Office of Policy and Management

**Program Name:** Neighborhood Youth Center

**Program Description:** The Neighborhood Youth Center Program is designed to increase the range and extent of positive experiences for at-risk urban youth ages twelve through seventeen years. Research findings on delinquency and substance use prevention consistently show that positive youth development approaches work best to prevent these undesirable behaviors in youth. Currently, 12 centers in six cities (Bridgeport, Hartford, New Britain, New Haven, Norwalk and Waterbury) are supported by the Neighborhood Youth Center Program with federal dollars from the U.S. Department of Education.

**Number of children and families served:** An average of 644 youth each day of operations during January – March 2006.

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**Long-Term Agency Goals:** Promote positive youth development and thereby reduce crime, delinquency and urban violence.

**Strategies:** The Neighborhood Youth Center Program supports specific local initiatives to increase positive experiences for youth ages 12 through 18 years. Neighborhood Youth Centers **must** include the following seven components.

1. Neighborhood Center Setting  
(safe, appropriate, accepting, accessible and open regular hours)
2. Neighborhood Center Staff  
(qualified, supervised and supported)
3. Neighborhood Youth Center Program  
(appropriate to the age, maturation level, gender, culture, and community needs of its youth clients)
4. Parent Involvement  
(in planning the program initially and on an on-going basis)
5. Youth Involvement  
(many viable opportunities for youth input into the planning and management of the center)
6. Applicant Agency  
(knowledgeable about and actively involved in the neighborhood)
7. Evaluation  
(participation in evaluation efforts)

**Outcomes:** Outcomes that the Office of Policy and Management uses to measure the success of the Neighborhood Youth Center Program include youth's **Satisfaction with the Center, Achievement Motivation, Attitudes Toward School, Peer Self Efficacy and Level of Substance Use.** In addition, process improvement data; such as **Attendance, Demographic Information** and youth's **Perceptions of Supports and Opportunities** within the programs at the centers; is collected. Summaries of these data are shared with the directors of the centers

who can then work on program improvement plans with technical assistance provided by youth development experts.

**Measure of Effectiveness:** The findings from the outcome evaluations suggest that involvement with the Neighborhood Youth Center Program has a positive influence on youth's attitudes towards school. It also appears that the staff and directors of the Neighborhood Youth Centers derived information of value from their participation in the process evaluation. The collection and interpretation of youth perception data and the development of implementation plans with expert consultation resulted in tangible and positive changes in youth's experiences of the programs. See the full evaluation reports at <http://www.opm.state.ct.us/pd1/grants/NYC.HTM>.

**Methods:** Neighborhood Youth Center Programs are required to provide programs that are appropriate to the populations they serve.

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**Program Name:** Norwich Pilot Reintegration Education Program (PREP)

**Program Description:** PREP is designed to successfully reintegrate juvenile offenders back into school following their release from adult and juvenile detention, the Connecticut Juvenile Training School, Department of Children and Families' residential placements, and the Department of Correction.

PREP had three primary objectives: (1) to promote information sharing among various public and private agencies involved in the lives of youth; (2) to create a single point of contact within the Norwich Public Schools for youth leaving detention or placement; and, (3) to implement short-term academic programs to increase the likelihood that youth will complete their education.

**Number of children and families served:** a total of 21 students were referred to the Program for the period of October 2004-December 2005 (the initial goal was to serve 10 students per year).

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**Long-Term Agency Goals:** Successfully reintegrate juvenile offenders back into school following their release from adult and juvenile detention, the Connecticut Juvenile Training School, Department of Children and Families' residential placements, and the Department of Correction

**Strategies:** Establishing a single point of contact and providing short-term alternative education services.

**Measure of Effectiveness:** Central Connecticut State University (CCSU) conducted an evaluation of PREP; the evaluation focused on ‘process measures’ to determine how closely the Norwich PREP followed the program model and to what success it had in achieving its stated goals and objectives. The CCSU findings were that:

- The Norwich PREP successfully achieved both of its primary goals (to provide a single point of contact and to provide short and long term academic support services for students).
- A re-entry center was established at Norwich High School with a PREP coordinator.
- The PREP coordinator became a valuable resource for the entire school; she helped refer PREP and non PREP students to outside agencies for additional services.

Overall, the Norwich PREP is following the PREP model and has achieved the goals that were stated in the school district’s grant proposal. The study was not able to conclude whether this program has produced long term successes, however, the evaluators were confident that this program will be successful if it maintains its current level of implementation.

