2022

Connecticut Family First Prevention Plan

STATE OF CONNECTICUT

DEPARTMENT OF CHILDREN AND FAMILIES

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Section 1: Introduction

The State of Connecticut's child welfare system values families and believes children are best served safely in their own homes. A strength of the system is a fundamental belief that the well-being of children and families is a shared responsibility with all members of the community. When a need is identified, families predominately require local "support" versus government "surveillance."

Connecticut practices within an integrated child welfare structure; one which collaborates, sets priorities, and supports families remaining together. CTDCF, sister state agencies, community-based organizations, early childhood, K-12 education, healthcare, law enforcement, judicial/courts, housing, behavioral health, labor and social service systems are all on the same team, working together to achieve optimal outcomes for children, youth, families and communities.

Connecticut has embraced the values and principles of the Family First Prevention Services Act[1] (Family First). Family First represents a shift in federal policy as it extends the use of Title IV-E funds beyond foster care and adoption assistance to prevention services intended to stabilize families and keep them together. Specific prevention services that are newly eligible for federal reimbursement include evidence-based mental health treatment programs, substance abuse prevention and treatment programs, and in-home parenting skill-based programs rated on the Title IV-E Prevention Services Clearinghouse.

Family First is being utilized as a tool, as part of Connecticut's overall prevention strategy, to assist in building upon an existing infrastructure, and its already diverse array of services and evidence-based programs (EBPs), with the goal to prevent maltreatment and children entering foster care. Connecticut's vision is to expand upon its collaborative child well-being system through enhanced focus on prevention and early intervention.

This prevention plan is Connecticut's plan - not solely the child welfare agency's plan - designed to enhance the lives of all of Connecticut's children, youth, and families.

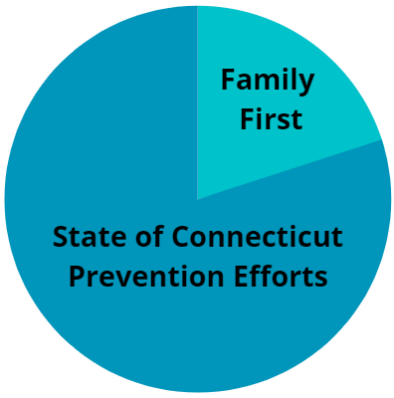


Figure 1. Connecticut prevention

This plan is also aligned with several other strategies currently being utilized in Connecticut, devoted to equitably meeting a family's needs, and which will be detailed throughout this plan. Connecticut's vision is to shift from a system solely focused on child protection, where action is taken after harm to a child has occurred, to a collaborative child well-being system focused on prevention and early intervention.

Connecticut has reimagined its system to not only serve those families who come to the attention of the child welfare agency, but to also develop supports for families "upstream," resulting in families being diverted from involvement with the child welfare agency. By empowering and supporting families, the well-being of Connecticut's

1 For a full summary of the Family First Prevention Services Act, including the prevention provisions, see the Children's Bureau's Information Memorandum, ACYF-CB-IM-18-02 available on https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf.

children, youth and families will be enhanced across systems making for a more promising future.

Connecticut is grateful to the hundreds of community partners, especially those parents and youth with lived experience, who have provided valuable insight into our planning process. Their voices influenced each section of this plan.

How We Have Approached the Work

The State of Connecticut Department of Children and Families (CTDCF) led a structured and collaborative process to develop a plan that advances a prevention-oriented system.

Over 400 community partners were involved, including parents and youth with lived experience, decision makers throughout state government, community organizations, advocates, and contracted providers. The priority was to ensure that children and families were truly at the center of the work.

Equally important to the inclusion of multiple partners was complete transparency of the process. To that end, a CT Family First website was established: https://portal.ct.gov/DCF/CTFamilyFirst/Home . All workgroup charters, meeting schedules, meeting minutes and documents used throughout the process have been posted and maintained within the website. A mailbox, DCF.CT.Family.First@ct.gov was established for community partners to ask questions and receive information about our planning.

To ensure cross-system collaboration and decision-making, Connecticut convened a Governance Committee and seven workgroups. The Governance Committee, comprised of CTDCF leadership and state and community partners, served to review evidence and community informed recommendations from each of the workgroups. After engaging in dialogue and receiving feedback to inform decision-making and ensure a connection between the prevention plan and other strategies designed to support children, youth and families, recommendations were provided to the CTDCF Commissioner.

The seven workgroups were co-led by an internal CTDCF staff member and an external community partner; the group participants were comprised of internal CTDCF staff and community partners.

An overview and description of each workgroup is as follows:

Candidacy - The workgroup strategized which populations of Connecticut children and their families were best positioned to benefit from Family First prevention services to address risk factors for maltreatment and prevent entry into foster care.

Community Partnerships and Youth and Family Engagement – The workgroup engaged with parents, youth, legislative officials, community providers, and other state agencies in the planning, development, and communication of Connecticut's planning process. This engagement included consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children who are at risk of foster care entry and their parents or kin caregivers and pregnant or parenting foster youth.

Fiscal and Revenue Enhancement – The workgroup completed fiscal modeling and provided recommendations regarding the fiscal and revenue impact of identified options.

Infrastructure Policy and Practice – The workgroup recommended modifications or additions to current policy, practice, and internal infrastructure to align with the revised model of care under Family First.

Kinship and Foster Care – The workgroup developed core recommendations to increase Connecticut's ability to support children's safe, supportive, and nurturing care in the most family-like caregiving setting possible when children cannot be with their parents.

Programs and Service Array – The workgroup aligned Connecticut's vast array of services and programs to the identified needs of the children and families served in candidacy groups, while ensuring a focus on quality services and interventions.

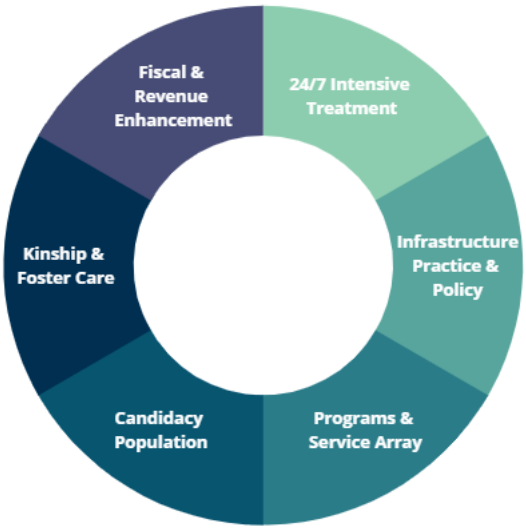


Figure 2. Family First Workgroups

24/7 Intensive Treatment QRTP (Qualified Residential Treatment Program) – The workgroup established expectations to achieve QRTP standards of care and supported providers throughout the planning process leading up to QRTP certification.

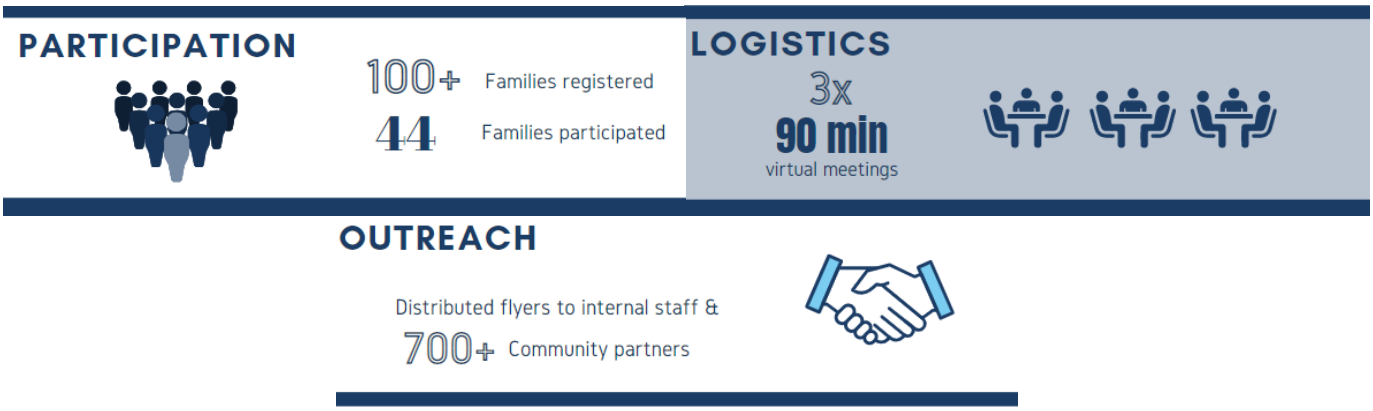


Figure 3. Parents as Experts process overview

In addition to the aforementioned workgroups, the Department was intentional about capturing the parent voice as evidenced by three focus groups in which the emphasis was the caregivers' lived expertise. "Parents as Experts" conversations were designed to actively seek input from families on their perspectives about how services can best be delivered to prevent maltreatment and promote family well-being. The discussions allowed for knowledge to be gathered about:

- What constitutes a good referral and service experience for a family
- How parents wish to be treated when considering and seeking support/when being supported in caring for their children
- What resources and methods engage children and families most effectively

The response to invitations to participate in these sessions was extraordinary. More than 100 families responded, with a total of 44 families being actively involved across all three sessions. Their feedback was thoroughly documented and shared with the Governance Committee. Caregivers appreciated the opportunity to share and express perspectives that were unique to their experiences. Overall themes included

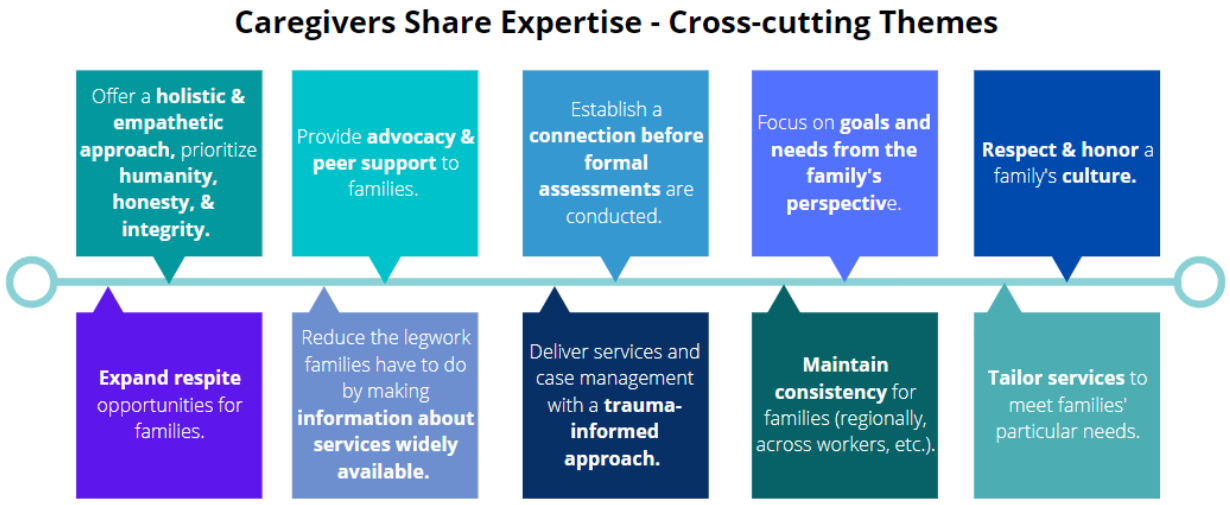


Figure 4. Caregivers share expertise, cross-cutting themes.

The Vision for Connecticut's Child Well-being System

CTDCF intends to maintain its foundational mandate to keep children safe with their families and thrive. to evolve our mission, vision and strategies to become an agency that empowers families to thrive by walking in partnership alongside them. In order to continue this evolution, CTDCF will need to rely on the collective thinking and collaborative contributions of sister agencies, providers, community partners, and most importantly our families, to build trust and reimagine our system.

Connecticut views Family First as an opportunity to continue and augment this transformation into a system of well-being; in part, by extending prevention services to families earlier and continuing to realign objectives towards prevention more broadly. Family First has already facilitated meaningful collaboration between partners in Connecticut to reimagine a coordinated system designed with and for families. Connecticut's youth and family serving agencies - including the Departments of Education, Social Services, and Mental Health and Addiction Services - have been engaged in planning for this work, relying on each agency's strengths, resources and opportunities to create collective positive impact for our families.

Along with expanding access to prevention services and fostering coalition building, one of the most exciting ways in which Connecticut intends to leverage Family First is as a tool to rethink which families are eligible for preventive services and the manner in which CTDCF plans to manage their cases. Connecticut developed a broad target population (families eligible for Family First services) definition that includes two population groups:

1) Those that are already "known-to-CTDCF" either through a call to the Careline, prior involvement in the system, or current involvement (pregnant and parenting youth in foster

care). This group of families will constitute Connecticut's initial candidacy population for Family First prevention services.

2) Families that will be referred through a "community pathway." This group of families will be served during the second phase of Family First implementation when the appropriate partnerships, infrastructure, and fiscal support are sufficiently established.

The community pathways population includes "upstream" families experiencing specific behavior, conditions, or circumstances that are likely to have an adverse impact on a child's development or functioning and for whom research establishes that such characteristics or conditions place them at increased risk for maltreatment, involvement with the child welfare system, or out-of-home placement. (See Section 2 for more information on candidacy.)

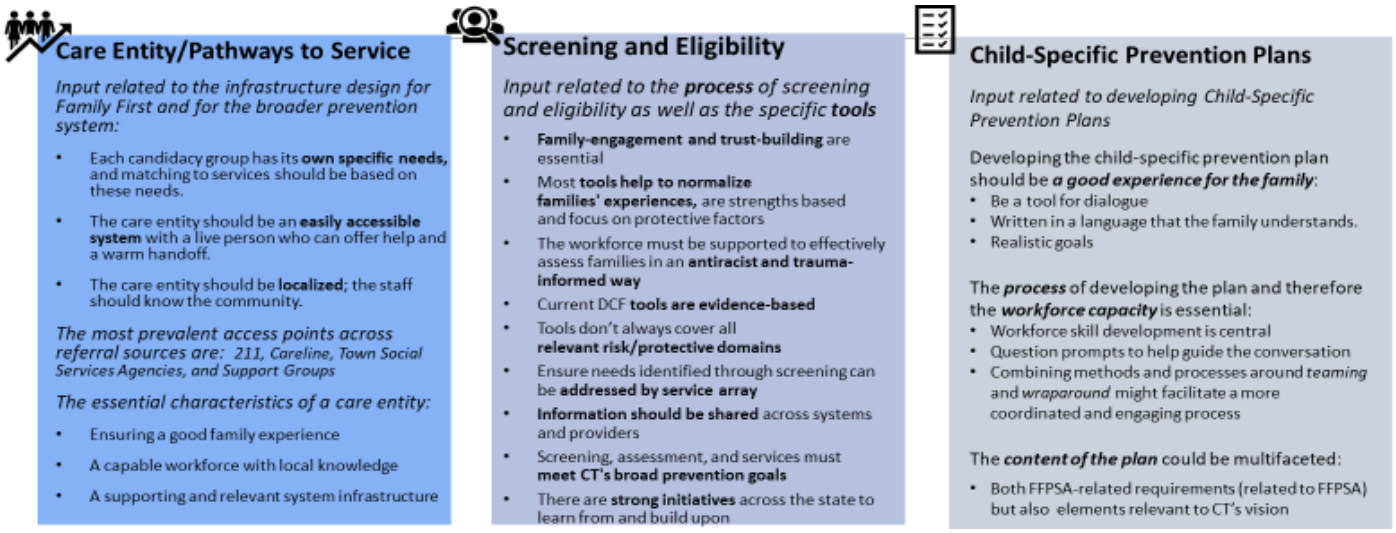
Families with certain characteristics that will be identified through a community or neighborhood pathway and eligible for services are:

- Families accepted for Voluntary Services *(Voluntary Care Management as of May 1, 2020)*
- Children who are chronically absent from preschool/school or are truant from school
- Children of incarcerated parents
- Trafficked youth
- Unstably housed/homeless youth
- Families experiencing interpersonal violence
- Youth who have been referred to a juvenile review board, youth service bureau, other diversion program, or who have been arrested
- Caregivers or children who have a substance use disorder, mental health condition or disability that impacts parenting
- Infants born substance-exposed as defined by the state's Child Abuse Prevention and Treatment Act (CAPTA) notification protocol[2]

Connecticut sees this pathway as a tremendous opportunity to provide services earlier to families to establish stability and family well-being, and to prevent foster care entry. To engage these families earlier, CTDCF heard directly from families and partners that it was important to develop an entity outside of the Department to assist in these families' cases. Therefore, as available funding allows, CTDCF plans to contract with a Care Management Entity (CME) to engage these "community pathways" families, provide case management, manage service referrals, and monitor ongoing progress. In response to feedback from

[2] CT definition of infants born substance-exposed for the purposes of the CAPTA notification: A newborn: (1) exposed in utero to methadone, buprenorphine, prescription opioids, marijuana, prescription benzodiazepines, alcohol, other illegal/non-prescribed medication, and/or the misuse of prescription/over the counter medication; (2) with withdrawal symptoms; (3) diagnosed with Fetal Alcohol Syndrome.

Figure 5. Infrastructure, Practice, and Policy workgroup strategies to improve CT practice

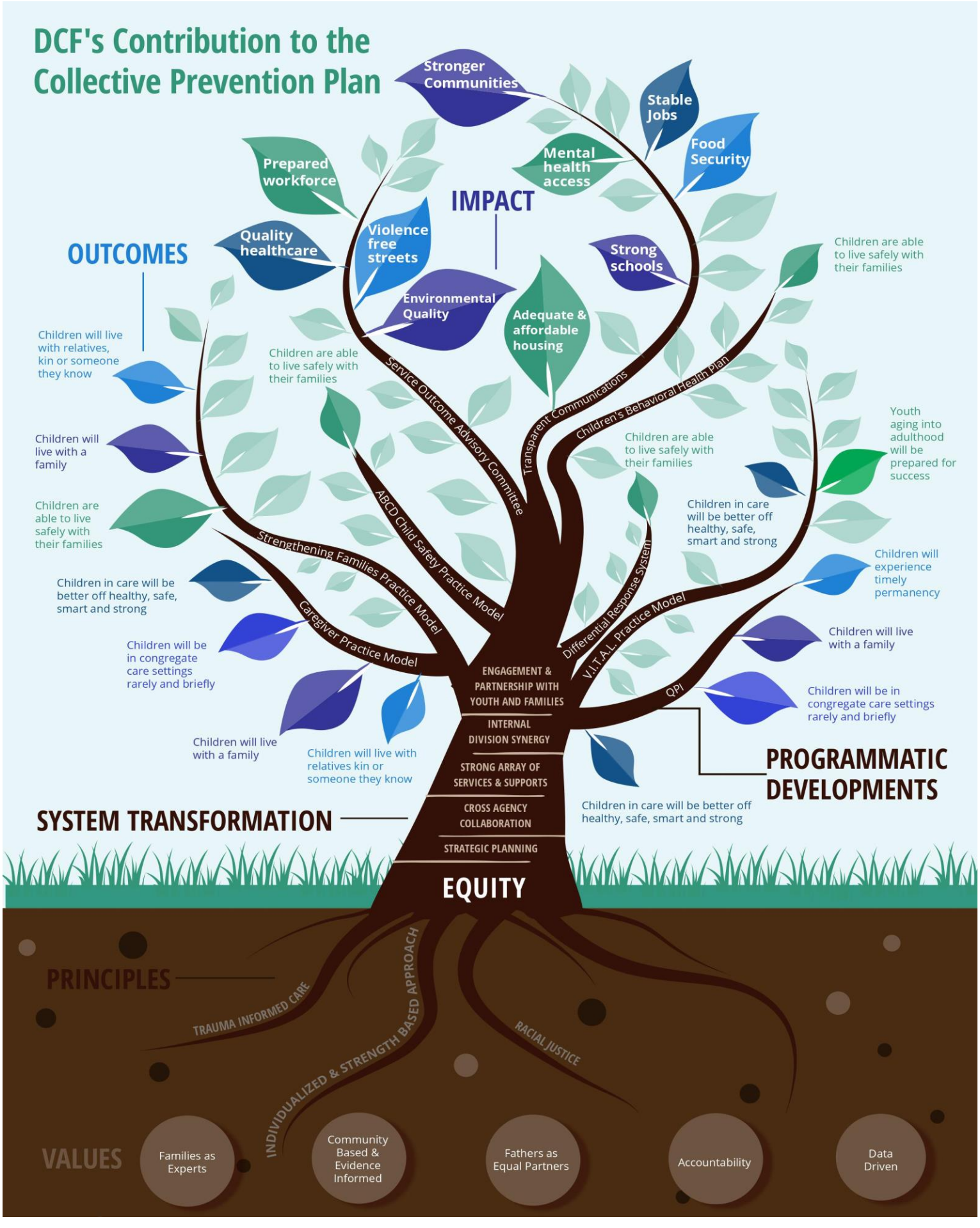


families and partners, CTDCF is eager to establish this relationship to capitalize on the ground-breaking Family First opportunities without magnifying CTDCF surveillance. CTDCF will develop a detailed request for proposal (RFP) in order to contract with the provider best suited to serve as the Care Management Entity (CME). The CME will have both statewide capacity to coordinate across all regions of CT and established offices within each of CT's DCF regions in order to ensure a better understanding of local resources and regional needs of CT's children and families.

While Family First offers Connecticut opportunities for innovation in prevention, it is only one mechanism among many that Connecticut intends to employ. For example, Connecticut recognizes that the list of evidence-based programs on the Prevention Services Clearinghouse does not capture the full range of needs of Connecticut families. Therefore, Connecticut intends to continue investment in efforts that address family and community economic supports, services that are developed with and for communities of color, and evidence-based practices that address the full continuum of mental, behavioral, and physical health needs of Connecticut children and families. To this point, the CME intends to accept all calls from children and families, unless safety factors are identified at which time a careline report will be made. Embodying the "no wrong door" philosophy, the CME will coordinate with the vast array of services outside of Title IV-E to ensure families are receiving the services they need regardless of the funding source. CME staff are mandated reporters and if they hear something that meets the statutory criteria of abuse or neglect, they will refer to the Careline.

Connecticut is enthusiastic about developing a well-being system and implementing Family First as the next step of its transformation journey, and invites its sister agency partners, communities, and families to continue to participate in this transformation and to help shape the system we envision for our families.

DCF's Contribution to the Collective Prevention Plan



Overview – Connecticut Department of Children and Families

The Connecticut Department of Children and Families' legislative mandates include prevention, child protective and family services, children's behavioral health, and educational services. With an annual budget of approximately $800 million, the Department operates a central office, fourteen (14) area offices, and two (2) residential facilities. CTDCF operates a Wilderness School that offers high-impact wilderness programs intended to foster positive youth development through experiential therapeutic recreational activities; and a Unified School District that provides quality education and support services that lead to educational success for children in foster care, those placed in a private residential facility by the Department with no other educational nexus, or who are receiving psychiatric treatment within one of the DCF-operated facilities.

CTDCF seeks to sharpen the safety lens by strengthening primary prevention across the child welfare system through five strategic goals: ***Safety, Permanency, Racial Justice, Well-being, and Workforce***.