**Appendix A**  
**Child Poverty and Prevention Council**  
**State Agency Subcommittee Membership**

Marybeth Bondaies  
Office of Health Care Access

Mary Marcial  
Department of Correction

Lisa Davis  
Department of Public Health

John McCarthy  
Department of Labor

Patricia Downs  
Department of Economic Community  
Development

Karen Ohrenberger  
Department of Mental Health and Addiction  
Services

Anne Foley  
Office of Policy and Management

Julia O'Leary  
Court Support Services Division

Karen Foley-Schain  
Children's Trust Fund

Christine Pollio  
Department of Mental Retardation

Sylvia Gafford-Alexander  
Department of Social Services

Charlene Russell-Tucker  
Department of Education

David Guttchen  
Office of Policy and Management

Dennis King  
Department of Transportation

Deanna Lia  
Department of Children and Families

John Swift  
Office of Workforce Competitiveness

Valerie Lewis  
Department of Higher Education

Pamela Trotman  
Office of Policy and Management

## Appendix B



### **Substitute House Bill No. 5254**

### **Public Act No. 06-179**

#### **AN ACT CONCERNING STATE INVESTMENT IN PREVENTION AND CHILD POVERTY REDUCTION AND THE MERGER OF THE STATE PREVENTION AND CHILD POVERTY COUNCILS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 4-67v of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

For the biennial budget for the fiscal years commencing July 1, [2003, and ending June 30, 2005] 2007, and July 1, 2008, the Governor's budget document shall, within available appropriations, include a prevention report [presenting] that corresponds with the prevention goals established in section 4-67x, as amended by this act. The prevention report shall:

(1) Present in detail for each fiscal year of [such] the biennium the Governor's recommendation for appropriations for prevention services classified by those budgeted agencies [*involved in the State Prevention Council and showing,*] that provide prevention services to children, youth and families;

(2) Indicate the state's progress toward meeting the goal that, by the year 2020, at least ten per cent of total recommended appropriations for each such budgeted agency be allocated for prevention services; and

(3) Include, for each applicable budgeted agency and [*its subdivisions,*] any division, bureau or other unit of the agency, (A) a list of agency programs that provide prevention services, (B) the actual prevention services expenditures for the fiscal year

[ending June 30, 2003] preceding the biennium, by program, (C) the estimated prevention services expenditures for the first fiscal year [commencing July 1, 2003, and of the biennium, (D) an identification of research-based prevention services programs, [The Governor's budget shall also include] and (E) a summary of all prevention services by each applicable budgeted agency [,] identifying the total for prevention services included in the budget.

Sec. 2. Section 4-67s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

As used in sections 4-67s to [4-67v] 4-67x, inclusive, as amended by this act:

(1) "Prevention" means policies and programs that promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.

(2) "Research-based prevention" means those prevention programs as defined in this section that have been rigorously evaluated and are found to be effective or represent best practices.

Sec. 3. Section 4-67x of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) (1) There shall be a Child Poverty and Prevention Council consisting of the following members or their designees: The Secretary of the Office of Policy and Management, the president pro tempore of the Senate, the speaker of the House of Representatives, the minority leader of the Senate and the minority leader of the House of Representatives, the Commissioners of Children and Families, Social Services, Correction, Mental Retardation, Mental Health and Addiction Services, Transportation, Public Health, Education, Economic and Community Development and Health Care Access, the Labor Commissioner, the Chief Court Administrator, the Chairman of the Board of Governors for Higher Education, the Child Advocate, [the chairperson of the State Prevention Council,] the chairperson of the Children's Trust Fund and the executive directors of the Commission on Children and the Commission on Human Rights and Opportunities. The Secretary of the Office of Policy and Management, or the secretary's designee, shall be the chairperson of the council. The council shall (1) develop and promote the implementation of a ten-year plan, to begin June 8, 2004, to reduce the number of children living in poverty in the state by fifty per cent, and (2) within available appropriations, establish prevention goals and recommendations and measure prevention service outcomes in accordance with this section in order to promote the health and well-being of children and families.