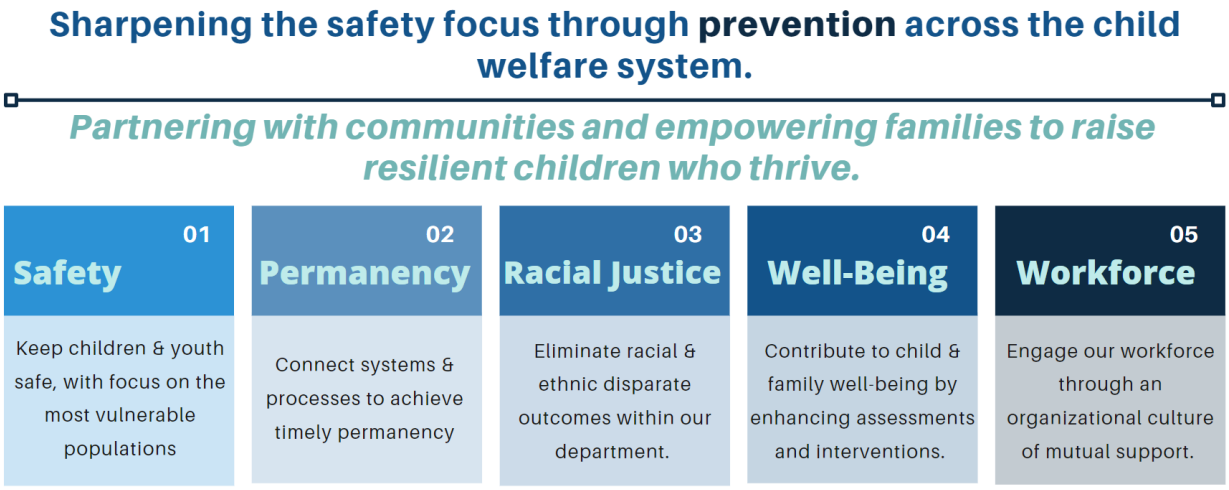


Figure 6. CTDCF Five Strategic Goals

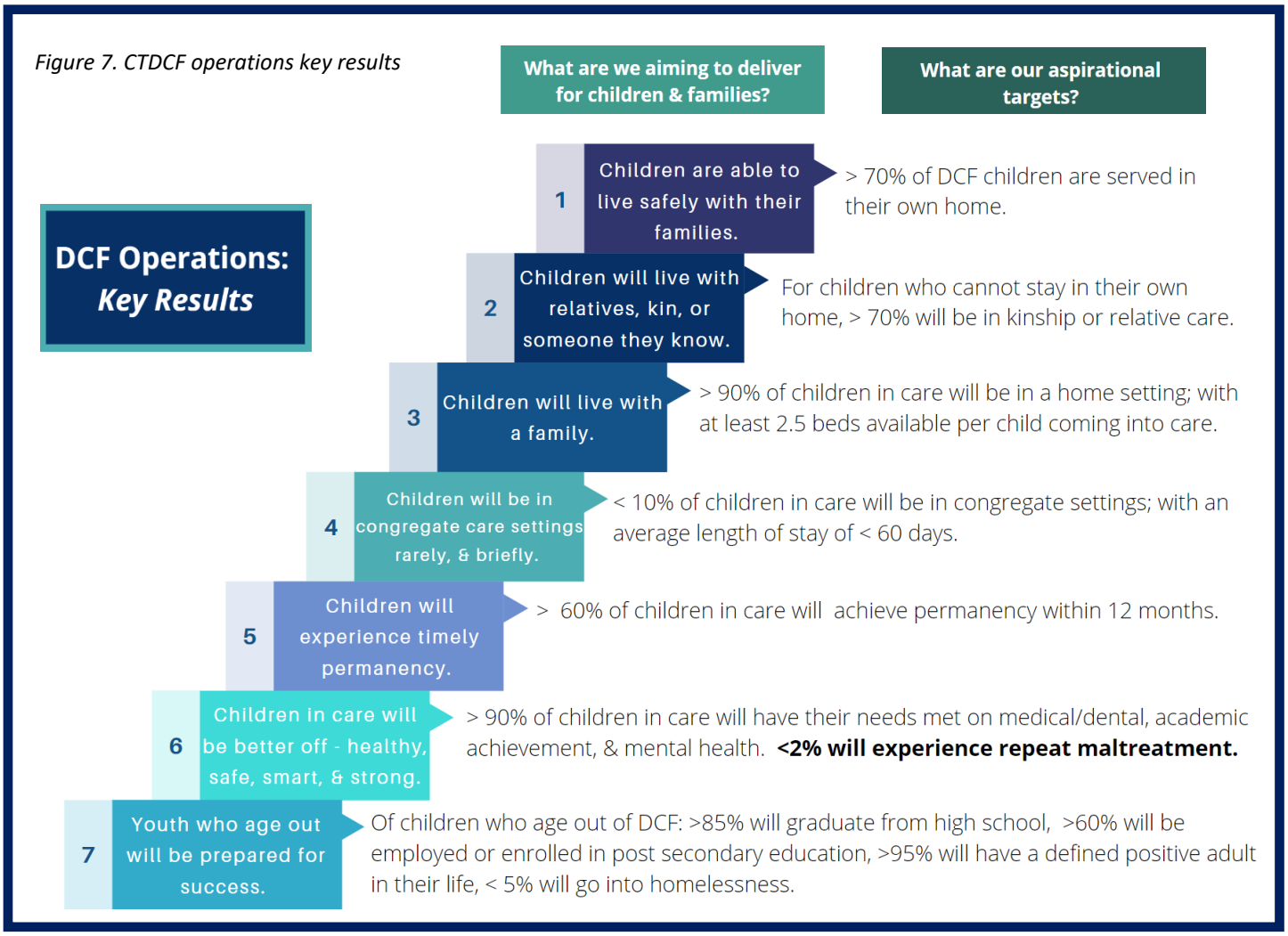
CTDCF believes that children do best when living safely at home with their family of origin. When living at home with a parent is not reasonably safe, the best alternative is to live with relatives, kin, or someone the child knows who can provide a safe and nurturing home. If no family member or kin can provide a suitably safe home that meets the child's needs, the child should receive care and services in an appropriate foster home or a setting that is able to meet their needs in a timely manner. If absolutely required, a child who needs to be placed into a congregate care setting for an identified treatment need should only remain there until they are stabilized enough to return to a home where treatment can continue in a family setting. The mission of CTDCF is grounded in a core set of seven Key Results that drive the Department's Strategic Goals for how to best meet the needs of and serve Connecticut's children and families.

CTDCF Mission

"Partnering with communities and empowering families to raise resilient children who thrive."

These strategies are about what CTDCF aims to do, but it is just as important to set the expectations for how CTDCF will work to achieve its goals. To this end, it is important that the agency's 3,200 staff members work with purposeful pride and passion for practice, and people. Prioritization of people further highlights our commitment to partnerships. We recognize that the basis for achieving a system of well-being through a dedicated stakeholder partnership is paramount as we cannot, and should not, do this work in isolation.

Figure 7. CTDCF operations key results



Programmatic Developments Essential for Systems Transformation

Connecticut continues to demonstrate its commitment to practice through various programmatic developments, strategies, and initiatives. Supported by the pillars mentioned above the following programmatic descriptions highlight Connecticut's prime positioning to implement Family First.

1. CTDCF Strengthening Families Practice Model

Recognizing the importance of a structured approach to practice, in 2011, the Department began its transformation through the development and operationalization of a Strengthening Families Practice Model, which is a framework of the agency's shared values and strategies applied to the work with families.

The practice model is built on a foundation of family engagement and family-centered assessment. Strategies actualized through this approach include purposeful visitation, initial and ongoing assessments of safety and risk, individualized services as well as supervision and management.

The seven cross-cutting themes that guide the mission and strategies of the practice model are:

- Implementing strength-based family policy, practice, and programs
- Applying the neuroscience of early childhood and adolescent development
- Expanding trauma-informed practice and culture
- Addressing racial inequities in all areas of our practice
- Building new community and agency partnerships
- Improving leadership, management, supervision, and accountability
- Becoming a learning organization

Implementation of the practice model leads to consistent and effective engagement across Department offices and improves the quality of work and supervision. Intended outcomes include:

- Prevention will lead to fewer families in need of CTDCF Services
- Children remain safely at home, whenever possible and appropriate
- Children who must come into CTDCF care achieve more timely permanency
- All children in our care and custody are healthy, safe and learning; they are successful in and out of school; and they are supported to find and advance their special talents and to give something back to their communities
- Youth who transition from CTDCF are better prepared for adulthood

With a firm emphasis on strengthening and preserving families, the practice model lends itself to the Family First vision through keeping children safely with their families and avoiding the traumatic experience of entering care.

2. Fathers as Equal Partners

As continued evidence of the commitment to family engagement and adherence to the Strengthening Families Practice Model, CTDCF is also firmly committed to meaningful fatherhood engagement. It is well documented that fatherhood involvement, particularly in communities of color, is vital to child development and strengthening the family. To that end, the Department has developed robust fatherhood programs to ensure active engagement by fathers in their children's lives. While the Department's focus has been on children in the care of CTDCF, the programming extends well beyond

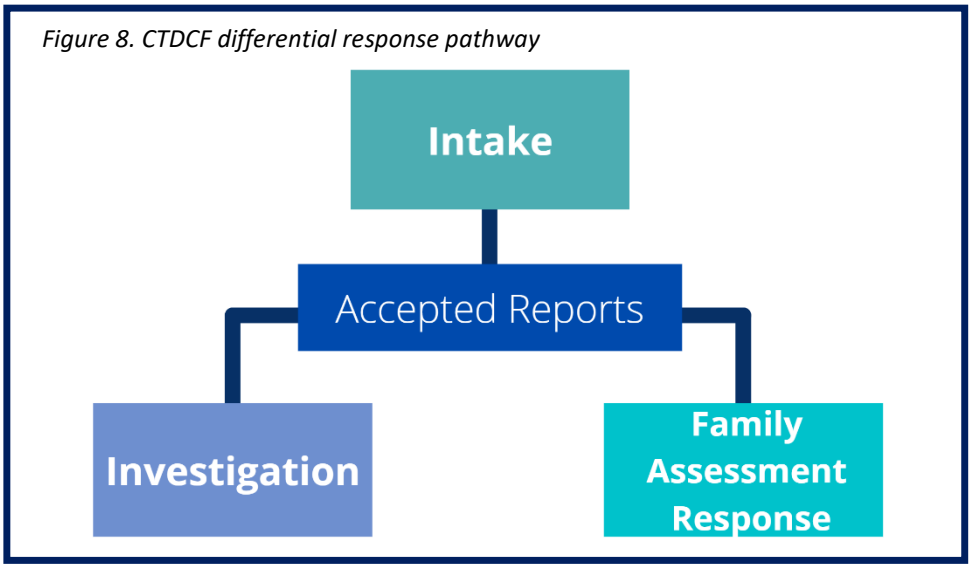
those committed to the Department, seeking to prevent the separation of families and strengthen the father's and paternal family's role in a child's life.

3. Differential Response

The Differential Response System is a core part of CTDCF's move to a more family-centered practice. It affords CTDCF the opportunity to customize its response to accepted reports of child maltreatment by using one of two response tracks: Traditional Investigation or Family Assessment Response.

In a traditional investigation, the family involuntarily works with the Department and, after facts are gathered, a formal determination is made as to whether maltreatment has occurred. When a family is the subject of a Family Assessment Response (FAR), the family is provided the opportunity to voluntarily work with the Department, and at the end of the assessment period the agency does not make a formal finding of child maltreatment.

Figure 8. CTDCF differential response pathway



A Family Assessment Response and a traditional investigation share many of the same principles described below:

- Focuses on the safety and well-being of the child
- Promotes permanency within the family whenever possible
- Recognizes the authority of CTDCF to make decisions about removal, out-of-home placement, and court involvement
- Acknowledges that other community services may be more appropriate and beneficial to families in some cases rather than receiving services from a child protection agency, such as “Community Support for Families” or the “Integrated Family Care and Support” program

4. Community Support for Families

CTDCF offers a voluntary, family-driven, individualized program entitled Community Support for Families (CSF), administered by seven community partner agencies throughout the state. CSF is for families that are discharged from a Family Assessment Response (FAR) but are still in need of additional support. CSF utilizes a wraparound philosophy and approach designed to:

- Promote child and family well-being
- Build and strengthen natural and community-based supports
- Connect families to resources and services in their community
- Place the family in the lead role of its own service delivery

CSF is a time limited program utilizing evidence-based tools to assess strengths and needs of families to help inform service delivery. The program utilizes flexible funding to meet basic, concrete needs.

5. Integrated Family Care and Support

Integrated Family Care and Support (IFCS) engages families while connecting them to concrete, traditional and non-traditional resources in their community, utilizing components of a Wraparound Family Team Model approach. Families have access to the full array of Department funded services.

Families are referred to the IFCS program after a traditional investigation has ended with an unsubstantiated finding but identified risk factors and service needs indicate the family would benefit from care coordination services. Traditionally, these families would have instead been transferred to CTDCF Ongoing Services. The family must be willing to engage in services and agree to the IFCS transfer.

The program was developed with the belief that families would be better served in their own community without CTDCF involvement and aligns well with Family First and the Department's prevention mandate.

6. Considered Removal - Child and Family Team Meetings

A Considered Removal Child and Family Team Meeting (CR-CFTM) is required when the Department identifies one or more safety factors that will lead to the immediate removal of a child from the family home unless the safety factor can be mitigated. The meeting is held prior to the removal of a child unless the family situation requires an emergency removal to ensure child safety.

Meeting participants include parents/guardians, children/youth, extended family, natural supports, service providers, and CTDCF staff. The process helps to identify the family's strengths, resources, and protective capacities.

The Structured Decision Making (SDM) tool is used during the considered removal meeting to inform removal decisions. The meetings are run by an independent trained facilitator outside of the decision-making chain of command. The purpose of the CR-CFTM is to:

- Mitigate safety factors to prevent removal by identifying and utilizing the family's natural/formal supports
- Address risk factors that impact child safety
- Engage families and their supports in safety planning and placement-related decisions
- Identify roles/responsibilities of team members and develop strategies to help keep the child safe
- Explore and identify extended family and kin as potential placement resources for the child should removal be necessary

7. Connecticut Children's Behavioral Health Plan

CTDCF submitted the Connecticut Children's Behavioral Health Plan in fulfillment of the requirements of Public Act 13-178. The public act was one component of the Connecticut General Assembly's response

to the December 2012 tragedy in Newtown, Connecticut, in which 20 grammar school children and 6 educators were murdered by a young adult who had unmet mental health needs. The legislation called for the development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children."

The plan provides Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and to promote healthy child development. Public Act 13-178 directed CTDCF to include in the plan the following strategies to prevent or reduce the long-term negative impact of mental, emotional, and behavioral health issues on children:

- Employing prevention-focused techniques, with an emphasis on early identification and intervention
- Ensuring access to developmentally appropriate services
- Offering comprehensive care within a continuum of services
- Engaging communities, families and youths in the planning, delivery, and evaluation of mental, emotional, and behavioral health care services
- Being sensitive to diversity by reflecting awareness of race, culture, religion, language, and ability
- Establishing results-based accountability measures to track progress towards the goals and objectives
- Applying data-informed quality assurance strategies to address mental, emotional, and behavioral health issues in children
- Improving the integration of school and community-based behavioral health services
- Enhancing early interventions, consumer input and public information and accountability by:
    - (i) In collaboration with the Department of Public Health, increasing family and youth engagement in medical homes
    - (ii) In collaboration with the Department of Social Services, increasing awareness of the 2-1-1 Infoline program
    - (iii) In collaboration with the State Department of Education in ensuring that school districts are identifying and engaging with community providers and partners to provide both inside the schoolhouse and community-based referral sources for students
    - (iv) In collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state, increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing behavioral health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system.

CTDCF has been implementing the children's behavioral health plan, in partnership with 11 other state partner agencies, numerous private agencies and the children and families of Connecticut. An example

of that partnership is the Voluntary Care Management (VCM) program, which serves youth with serious emotional challenges, mental illnesses and/or substance use disorders and their families. The goal is to support families by increasing their access to care. Previously, these families were directly served by CTDCF and now this work is conducted through a private provider, eliminating the need for these families to be involved with the child welfare agency to receive behavioral health support.

8. ABCD Child Safety Practice Model

To further demonstrate commitment to strengthening practice, CTDCF is developing the CT Child Safety Practice Model. First and foremost, this practice model aims to ensure safety throughout all CTDCF's assessments, responses, services, and operations across the entire child welfare continuum. The practice model maps out how agency employees, families and stakeholders conduct their activities in an environment that focuses on keeping children safe from maltreatment. The model guides the daily interactions of employees, families, and community members in their work with the Department in conjunction with the standards of practice to achieve child safety outcomes by:

- Increasing consistency of safety related language
- Increasing consistency of decisions and outcomes
- Clarifying interactive expectations for frontline staff, supervisors, and community-based partners
- Unifying the statewide internal and external understanding of applied safety concepts

The six core components of the child safety practice model are:

- Safe and sound culture and safety science
- Commitment to equitable safety outcomes and racial justice
- Comprehensive assessment, resources, tools, and protocols to support safety and consistent decisions
- Supervision and consultation to inform critical thinking
- Community partners and comprehensive service array focused on safety
- Supports for kin, foster, and adoptive families and young adults

An integral component of strengthening families, development of the Child Safety Practice Model further advances Connecticut's commitment to achieving the safest outcomes for children.

9. V.I.T.A.L. Practice Model Overview

In order to ensure lifelong well-being and success for young adults, the CTDCF Transitional Supports and Success (TSS) Division recently began work with several partners to shape a new practice model for Transitional Age Youth (TAY, young people 16-23 years of age). The purpose was to establish a consistent and recognizable approach to adolescent practice that would improve outcomes. The shared focus of the team was to ensure that all youth have relationships, supports, and opportunities to thrive as they launch into adulthood.

One of the Department's goals is to shift the focus from preparing youth to transition out of the child welfare system, to launching youth towards opportunities. A shared hope is to develop a supportive system that is youth directed, focused on permanency throughout, informed by brain development research, and advances inclusion and equity. Efforts are designed to help youth walk on a path towards becoming civically engaged, having a career, maintaining connections to others, and becoming lifelong

learners. Support and planning efforts coalesced across four case management stages: Engagement and Assessment, Youth Driven Transition Preparation, Launch, and Re-entry. This is especially critical for students with disabilities who continue to be eligible for educational services and attending traditional school or transitional alternative programs until their 21st birthday.

10. Kinship Navigation

Connecticut is developing a Kinship Navigator program to highlight the importance of kin in a prevention-oriented system. The model will strengthen the array of resources and supports available to families outside of the formal CTDCF care system. More specifically, kinship navigation will primarily operationalize an overarching Connecticut Caregiver Practice Model to support an organizing framework for Connecticut's work with families, including birth, adoptive, kin/fictive kin, and core foster families, which will ultimately serve as the foundation for the kinship navigation model.

By ensuring that caregivers have access to the resources they need, assistance in navigating public programs for which they are eligible, and peer networking and support, CTDCF can promote children's stability and improve the well-being of the entire family.

Overview of System Transformation

Connecticut's numerous successful programmatic developments serve as a natural conduit for overall system transformation in collaboration with our sister agencies, community and provider partners, and families and youth with lived experience. Commitment to congregate care reduction, juvenile justice partnerships, and pivotal shifts in organizational culture with a magnified emphasis on racial justice makes Connecticut well positioned to implement Family First for their candidacy populations.

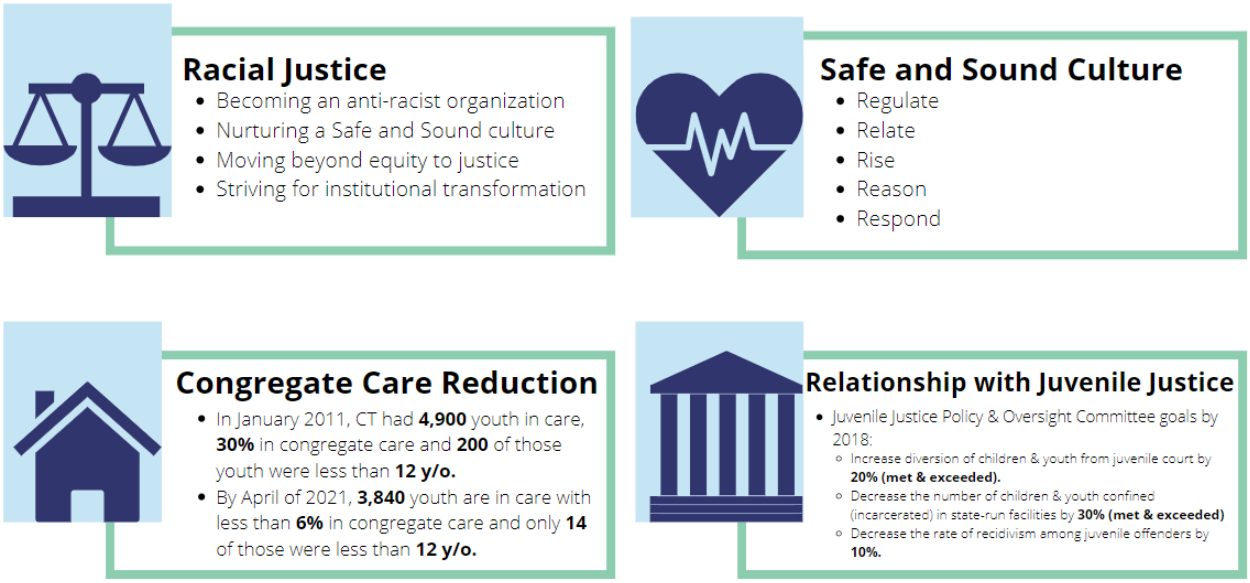


Figure 9. System Transformation Efforts

1. Racial Justice

In 2020, with racial disparities illuminated in a global pandemic and our nation gripped in civil unrest, CTDCF reaffirmed its commitment to becoming an anti-racist organization whose beliefs, values, policies, and practices achieve racially just outcomes. The overarching mission of anti-racist work is to examine and redesign the CTDCF as an authentically anti-racist agency that will be apparent in its structures, partnerships policies, practices, norms, and values. At this time, it is believed that becoming an anti-racist agency is a necessary means to achieving the goal of becoming a racially just organization.

In furtherance of the agency mission, the Department has established four grounding principles, values, and foundations to guide the organization

Figure 10. CTDCF guiding principles, values, and foundations

Becoming an Anti-Racist Organization

As an anti-racist organization, CTDCF will decisively identify, discuss, and challenge issues of race and color and the impact(s) they have on the agency, families, community, staff and external partners. A structured framework has been developed to guide conversations within and outside the Department, with an emphasis on leadership support and development, and reflective of the positional authority necessary to carry racial justice expectations throughout CTDCF. Over the past year, this framework has been utilized across the Department at all levels and now moves to external stakeholders. Also, in 2020, the Department made a commitment to move beyond equity to justice to further ensure that services are individualized and based on a comprehensive assessment of a child's and a family's strengths and needs. CTDCF recognizes that these assessments must occur in partnership with providers, the family, youth and children, in an age and developmentally appropriate manner, shaped by clients' racial, cultural, and linguistic self-identification and needs.

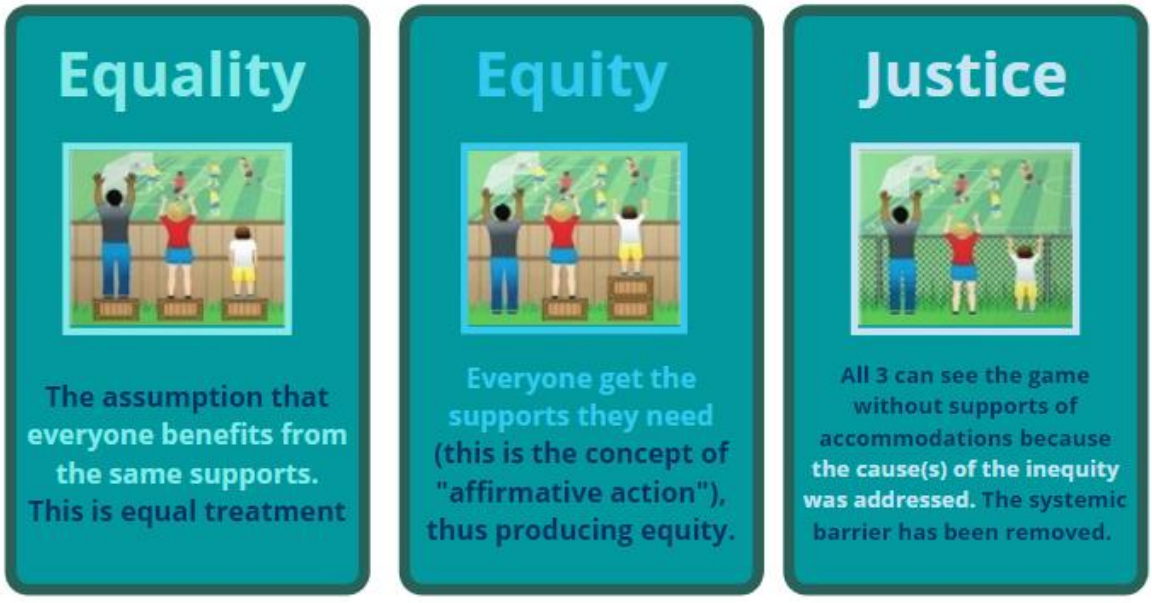


Figure 11. Equality, equity, and justice visual

Striving for Institutional Transformation

Striving for Institutional Transformation looks beyond small transactional changes, but rather makes changes that fundamentally transform the work with children, families, and the greater community.

CTDCF is paying particular attention to our data infrastructure to assess and implement these change initiatives. CTDCF has a strong data infrastructure that is accessible to all staff, one that assists in evaluation of its practices and outcomes through a racial justice lens. The Department has deliberately invested in capabilities that allow for disaggregation of most reports by race and ethnicity. This provides agency leaders the ability to observe trends that can be used for the consideration of strategies to eliminate racial and ethnic disparate outcomes within CTDCF.

2. Safe and Sound Culture

The Department's values, attitudes, and behaviors support an environment that promotes psychological and physical safety for children, families, and staff. Our culture of safety model is "how" our work is done.

As a culture of safety, CT Safe and Sound Culture is rooted in principles of respect, trust, candor, equity, and racial justice. When put into action, this enables the Department to be engaged, supportive, accountable, and open to learning. It empowers sound decisions and competent provision of services that help children and families achieve safe and healthy outcomes.

CTDCF is mindful that this work is hard and oftentimes painful for some; therefore, CTDCF is committed to cultivating and sustaining an environment that is supported and grounded in the context of the Department's Safe and Sound Culture. There are five main principles, branded as the "5R's," that provide a framework for our work within a culture of safety and racial justice:

- Regulate – Mindfulness of physical and psychological well-being
- Relate – To build and sustain relationships and community with respect, trust, and candor
- Rise – To be brave and bold with relevant actions
- Reason - Decision making based on consultation, teamwork, and knowledge
- Respond – To plan with competence, confidence, and compassion

Reflecting Back and Planning Forward

Our Safe and Sound culture creates a learning environment in which we strive to try new ideas, identify and plan for what could go wrong, talk about and learn from our mistakes, tap into others' expertise, and honor the unique skills we each bring to our work.

Figure 12. CTDCF Safe and Sound Culture visual

3. Congregate Care Reduction

CTDCF is proud of our successfully proven efforts to safely reduce congregate care by developing a blueprint for rightsizing.

In January of 2011, Connecticut had 4,900 children in care - 30% in congregate care, 200 of which were less than 12 years of age. By April of 2021, through transformation efforts with an intentional emphasis on increasing kinship care and providing in-home supports to foster parents and kin providers, the number markedly dropped to 3,480 children in care - with less than 6% in congregate care, of which only 14 children were less than 12 years of age. Connecticut is viewed as a national champion for the manner in which children are maintained in a family setting. This work was recently highlighted in a report entitled "Families over Facilities" produced by Children's Rights. The report documents the dramatic reduction in institutional care that Connecticut achieved by adopting many positive practices, including providing preventive services that keep families together and children out of foster care in the first place and by significantly increasing the number of children living with relatives.

CTDCF's efforts to achieve congregate care reduction were guided by the inherent value that, first and foremost, children should be placed into kinship care when they cannot remain safely at home. Specialized community-based services were developed so youth could have wraparound supports within a family setting. Increased recruitment and retention of foster parents were also a focus with the most intensive form of foster care, "Family and Community Ties," developed for children with behaviors consistent with congregate care requiring a specialized plan to be developed for them within a family setting.

4. Relationship with Juvenile Justice

The Juvenile Justice Policy and Oversight Committee (JJPOC) was created by Public Act 14-217 and charged with evaluating policies related to Connecticut's juvenile justice system. The committee was

tasked with recommending changes in state law regarding juvenile justice that would eventually lead to diverting children and youth from juvenile courts, decreasing the number of children and youth confined (incarcerated) in state run facilities, decreasing the rate of recidivism, reducing racial and ethnic disparities of youth within the juvenile justice system, and setting appropriate lower and upper age limits for youth involved in the system.

The JJPOC promulgated the following goals to improve youth justice in Connecticut, to be achieved by mid-2018:

- Increase diversion of children and youth from juvenile court by 20%
- Decrease the number of children and youth confined (incarcerated) in state-run facilities by 30%
- Decrease the rate of recidivism among juvenile offenders by 10%

Workgroups and sub-workgroups were established across the state aligning with each of those goals, as well as a Cross Agency Data-Sharing Workgroup. Each year, the Cross-Agency Data Sharing Workgroup Co-chairs present a progress report on the status of the established numerical targets for the goals.

By fall 2018, the state's juvenile justice system exceeded two of the three identified goals. The reduction in incarceration reached more than 50%, far exceeding the goal; the increase in diversion reached 30%, also far exceeding the goal. The reduction in recidivism is not yet at the promised 10% level, but is stalled at 2%, largely due to the changing nature of the juvenile population. This population is dramatically smaller in number but encompasses youth with a higher degree of complex needs.