(b) The [ten-year](#) plan shall contain: (1) An identification and analysis of the occurrence of child poverty in the state, (2) an analysis of the long-term effects of child poverty on children, their families and their communities, (3) an analysis of costs of child poverty to municipalities and the state, (4) an inventory of state-wide public and private programs that address child poverty, (5) the percentage of the target population served by such programs and the current state funding levels, if any, for such programs, (6) an identification and analysis of any deficiencies or inefficiencies of such programs, and (7) procedures and priorities for implementing strategies to achieve a fifty per cent reduction in child poverty in the state by June 30, 2014. Such procedures and priorities shall include, but not be limited to, (A) vocational training and placement to promote career progression for parents of children living in poverty, (B) educational opportunities, including higher education opportunities, and advancement for such parents and children, including, but not limited to, preliteracy, literacy and family literacy programs, (C) housing for such parents and children, (D) day care and after-school programs and mentoring programs for such children and for single parents, (E) health care access for such parents and children, including access to mental health services and family planning, (F) treatment programs and services, including substance abuse programs and services, for such parents and children, and (G) accessible childhood nutrition programs.

(c) In developing the [ten-year](#) plan, the council shall consult with experts and providers of services to children living in poverty and parents of such children. The council shall hold at least one public hearing on the plan. After the public hearing, the council may make any modifications that the members deem necessary based on testimony given at the public hearing.

(d) Funds from private and public sources may be accepted and utilized by the council to develop and implement the plan and the provisions of this section.

(e) Not later than January 1, 2005, the council shall submit the plan, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children, along with any recommendations for legislation and funding necessary to implement the plan.

(f) [\(1\)](#) On or before January 1, 2006, and annually thereafter, until January 1, 2015, the council shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services and to the select committee of the General Assembly having cognizance of matters relating to children on the implementation of the plan, progress made toward meeting the child poverty reduction goal specified in subsection (a) of this section and the extent to which state actions are in conformity with the plan. The council shall meet



at least two times annually [to review and coordinate state agency efforts to meet the child poverty reduction goal specified in subsection (a) of this section] for the purposes set forth in this section.

(2) On or before January 1, 2007, the council shall, within available appropriations, report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, education, human services and public health and to the select committee of the General Assembly having cognizance of matters relating to children, on the state's progress in prioritizing expenditures in budgeted state agencies with membership on the council in order to fund prevention services. The report shall include (A) a summary of measurable gains made toward the child poverty and prevention goals established in this section; (B) a copy of each such agency's report on prevention services submitted to the council pursuant to this subsection (g) of this section; (C) examples of successful interagency collaborations to meet the child poverty and prevention goals established in this section; and (D) recommendations for prevention investment and budget priorities. In developing such recommendations, the council shall consult with experts and providers of services to children and families.

(g) (1) On or before November 1, 2006, and on or before November 1, 2007, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection.

(2) Each agency report shall include at least two prevention services for the report due on or before November 1, 2006, and the report due on or before November 1, 2007, not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for the report due on or before November 1, 2007, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

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

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

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

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

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

**[(g)] (h)** Not later than July 1, 2006, the Office of Policy and Management shall, within available appropriations, develop a protocol requiring state contracts for programs aimed at reducing poverty for children and families to include performance-based standards and outcome measures related to the child poverty reduction goal specified in subsection (a) of this section. Not later than July 1, 2007, the Office of Policy and Management shall, within available appropriations, require such state contracts to include such performance-based standards and outcomes. The Secretary of the Office of Policy and Management may consult with the Commission on Children to identify academic, private and other available funding sources and may accept and utilize funds from private and public sources to implement the provisions of this section.

**[(h)] (i)** For purposes of this section, the Secretary of the Office of Policy and Management, or the secretary's designee, shall be responsible for coordinating all necessary activities, including, but not limited to, scheduling and presiding over meetings and public hearings.

**[(i)] (j)** The council shall terminate on June 30, 2015.

Sec. 4. Section 17b-16 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

The Labor Department, in cooperation with the Department of Social Services, shall provide information and assistance in obtaining, within available appropriations, the federal earned income credit established pursuant to 26 USC 32, to each applicant for or recipient of assistance from the department. The Labor Department, in cooperation with the Department of Revenue Services, shall promote the earned income credit program to recipients of benefits pursuant to section 17b-112. The Department of Social Services, in consultation with the Child Poverty and Prevention Council established in section 4-

[67x, as amended by this act](#), shall, within available appropriations, promote greater utilization of the federal earned income credit to municipalities, public and private employers, community-based organizations and other entities that have frequent contact with low-income families and shall enhance financial literacy and self-sufficiency programs. School and business partnership funds, private funds and other available funds may be used for purposes of this section.

Sec. 5. Sections 4-67t, 4-67u and 4-67w of the general statutes are repealed. (*Effective October 1, 2006*)

Approved June 9, 2006