As the timeline for the original goals expired, the JJPOC set new goals to be achieved by mid-2021:

- Limit youth entry into the justice system
- Reduce incarceration
- Reduce racial and ethnic disparities of youth in Connecticut's juvenile justice system
- Right-size the juvenile justice system by setting appropriate lower and upper age limits

Legislation was passed in 2018 shifting funding and programmatic responsibility for key diversion resources, namely Juvenile Review Boards (JRBs) and Youth Service Bureaus (YSBs), to CTDCF. JRBs and YSBs are connected to communities and act as local hubs for juvenile justice diversion. Most of the YSBs (there are 102, covering 143 towns) are connected to JRBs, which are panels evaluating referred youth and providing alternatives to court involvement.

Additionally, legislation was enacted during the 2021 legislative session calling for CTDCF to undertake educational oversight of youth placed in juvenile justice facilities and those that are incarcerated.

Connecticut remains committed to achieving the newly developed goals to limit youth entry into the juvenile justice system to ultimately allow for more positive long-term outcomes for this population.

The Road Ahead

As Connecticut continues its transformation, the implementation of Family First will be an integral landmark on the road to an optimal child and family well-being system illustrative of wide reaching and strengthened community and stakeholder partnerships, attention and integration of the caregiver expertise, racial justice, evidence-based practice and intentional engagement of children, youth, and families to achieve the most optimal outcomes for safety and well-being.

Section 2: Eligibility and Candidacy Identification

Connecticut Candidacy Population Overview

Developing Connecticut's target population was foundational to Connecticut reimagining a prevention-oriented system. The Family First Candidacy Workgroup included members from CTDCF, other state agencies, community partners, philanthropic organizations, service providers, advocates, and parents and youth with lived experience. Members reviewed CTDCF data and data provided by partners to consider which groups of children and families may be at imminent risk for foster care and those that could benefit from prevention-related services. The Family First Candidacy Workgroup counted family well-being and racial justice as core tenets when considering how to broaden access to prevention services in Connecticut.

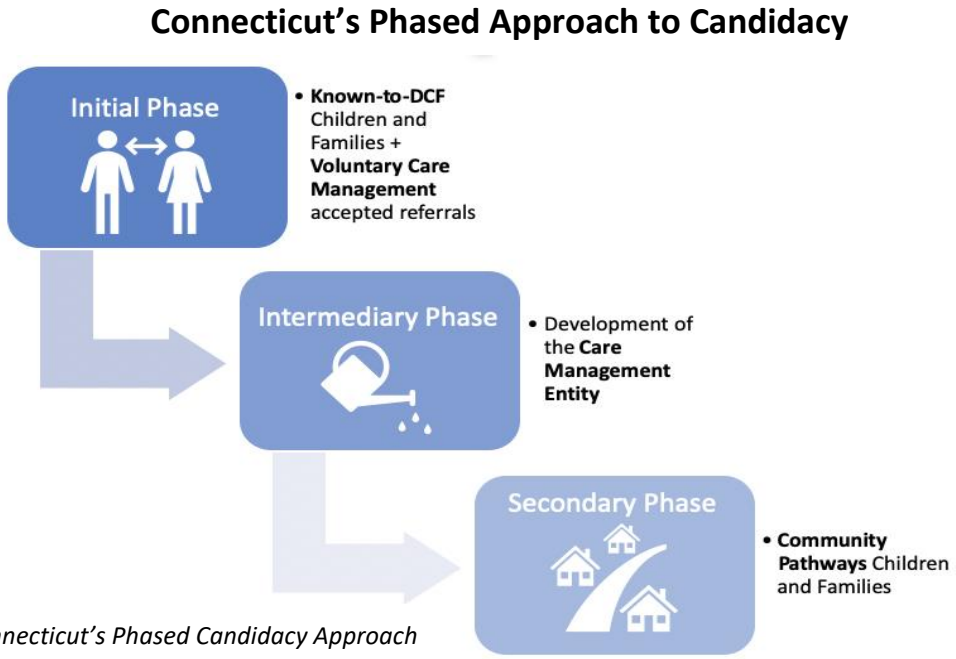


Figure 13. Connecticut's Phased Candidacy Approach

CTDCF's initial candidacy population for prevention services under Family First includes two sub-populations of children at risk of entry into foster care and their caregivers: children and families already **"known-to-CTDCF"** through calls to the CTDCF Careline or through prior foster care involvement and pregnant and parenting youth in foster care.

Connecticut's second population consists of children and their caregivers with particular needs or characteristics that ultimately may result in CTDCF-involvement and that are identified through a **community pathway**.

These sub-populations were recommended by CTDCF's Family First Candidacy Workgroup because Connecticut sees Family First both as an opportunity to strengthen stabilization services for children and families already being served by CTDCF, and as the impetus for a new approach to provide prevention services to families before they have ever been involved with the Department.

For the "known to CTDCF" population, CTDCF was able to review data on rates of foster care or re-entry as well as information from the Structured Decision Making © (SDM) Model employed as families move

from intake through discharge. For the community pathways population, CTDCF sought evidence and data, where available, to form a deeper understanding of each sub-population's risk of foster care entry.

1. Candidacy Populations: "Known-to-CTDCF

Connecticut primarily used data from 2019 as it is likely more representative than the data gathered during the COVID-19 pandemic.

Table 1. "Known-to-CTDCF" candidacy population

"Known–to-CTDCF"	Candidacy Estimates	Date
Families with accepted Careline calls	29,488	2019
Siblings of youth in foster care	1,353	2021
Pregnant and parenting youth in foster care	Estimates	Date
Pregnant and parenting youth in foster care	29	2019

Families with accepted Careline calls

In 2018, there were 107,000 calls made to the Careline; 67,000 of these calls were referrals about concerns related to allegations of child abuse and neglect and 29,000 of those calls were accepted. In Connecticut there are two response tracks for an accepted Careline call: 1) Investigations, and 2) Family Assessment Response (FAR). Results from Connecticut's SDM tool, completed during intake, determine a CTDCF response. FAR is Connecticut's differential response model, in which rather than a formal determination of abuse or neglect, the outcome for a family is a determination of whether services are needed to strengthen the family and promote child safety and well-being.

The number of families with accepted Careline calls being referred to Family Assessment Response (page 12) has gradually increased since FY 2017 and, in FY 2019, 45.4% of families with accepted Careline calls were assigned to this response track. In FY 2018 there was a 27.6% 12-month subsequent report rate and a 6.5% substantiated report rate for families served through FAR. Depending on the evolving nature of a family's circumstance, CTDCF can refer a family from assessment to the Community Support for Families program (page 13).

CTDCF determined that families involved with both Investigations and FAR tracks should be eligible for Family First prevention services in order to provide all families with accepted Careline calls enhanced family supports to prevent occurrence or recurrence of maltreatment and to keep children at home when safe.

Siblings of youth in foster care

The exact number of youth who remain at home but have siblings in foster care is estimated by the Department to be about 1,353 in 2021. While the number is relatively small, CTDCF recognizes that a child's separation from their family impacts the entire family, causes additional trauma, invites additional surveillance and scrutiny into the family and, as such, may put siblings at a heightened risk of out-of-home placement. This heightened risk level indicates that siblings and their parents could benefit from access to services to strengthen the family and prevent more children from entering care. As part of existing intake procedures, Connecticut already assesses all children in the home, therefore identification of siblings and their needs is consistent with current casework.

Pregnant and Parenting Youth in Foster Care

Under Family First, pregnant and parenting youth in foster care are automatically eligible for Family First prevention services.

Table 2. Pregnant and parenting youth in foster care data 2016-2020

Parenting/Expectant Parent	FY 2016 (2015 - 2016)	FY 2017 (2016 - 2017)	FY 2018 (2017 - 2018)	FY 2019 (2018 - 2019)	FY 2020 (3Q and 4Q 2019)
Male	9	6	11	6	3
Female	26	34	30	23	19
Total parenting/pregnant	**35**	40	41	29	22
Total Discharged	276	258	224	270	152
Percentage parenting/expectant parent	12.7%	15.5%	18.3%	10.7%	14.5%

2. Candidacy Populations: Community Pathways

Connecticut is eager to extend prevention services to families with identified children experiencing behaviors, conditions, or circumstances that are likely to have adverse impacts on a child's development or functioning, but do not present immediate safety concerns. By engaging these families earlier and connecting them with the right services, they may never come to the attention of the Department and future incidents of maltreatment or foster care placement can be prevented. However, the varied and thoughtful partners that contributed to the development of this plan cautioned CTDCF about the importance of extending services without increasing surveillance, particularly to communities of color. Furthermore, caregivers specifically shared that they have reservations about involving CTDCF when they need support and prefer to seek assistance from trusted individuals outside the agency. In response to these concerns, it is anticipated that CTDCF will develop a contract with an outside Care Management Entity (CME) to work with families, local providers and CTDCF, to ensure that Connecticut can facilitate preventive services to families who need them to thrive with a racial justice and trauma-informed lens.

Connecticut's community pathways candidates were selected based on available data and the expertise of the Family First Candidacy Workgroup. The broadness in this candidacy population definition is intended to provide prevention services to families that have a heightened risk of out of home placement so that CTDCF may prevent the occurrence of maltreatment likely to lead to foster care placement.

Connecticut recognizes that the services in this plan and on the federal Prevention Services Clearinghouse may not meet the full range of needs families have in the community pathways candidacy sub-groups and therefore intends to supplement Family First prevention services with resources offered by community partners. This candidacy sub-group offers exciting opportunities to strengthen cross-system support of families in Connecticut.

Because of the resources, infrastructure, and culture shift required to effectively serve families in the community pathways target population, Connecticut intends to serve these families in its second phase of implementation, with the exception of families accepted for Voluntary Care Management services who will be served in the initial phase due to its existing infrastructure.

Table 3. Community Pathways candidacy populations

Community Pathways	Candidacy Estimates	Date
Families accepted for Voluntary Services *(Voluntary Care Management as of May 1, 2020)*	294	2019
Youth that have exited foster care	270 discharged to permanency	2019 2019
Children who are chronically absent from preschool/school or are truant from school	53,191	2018-2019
Children of incarcerated parents	Unknown	N/A
Trafficked youth	547 referred to CTDCF for human trafficking concerns	2015-2017
Unstably housed/homeless youth and their families	7,823 children and youth	2019
Families experiencing interpersonal violence	4,274 accepted CTDCF reports were for Interpersonal Violence 4,632 children were victims of Interpersonal Violence	2019
Youth who have been referred to juvenile review boards, youth service bureaus, or another diversion program or who have been arrested	2,307 (statewide Juvenile Review Board referrals)	2018-2019
Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting	103,819 adults with diagnosis of substance-use disorder, or mental health disorder Youth 12-17 (~26,000 estimated to use illicit drugs in the past month SAMHSA Behavioral Health Barometer, Connecticut, 2019) Children 0-18 (~74,500 were likely to have had a serious emotional disturbance (SED) defined as a child with a DSM diagnosis that without treatment could lead to out of home/out of community treatment, Williams, Scott, & Aarons, 2017)	2019
Infants born substance-exposed (as defined by the state CAPTA notification protocol)	1,206 notifications	March-December 2019

Families accepted for Voluntary Care Management Services

Connecticut's Voluntary Care Management (VCM) Program serves families with youth under 18 years of age with serious emotional challenges, mental illnesses and/or substance use disorders. Prior to May of 2020, CTDCF managed the care for families receiving voluntary services internally through the Voluntary Services Program but made the decision to contract out that responsibility in order to provide services further upstream and prevent unneeded scrutiny of families. Now, to access VCM, families call the CTDCF Careline to request services. Careline staff gather eligibility information about the family through a questionnaire/referral that is submitted to Beacon Health Options, the contacted provider, and the Office of Health Care Advocate to ensure all potential alternative insurance resources have been explored. In 2019, 302 children were referred to VCM Services and 97.4% were accepted.

Families seek out the VCM Program because they are unable to access services to address the acute needs of their children. Historically, some families saw the only pathway to services for their children with serious emotional or behavioral challenges as involving contact with the child welfare agency, which exposed the families to the possibility of losing guardianship or having their child committed to the Department. In order to ensure that these families have access to the services they need without CTDCF involvement, Connecticut believes it is essential to continue to strengthen the infrastructure and service array of the VCM Program. Therefore, CTDCF anticipates that by extending eligibility to these families and expanding their access to prevention services, Connecticut will be able to better support them and prevent unnecessary out-of-home care.

Families served through Voluntary Care Management initially elect for services by calling the CTDCF Careline, but because CTDCF does not open a case on these families and a contracted provider is responsible for determining and delivering services, Connecticut has decided to categorize these families as part of the “Community Pathways” candidacy population. However, because of the existing referral and service infrastructure, Connecticut will serve these families as part of their initial phase of implementation.

Youth that have exited foster care

Youth exiting to permanency

According to Connecticut data, between January 1, 2009 and December 31, 2018, 18,266 children were discharged to permanency; of these children, 28.3% were discharged to adoption, 15.2% to guardianship, 2.7% to relative placement, and 53.8% were reunified with their family. Of the 18,266 children who were discharged to permanency, 2,774 (15.2%) had a reentry. More than half (1,500 of 2,774, or 54%) of the reentries occurred within 12 months following the discharge (an 8.2% reentry rate), with the preponderance occurring during the first eight months. Furthermore, CTDCF is aware that if a family has interacted with the child welfare system, there is an increased likelihood that they may have some level of interaction again in the future. In order to provide support proactively and to offer stabilization services before removals are considered, Connecticut is hopeful that providing additional supports to families leaving CTDCF's care will contribute to increased stabilization and a reduced reentry rate for families, particularly during the first eight months following discharge.

Children who are chronically absent from preschool/school or who are truant from school

In Connecticut, educational neglect is defined to occur when "by action or inaction, the parent or person having control of a child five (5) years of age and older and under eighteen (18) years of age who is not a high school graduate: 1) fails to register the child in school; 2) fails to allow the child to attend school or

receive home instruction in accordance with Connecticut law; or 3) fails to take appropriate steps to ensure regular attendance in school if the child is registered" (CTDCF, 2021). According to Connecticut data, in 2018 there were 3,618 total reports of educational neglect, with 759 of those reports substantiated. This data reveals a relationship between absenteeism and child welfare involvement.

In Connecticut, chronic absenteeism is defined as missing 10% or greater of the total number of days enrolled in the school year for any reason. It includes both excused and unexcused absences. Connecticut's statewide chronic absenteeism rate for students in Grades K-12 was 10.4% in 2018-19. Although there is significant variation between districts, in 2018-19, a total of 53,191 students qualified as chronically absent (CT State Department of Education, 2019). This population has high comorbidity with other risk factors associated with incidents of maltreatment and removal. The State Department of Education works directly with districts through many initiatives to support district's use of data to drive decisions to support students who are chronically absent – or at risk for chronic absenteeism. Districts use these data to identify and provide specific supports tailored to those needs to reduce the need for reporting families due to educational neglect and to connect them to community and state resources and services to support regular school attendance.

Research indicates that there are a variety of factors related to school absenteeism:

Table 5: Factors related to absenteeism (Jacob & Lovett, 2017)
Student-specific: Teenage motherhood, low academic performance and repeating grades, lack of caring relationships with adults, negative peer influence, bullying
Family-specific: Low family income, low parent involvement, unstable housing, at-home responsibilities, stressful family events, conflicting home and school priorities, language differences
School-specific: Poor conditions or lack of school facilities, low-quality teachers, teacher shortages, poor student-teacher interactions, lack of geographic access to school, less challenging courses and student boredom
Community-specific: Availability of job opportunities that do not require formal schooling, unsafe neighborhoods, low compulsory education requirements, lack of social and education support services
Source: REL Pacific, Review of research on student non-enrollment and chronic absenteeism

Based on the child-specific and family-specific factors related to absenteeism as well as Connecticut's educational neglect data, CTDCF is seeking to make prevention services available to chronically absent and truant children and their caregivers in order to strengthen families and prevent out-of-home placement.

Children of an incarcerated parent

While Connecticut does not know the exact number of youth who have an incarcerated parent, in January of 2021, there were 9,100 people incarcerated in Connecticut (CT DOC, 2021).

A 2006 study found that while parental incarceration may not be the reason children are placed in foster care, 27% of mothers who had been incarcerated had a child who had been placed in foster care at some point during the child's life demonstrating a relationship between risk factors of incarceration and risk factors of child welfare involvement (Moses, 2006).

There also is clear evidence that there are both financial and developmental consequences for children and families when a parent is incarcerated (Central Connecticut State University, 2007). A 2013 study found that parental incarceration is associated with the following conditions for children: learning disabilities, attention deficit disorder and attention deficit hyperactivity disorder, behavioral or conduct problems, developmental delays, and speech or language problems (Turney, 2014). Based on these heightened risk factors for youth with incarcerated parents, Connecticut intends to offer prevention services when appropriate to support these families and prevent future out-of-home placement.

Trafficked youth

Connecticut's data indicates that between 2015 and 2017, 547 youth were referred to CTDCF due to concerns of human trafficking victimization. Research suggests that there is a significant intersection between youth who are or have been involved in the child welfare system and trafficking victimization (Child Welfare Information Gateway, 2017). By identifying trafficked young people as candidates, CTDCF seeks to expand access to prevention services that may keep children connected to their families when appropriate or address vulnerable youth exiting foster care. The CTDCF has developed specific training modules on human and child trafficking tailored to school staff. These trainings are required under CT state statute and the State Department of Education continues to partner with the CTDCF and state anti-trafficking organizations to make these trainings and other resources available to school leaders, educators and staff.

Unstably housed/homeless youth and their caregivers

Research indicates that unstable or inadequate housing increases the risk of children entering foster care both because of the physical dangers presented by unsafe or unstable living conditions, but also due to the heightened stress imposed on caregivers in these environments (Child Welfare Information Gateway, 2019).

According to Connecticut data collected between January 1, 2011 and December 31, 2016, 5.4% of families undergoing a new child maltreatment investigation demonstrated severe housing problems. Additionally, 21% of families with substantiated child welfare determinations demonstrated significant to severe housing risk.

By identifying unstably housed youth and their caregivers as candidates, Connecticut intends to provide prevention services to address underlying needs and plans to connect families with existing housing initiatives led by partner agencies to help address housing-specific needs. Under the McKinney-Vento Homeless Assistance Act, school districts are required to identify a liaison for identifying and ensuring immediate and consistent access to education and subsequent support services. The State Department of Education maintains a program manager to oversee the provision of educational and related services, rights and opportunities for students experiencing homelessness or unstable housing.

Families experiencing interpersonal violence (IPV)

Research suggests that families experiencing domestic violence may also be involved with the child welfare system because of children's exposure to violence or the co-occurrence of child abuse and neglect (Child Welfare Information Gateway, 2019a). In Connecticut in 2019, there were allegations of IPV in 4,274 reports and 49.2% of those reports were substantiated. For reports with IPV and substance use allegations, 67.7% of reports were substantiated. By identifying these families as candidates, Connecticut seeks to expand early access to prevention services to families experiencing IPV as well as reduce opportunities for reentry due to IPV.

Youth who have been referred to a Juvenile Review Board (JRB), a Youth Service Bureau (YSB), or another diversion program; or who have been arrested

There is growing evidence of the overlap between the child welfare and juvenile justice systems. This intersection is primarily evidenced by maltreated children who become involved with the juvenile justice system while in care, juvenile justice-involved children with histories of maltreatment, and families that have intergenerational histories with both systems (Wiig, Tuell, & Heldman, 2013). According to the Statewide Juvenile Review Board, there were 2,307 youth referred to a JRB between 2018 and 2019. (While there are other diversionary programs in Connecticut, the most information is available about the Juvenile Review Boards.)

Because national research estimates that nearly 40% of juvenile justice-involved youth are also involved with the child welfare system, Connecticut seeks to expand prevention services to these youth and their families to prevent out-of-home placement in either of these systems. On average, there are about 50 dually involved youth in Connecticut annually. Currently, the Department participates in and co-chairs several interagency workgroups related to juvenile justice and child welfare through the Juvenile Justice Policy and Oversight Committee. The workgroups guide efforts related to diversion, truancy, youth incarceration, and meeting educational needs. Connecticut seeks to better understand and serve dually involved youth in Connecticut through these partnerships and initiatives.

Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting

a. Substance use and mental health

Research suggests that substance use disorder is a risk factor for maltreatment and neglect, as it may affect a parent's ability to function as a caregiver and provide for their children's basic needs (Child Welfare Information Gateway, 2019b). Substance use prevention and treatment is also a service type selected by the Prevention Services Clearinghouse and therefore a priority for addressing to stabilize families. While Connecticut does not have a clear picture of how many caregivers are challenged with substance use disorder, there were 103,819 adults with a diagnosis of substance-use disorder or mental health disorder in 2019 in the state. In 2019, it is estimated that there were approximately 26,000 youth between 12-17 that had used an illicit drug in the past month, and about 74,500 youth 0-18 that had a serious emotional disturbance (SED).

According to Connecticut data, between January 1, 2011, and December 31, 2016, there was a 16% increase in the odds for maltreatment among caregivers with drug misuse, and specifically for caregivers with alcohol use those odds increased to 30%. By expanding the substance use services in Connecticut's continuum, CTDCF seeks to keep families safely intact as caregivers seek treatment.

Like substance use, Family First prioritized services to address the mental health needs of children as well as their caregivers. A 2019 survey indicated that parents with a serious mental illness were approximately eight times more likely to have CPS contact (Kaplan, Brusilovskiv, O'Shea, & Salzar, 2019). According to Connecticut data collected between January 1, 2011, and December 31, 2016, there was a 25% increase in the odds of a subsequent substantiation for caregivers with mental health issues. Based on this heightened risk for child welfare involvement, Connecticut seeks to enhance access to mental health supports to caregivers and families with mental health issues that impact parenting.

b. Disabilities

There is limited understanding in the United States about the incidence of parents with differing cognitive abilities within the child welfare system, but a 2011 study in Canada demonstrated that parents with intellectual disabilities are overrepresented in the child welfare system (McConnel, Feldman, Aunos, & Prasad, 2010). Furthermore a 2010 study reported that 27% of child maltreatment court-involved cases involved at least one parent with an intellectual disability and those parents with various disability labels were two times more likely than their peers without a disability label to experience child welfare involvement (Child Welfare Information Gateway, 2018). While research indicates that the majority of caregivers with disabilities can safely and effectively parent their children, Connecticut is seeking to provide support to those caregivers that report they could benefit from enhanced services to strengthen parenting, to keep their families safely together (Child Welfare Information Gateway, 2019c).

Children with complex needs are at two to three times the risk for abuse or neglect than children without disabilities (Jones, et al., 2012). According to Connecticut data, between January 1, 2011, and December 31, 2016, children with physical or developmental disabilities were 22% more likely to have subsequent substantiations. Connecticut does not have a precise estimate of the number of children with disabilities, but in 2019 there were 27,441 children and young adults, 0-22 years of age, identified as having a mental health disorder, substance use disorder, or disability.

Based on the fact that caregivers and youth with disabilities are overrepresented in the child welfare system, Connecticut would like to extend prevention services to this population. CTDCF leads the Connecticut Parents with Differing Cognitive Abilities Workgroup, which is a statewide partnership among public and private agencies and families seeking to promote system change and enhance capacity of professionals to serve parents of all abilities. Connecticut intends to continue to leverage the expertise of this workgroup to inform prevention planning. Connecticut will also collaborate with community partners to better support the particular needs caregivers and youth with disabilities may have outside of what Family First prevention services can address.

Infants born substance-exposed

Research indicates that infants born substance-exposed are at higher risk of coming into contact with the child welfare system at some point (Young, Gardner, Otero, Dennis, Chang, Earle, & Amatetti, 2009). In response to this heightened risk, Connecticut enacted a law, effective March 15, 2019, requiring birthing hospitals to make an online notification to the Department at the time of the birthing event of infants born substance exposed and/or those who experience withdrawal symptoms consistent with prenatal substance exposure. Between March-December of 2019, there were 1,206 such “CAPTA” notifications of infants born substance-exposed in Connecticut. CTDCF seeks to provide services to those families as soon as possible in order to prevent out-of-home placement.

Identifying Candidates and Pregnant and Parenting Youth in Foster Care

As outlined in the Family First legislation, only CTDCF staff will determine child-specific eligibility for prevention services. For the "known–to-CTDCF" population, eligibility will be determined initially at the Careline due to the fact that families associated with all accepted Careline calls will be eligible for Family First service. There are various opportunities during intake and routine casework, such as the administrative case review process, for Connecticut CTDCF staff to identify pregnant or parenting youth. Enhancements are being made to intake policy and procedures as well as case planning elements of

Connecticut's data system to prompt staff to identify youth that meet these criteria. All "known–to-CTDCF" populations' eligibility will be documented in Connecticut's data system, "LINK."

Table 6. Identification and documentation of "known-to-CTDCF" candidacy populations

Candidacy Populations "Known–to-CTDCF"	Staff Responsible for Identifying	Documentation
Families with accepted Careline calls	Careline staff	LINK
Pregnant and parenting youth in foster care	Intake worker or Ongoing Services worker	LINK
Siblings of youth in foster care	Intake worker or Ongoing Services worker	LINK

Families are referred to the VCM program from the CTDCF Careline, and therefore all families that CTDCF refers will be deemed eligible. Once Beacon Health Options assesses a family, a final determination will be made with the family about their needs and ultimate service referrals. The VCM Program is a contracted service, and a separate data system is managed by the contracted partner with relevant data reported to the Department. CTDCF anticipates refining this contract to ensure relevant child-specific data is collected and shared.

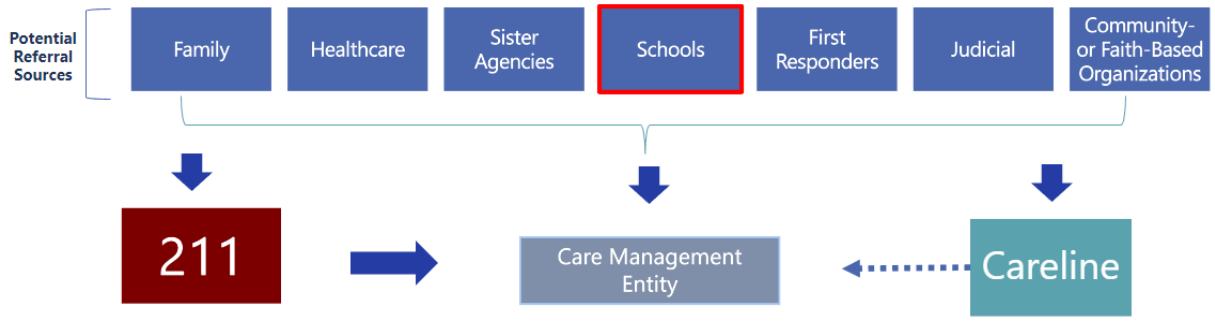
For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families. Once those elements are established, the CME will collaborate with community partners to identify and engage potentially eligible children and families. In order to identify community pathway candidates, Connecticut anticipates three primary entry points for referrals.

First, and most significantly, Connecticut will encourage partners such as schools, sister agencies, faith-based organizations, etc. to refer families directly to the Care Management Entity unless an observed safety concern indicates that a call to the Careline would be the appropriate response. Connecticut recognizes the development of partnerships between referral sources and the CME will require a significant educational campaign and will take time to develop the relationships necessary for it to become the preferred pathway to prevention services. By building relationships across referral sources, CTDCF anticipates it will be able to connect the wide range of candidates eligible for prevention services with the CME. Recognizing the necessity of a phased approach, Connecticut seeks to prioritize a partnership with schools during the early phases of the CME as schools have strong relationships and exposure to children and families, but also make up a significant portion of unsubstantiated calls to the Careline. To help inform our strategies related to a prevention partnership with schools, CTDCF has launched a prevention pilot program in collaboration with one of Connecticut's urban school districts in Waterbury at three elementary schools. The pilot officially launched for the 2021/2022 academic year with the goals of reducing chronic absenteeism and reducing calls to Careline where families present with underlying service needs that do not correlate with concerns of suspected abuse or neglect. The collaboration has focused on connecting families with services and resources in the community so that these families do not become involved with the child welfare system.

Second, because Connecticut anticipates that it will take time and resources to build a direct referral pathway from the community to the CME, CTDCF plans to capitalize on one of Connecticut's existing pathways to prevention services, 211. Because 211 already is a trusted pathway to services, Connecticut will work with 211 to make direct referrals to the CME for families that align with CTDCF's community pathway candidacy population.

Finally, when a mandated reporter or a family calls the Careline and the case is ultimately not accepted, the Careline worker will provide an indirect referral (i.e., information about the CME referral process) to the CME via the Mandated Reporter Letter.

While Connecticut anticipates ongoing learning about how to best build referral pathways to the CME, CTDCF is confident that these three pathways will facilitate sufficient referrals to initiate the CME.



In order to make an eligibility recommendation, the CME will first administer an assessment protocol (further explained in Section 4: Child Specific Prevention Plan) 1) to ensure there are no safety concerns that would be better handled by the Careline, 2) to identify risks, strengths, and needs that will inform case planning and service matching, and 3) to evaluate whether children and youth meet Connecticut's criteria for imminent risk and align with CTDCF's community pathway candidacy definition. Next, the CME will develop a child-specific prevention plan that includes approved Title IV-E prevention services that align with the identified child and family needs. Once the assessment protocol and the initial child specific prevention plan have been developed, the CME will make a recommendation to CTDCF about eligible candidates and CTDCF will make the ultimate determination regarding candidacy eligibility. While this determination decision will be essential for families to receive reimbursable Title IV-E services, it will not determine whether they are served by the CME. Connecticut intends to serve all families that come through the CME and intends to make candidacy determination a claiming decision that will happen behind the scenes and will not impact the family's service experience. CTDCF plans to develop a shared community portal that can interface with its CCWIS system in order for the CME to track all relevant Family First data elements.

Table 7. Identification and documentation of community pathway candidacy populations

Candidacy Populations Identified through Community Pathways	Staff Responsible for Identifying	Documentation
Families accepted for Voluntary Care Management Services	Careline staff	VCM Data System
Youth that have exited foster care	CME Staff with CTDCF	Community Portal
Children who are chronically absent from preschool/school or are truant from school	CME Staff with CTDCF	Community Portal

Children of incarcerated parents	CME Staff with CTDCF	Community Portal
Trafficked youth	CME Staff with CTDCF	Community Portal
Unstably housed/homeless youth	CME Staff with CTDCF	Community Portal
Families experiencing interpersonal violence	CME Staff with CTDCF	Community Portal
Youth who have been referred to a Juvenile Review Board, a Youth Service Bureau, or another diversion program; or who have been arrested	CME Staff with CTDCF	Community Portal
Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting	CME Staff with CTDCF	Community Portal
Infants born substance-exposed (as defined by the state CAPTA notification protocol)	CME Staff with CTDCF	Community Portal

Section 3: Title IV-E Prevention Services Description and Implementation Plan

Connecticut's Family First Prevention Plan is intended to enhance its current robust service array of empirically supported services and resources. CTDCF is grateful to the families, advocates, providers, sister agencies and program developers that have cultivated a state landscape equipped to meet a wide array of community needs. Because of this existing strength, Connecticut intends to continue to invest in the services, resources, and supports beyond Family First prevention services in order to serve children and families in a holistic way. Connecticut seeks to leverage Family First as a tool to expand and strengthen its service continuum, recognizing that the services on the Prevention Services Clearinghouse do not meet all the complex needs families may have.

In order to develop Connecticut's Family First prevention service array, the Programs and Services Workgroup engaged over 100 members including model developers, sister state agencies, providers, advocates, and families with lived expertise. This workgroup developed and implemented a rigorous process informed by implementation science to assess the services on the Prevention Services Clearinghouse, as well as programs and services not currently eligible for reimbursement, in order to develop the appropriate array to meet the specific intervention needs of the families that were defined as the candidacy groups for Connecticut's Prevention Plan.

Below are the steps the Programs and Services Workgroup took to make service recommendations to Connecticut's Governance Committee:

1. **Step 1**: The Programs and Services Workgroup utilized the expansive and diverse expertise of its membership to identify the specific intervention needs and desired outcomes for each of the candidacy populations that were identified by the Candidacy Workgroup, in order to ensure that the selection of programs and services could be best matched to strengthen families that would be served under Family First. Appendix A outlines these needs by candidacy population.
2. **Step 2**: The workgroup catalogued all relevant services in Connecticut, including, but not limited to those on the Prevention Services Clearinghouse; documented service information about each program (target population, duration, intensity, service location, research supported outcomes, etc.); and matched each Evidence-Based Program (EBP) to Connecticut's candidacy populations.

3. **Step 3**: Once this service-specific information was collected and organized, the Programs and Services Workgroup organized this list of services based on their levels of evidence:
    - Tier 1: "Well-Supported" programs on the Clearinghouse
    - Tier 2: "Supported" and "Promising" programs on the Clearinghouse
    - Tier 3: Services with the evidentiary support that may be eligible for an Independent Systematic Review (as evidenced by rating on the California Evidence-Based Clearinghouse for Child Welfare (CEBC) or Randomized Control Trials/Quasi-experimental studies)
    - Tier 4: Services in Connecticut that may be highly effective with families and aligned with the goals of Family First and should be considered for the broader Connecticut prevention service continuum
4. **Step 4:** Then, the Programs and Services Workgroup developed a set of criteria related to fit and feasibility to determine which EBPs should be shared with the Fiscal and Revenue Enhancement Workgroup for further consideration.
    a. **Fit Criteria:**
        i. Prioritization of EBPs matching three or more candidacy populations
        ii. Evidence of research with communities of color as evidenced by studies reviewed on the CEBC or the Title IV-E Prevention Services Clearinghouse
    b. **Feasibility Criteria**:
        i. Tier of evidence (1-4)
        ii. Wide availability in Connecticut, as defined by existing within three or more CTDCF regions

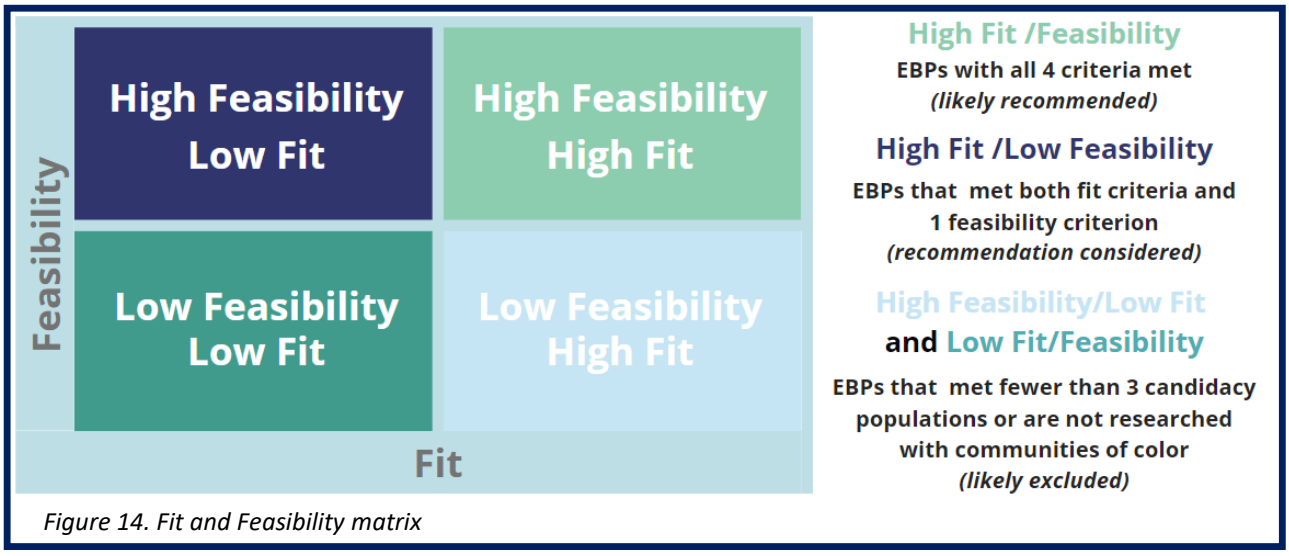


Figure 14. Fit and Feasibility matrix

5. **Step 5:** EBPs with high fit/high feasibility and those with high fit/low feasibility were passed on to the Fiscal and Revenue Enhancement Workgroup, which estimated the cost per unit for each EBP, analyzed alternative funding streams, and calculated cost benefit analysis potential with a 50% reimbursement rate.
6. **Step 6:** This analysis was passed on to the Governance Committee which made the ultimate recommendations to the CTDCF Commissioner.

Prevention Services Details and Rationale

Table 8. Connecticut Family First prevention service array

Practice	Target Population	Type of Service	Prevention Services Clearinghouse Rating	EBP model & manual
Functional Family Therapy	Youth 11-18 with behavioral or emotional difficulties and their families	Mental Health	Well-Supported	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy for Adolescent Behavioral Problems. Washington, D.C.: American Psychological Association
Multisystemic Therapy	Youth aged 12-17 with serious emotional/behavioral difficulties and their families	Mental Health & Substance Abuse	Well-Supported	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic Therapy for Antisocial Behavior in Children and Adolescents (2nd ed.). New York: The Guilford Press.
Brief Strategic Family Therapy	Families with children or adolescent (6-17 years) who display or are at risk of developing problem behaviors including drug use and dependency, antisocial peer associations, bullying or truancy.	Mental Health & Substance Abuse & Parent Skill-Based	Well-Supported	Szapocznik, J. Hervis, O., & Schwartz, S. (2003). Brief Strategic Family Therapy for adolescent drug abuse (NIH Pub. No. 03-4751). National Institute on Drug Abuse.
Parent Child Interaction Therapy	Children 2-7 and their parents/ caregivers	Mental Health	Well-Supported	Eyberg, S. & Funderburk, B. (2011) Parent-Child Interaction Therapy Protocol: 2011.PCIT International, Inc.
Nurse Family Partnership	First time, low-income mothers of children 0 - 2	Parent Skill-Based	Well-Supported	Consistent with current training and certification (Nurse Family Partnership, 2020).
Parents as Teachers	Families with children age 0-5	Parent Skill-Based	Well-Supported	PAT will be implemented as developed according to core trainings and curriculums (Parents as Teachers, 2016).
Healthy Families America	Families can be enrolled prenatally -up to 3 months postpartum and most families receive services for a minimum of 3 years.	Parent Skill-Based	Well-Supported	Consistent with current required model training and manuals for Healthy Families America (Healthy Families America, 2018).

Functional Family Therapy (FFT)

FFT is a clinical, home-based treatment offered to families with an adolescent between the ages of 11-18 years experiencing psychiatric, emotional, or behavioral difficulties including substance misuse. FFT is a strength-based model that looks to build upon protective factors and reduce risk factors that impact

adolescent behavior and well-being. The FFT model aims at helping families to identify patterns that lead to adverse symptoms and behaviors and seeks to support the family in developing more successful interactions and stability.

In Connecticut, FFT is currently provided to children and youth who have returned or are returning home from out-of-home care or psychiatric hospitalization and require intensive community-based services or are at imminent risk of placement due to mental health issues, emotional disturbance, or substance abuse. Connecticut has four providers offering five FFT teams located in four regions throughout the state.

Connecticut selected FFT to be part of its Family First service continuum because it has a strong infrastructure in the state and matches the needs of many of Connecticut's candidacy populations including those where services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Furthermore, there is interest in growing current capacity by the Court Support Services Division (CSSD) of the State of Connecticut Judicial Branch and there are opportunities to expand current provider caseloads and teams throughout the state. FFT data in Connecticut demonstrates strong outcomes indicating youth receiving FFT are more likely to remain in their homes, remain in school, and avoid arrest.

Connecticut selected FFT with the goals of improving outcomes for youth and families and reducing the use of out-of-home placements. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving FFT:

- Child Well-Being:
    - Improved behavioral and emotional functioning
    - Reduced delinquent behavior
    - Reduced substance-use
- Adult Well-Being:
    - Improved family functioning

For CTDCF to ensure the fidelity of FFT and monitor ongoing services, providers will report agreed upon metrics on a monthly basis. Metrics are detailed in the CQI section of this plan.

Table 9. Connecticut FFT outcome data

CT FFT Program Data for youth who completed FFT*			
	2017	**2018**	**2019**
% of youth who remained in home	97%	98%	98%
% of youth who remained in school	99%	99%	100%
% of youth with no arrests	95%	93%	96%

*Measures at discharge

Youth Functioning FFT Ohio Scales Results 2019 % Discharges with >= point increase in Functioning			
Race/Ethnicity	**Worker Rating**	**Parent Rating**	**Youth Rating**
White youth	63.9%	50%	44%
Hispanic youth	76.5%	65%	62%
Black Youth	70.0%	60%	45%
Statewide	67.8%	55%	48%

Problem Severity FFT Ohio Scales Results 2019 % Discharges with >= point increase in Functioning			
Race/Ethnicity	**Worker Rating**	**Parent Rating**	**Youth Rating**
White youth	67%	60%	48%
Hispanic youth	74%	72%	61%
Black Youth	75%	73%	58%
Statewide	70%	64.3%	51.3%

Multisystemic Therapy (MST)

MST is an intensive, in-home, community-based treatment for families of adolescents, 12-17 years of age, at risk of out-of-home placement because of delinquent or antisocial behaviors including substance abuse. MST engages the entire family and builds the capacity for caregivers to address current and future problems. MST therapists assess the youth's behavior in the context of the youth's full ecology including their family, peers, school, neighborhood, etc.

In Connecticut, MST is funded jointly by the Court Support Services Division (CSSD) and the Department of Children and Families (DCF) and is available statewide. Advanced Behavioral Health, Inc. (ABH) provides all training and consultation services for the 18 standard MST teams in Connecticut as a Network Partner of MST Services, and serves as the liaison between state contractors, providers, and key community stakeholders. ABH monitors data for quality assurance purposes and analyzes the data to be used for system improvements at the larger system level as well as at the agency and team levels. Connecticut has been implementing MST for more than 20 years.

Connecticut selected MST to be part of its Family First service continuum because, like FFT, it has a strong infrastructure in the state and matches the needs of many of Connecticut's candidacy populations including those where services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program, youth with a mental health or substance use disorder, etc.). Connecticut MST data demonstrates strong outcomes indicating youth receiving MST are more likely to remain in their homes, remain in school, and avoid arrest as evidenced by *Table 10*.

Connecticut selected MST with the goals of improving outcomes for youth and families and serving youth in their homes, thereby reducing out-of-home placements. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving MST:

- Child Well-Being:
  - Reduced out-of-home placement
  - Improved behavioral and emotional functioning
  - Reduced delinquent behavior
  - Reduced substance use
- Adult Well-Being:
  - Improved positive parenting practices
  - Improved parent/caregiver mental or emotional health
  - Improved family functioning

To ensure the fidelity of and to monitor MST services, CTDCF will receive regular reports from the service provider regarding specific child and family outcomes. These specific metrics can be found in the CQI section of this plan.

Table 10. Connecticut MST outcome data; includes CTDCF and CSSD cases

CT MST Outcomes				
	2017	2018	2019	**MST Benchmark**
% of youth who remained in home	92%	88%	88%	**80%**
% of youth who remained in school	82%	72%	70%	**80%**
% of youth with no arrests	79%	77%	69%	**72%**

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) is an intervention offered to families with children between the ages of 6-17 years that are at risk for or are displaying problem behaviors including substance use disorder, conduct problems and delinquency. BSFT uses a family systems approach in order to transform family interactions that perpetuate problems into more effective and adaptive interactions.

BSFT does not currently exist in Connecticut, however CSSD previously funded BSFT as part of its programming for moderate risk youth involved with the juvenile court system (from 2005 to 2013), with four providers and 14 teams across the state at its broadest dissemination level. CTDCF intends to learn from those past efforts. As available funding allows, CTDCF will begin to support the infrastructure and implementation of services models in our plan that would be new additions to the CTDCF service array, including BSFT.

Connecticut selected BSFT to be part of its Family First continuum because of its alignment with candidacy populations in which services would be initiated based on the behavior and needs of youth (VCM, siblings of youth in foster care, chronically absent youth, youth referred to a diversion program,

youth with a mental health or substance use disorder, etc.). Connecticut saw BSFT as an important addition to its continuum because of its broad target population age range, which would expand services to the often-excluded latency age population. Furthermore, due to the fact that BSFT was developed to respond to the cultural/contextual factors that influence youth behavior problems and its promising outcomes with communities of color and Spanish-speaking communities, Connecticut saw the addition of BSFT as an opportunity to provide more equitable, racially just, inclusive, and culturally responsive services.

Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving BSFT:

- Child Well-Being:
    - Reduced delinquent behavior
- Adult Well-Being:
    - Improved family functioning

Parent Child Interaction Therapy (PCIT)

PCIT is a treatment for children ages 2-7 years with emotional or behavioral issues and their parents and caregivers. It utilizes dyadic therapy that is conducted through "coaching" sessions where a therapist monitors parent and child interactions through a two-way mirror and communicates with the parent via a wireless communication device to build caregiver skills to manage the child's behavior.

While PCIT is not currently funded by CTDCF or any other Connecticut state agency, it has been installed by a number of therapists and a few community providers. As available funding allows, CTDCF will begin to support the infrastructure development and implementation of services models in our plan that would be new additions to the Connecticut DCF service array, including PCIT.

Connecticut selected PCIT to be part of its Family First service continuum because it matches the needs of Connecticut's candidacy populations whose services would be initiated based on the behavior and needs of younger children (VCM, siblings of youth in foster care, chronically absent youth, children with behavioral health disorders, etc.). PCIT is also culturally responsive and can be provided in multiple languages. It has demonstrated similar outcomes with parents who are impacted by intellectual and/or developmental disabilities.

Connecticut selected PCIT with the goals of improving outcomes for youth and families and preventing out-of-home placement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving PCIT:

- Child Well-Being:
    - Improved behavioral and emotional functioning
- Adult Well-Being:
    - Improved positive parenting practices
    - Improved parent/caregiver mental or emotional health

Connecticut's Office of Early Childhood (OEC) offers home visiting programs to improve the health of young children by providing supports and services to children and their families. OEC currently offers five different types of home visiting programs that are evidence-based, including Parents as Teachers

(PAT) and Nurse Family Partnership (NFP), and as of 2021, Healthy Families America (HFA). Prior to the recent expansion of home-visiting models in 2021, Connecticut OEC supported 2,000 home visiting slots statewide. These home visiting services are supported by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, an initiative funded by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF).

Nurse Family Partnership (NFP)

NFP is a home visiting program in which nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the needs/requests of the parent. It targets young, first-time, low-income mothers from early pregnancy through the child's first two years (Nurse Family Partnership, 2020).

In Connecticut, NFP is funded by OEC with support from the MIECHV program. OEC contracts with two NFP providers who support families across two Connecticut regions. Since 2012, the Visiting Nurse Association of Southeastern Connecticut has been providing NFP to families in New London and Middlesex counties, and in 2020 the New Milford Visiting Nurse Association expanded NFP to serve families in the western part of the state. Furthermore, in 2020 NFP merged with Child First - an evidence-based program for vulnerable young children and their families that is implemented across Connecticut. CTDCF expects that this partnership may support implementation and expansion of NFP in CT.

Connecticut selected NFP to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include first time mothers (pregnant and parenting youth in foster care, children with mental health or developmental disabilities, substance-exposed infants). NFP's existing infrastructure, combined with the expected expansion through OEC, exemplifies the strong NFP network in Connecticut.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving NFP:

- Child Well-Being:
  - Improved cognitive functions and abilities
  - Improved physical development and health
- Adult Well-Being:
  - Increased economic and housing stability

Table 11 Connecticut NFP outcome data [3]

NFP Target Outcome	Connecticut 2019 Data
Babies born full term	86%
Mothers initiated breastfeeding	93%
Babies received all immunizations by 24 months	100%
Clients 18+ employed at 24 months	57%

[3] https://www.nursefamilypartnership.org/wp-content/uploads/2020/04/CT_2020-State-Profile-1.pdf

Parents as Teachers (PAT)

Parents as Teachers is a home visiting parent education model that supports new and expectant parents/caregivers to develop positive parenting skills. It aims to increase parent knowledge of early childhood development and prevents child maltreatment by improving parenting practices (Parents as Teachers National Center, Inc, 2016).

In Connecticut, PAT is funded by the Office of Early Childhood with support from the MIECHV program. In 2021, OEC expanded the number of PAT providers it contracts with from 20 to 22 providers who serve families statewide.

Connecticut selected PAT to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include parents with children under 5 years of age (pregnant and parenting youth in foster care, chronically absent children (the Connecticut State Department of Education indicated there were 5,301 kindergarten students who were chronically absent in 2019), children with behavioral health or developmental disabilities, substance-exposed infants, etc.). PAT's existing statewide infrastructure combined with the recent expansion through OEC, exemplifies the established PAT network in Connecticut.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. The PAT curriculum has a demonstrated impact on improving outcomes for families at risk of child welfare involvement. Additionally, the program is culturally responsive and has shown effectiveness with non-white populations. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving PAT:

- Child Well-Being:
    - Improved social functioning
    - Improved cognitive functions and abilities

In order for CTDCF to ensure fidelity of the service and monitor ongoing progress, PAT service providers will send regular data relating to specific metrics. Information on the specific metrics can be found in the CQI section of this plan.

Healthy Families America (HFA)

HFA is a home visiting program for new and expectant parents/caregivers with children at a high risk of abuse or neglect or other adverse childhood experiences. Enrollment for HFA begins prenatally and can continue until three months after birth; most families are offered services for at least three years. HFA seeks to prevent child abuse or neglect by strengthening positive caregiver-child relationships, promoting healthy childhood growth and development, and enhancing family functioning by building protective factors and addressing risks (Title IV-E Prevention Services Clearinghouse).

HFA is newer to Connecticut and has a growing provider network that has been strengthened and expanded by Connecticut's 2021 Office of Early Childhood home visiting RFP. As of July 1, 2021, HFA is

offered by 9 agencies in four of Connecticut's six regions. Connecticut selected HFA to be part of its Family First service continuum because of its established infrastructure and its alignment with candidacy populations that may include parents with children under 3 years of age (pregnant and parenting youth in foster care, children with behavioral health or developmental disabilities, substance-exposed infants, etc.). CTDCF seeks to leverage OEC's investment in HFA to build programmatic infrastructure in the state.

Currently these services are aimed at families identified through OEC and eligible for MIECHV funding; Connecticut's goal is to use Family First as a lever to expand the reach of home visiting programs to the families identified through Connecticut's candidacy populations, including child welfare system-involved families or families at risk of child-welfare involvement. Connecticut also seeks to leverage the favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving HFA:

- Child Safety:
    - Reduced self-report of maltreatment
- Child Well-Being:
    - Improved educational achievement
- Adult Well-Being:
    - Improved parent/caregiver mental health
    - Improved parenting practices
    - Reduced substance abuse

Future Interventions under Consideration

Connecticut intends to seek additional evaluation partners and financial resources to support the following three EBPs as each has a strong infrastructure in Connecticut and demonstrates favorable outcomes with Connecticut's children and families. Connecticut currently partners with the Child Health and Development Institute (CHDI) of Connecticut for implementation and evaluation support for TF-CBT and seeks to leverage this partnership as it considers future evaluation opportunities.

Table 11. Future EBPs for evaluation and consideration in Connecticut

Service & Description	Target Population	Title IV-E Clearinghouse Rating
Multidimensional Family Therapy (MDFT): MDFT is an integrated, comprehensive, family-centered treatment to address youth problems and disorders and to prevent out-of-home placements.	Adolescents and young adults 9-26 years old with substance use, delinquency, mental health, academic/vocational, and emotional problems	Supported
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): TF-CBT is a clinical model for children and adolescents exhibiting symptoms associated with trauma exposure	Children and adolescents who have experienced trauma	Promising
Triple P – Positive Parenting Program – Standard (Level 4): Triple P-Standard is a parenting	Families with children up to age 12 who exhibit behavior	Promising

intervention for families with concerns about their child's moderate to severe behavioral problems	problems or emotional difficulties	

Connecticut plans to continue to engage the Programs and Services Workgroup as well as the Fiscal and Revenue Enhancement Workgroup in order to evaluate additional EBPs to meet gaps in addressing candidacy population needs.

There are a number of EBPs currently implemented in Connecticut that are on the Prevention Services Clearinghouse or in the Clearinghouse's queue that Connecticut intends to consider for future iterations of the Prevention Plan. As previously mentioned, Connecticut has a wide array of well-established treatment programs with strong bodies of evidence that demonstrate their efficacy. Connecticut intends to take a more in-depth look at the research base of these EBPs in order to determine whether an independent systematic review may be a viable option for future reimbursement.

Trauma-Informed Framework

Connecticut intends to build upon its existing trauma-informed, mental and behavioral health infrastructure, in order to deliver Family First EBPs within a trauma-informed framework. One of CTDCF's six cross-cutting values is Trauma-Informed Practice, which means delivering services to children and families with an understanding of the impact that trauma can have on their lives and using interpersonal skills to ensure that our work is supportive of trauma recovery and not re-traumatizing. It requires a partnership with all those involved with the child (caregivers, providers and other stakeholders), using the best available science to facilitate and support the recovery and resiliency of the child and family. Reflective of CTDCF's Strengthening Families Practice Model and the six Principles of Partnership, trauma-informed child welfare practice emphasizes the development of family-focused, strengths-based relationships with families to ensure the safety and well-being of their children.

In 2011, CTDCF was awarded a $3.2 million, five-year federal grant to develop the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT), in order to integrate trauma practices into all levels of the child welfare system. Through CONCEPT, CTDCF engaged the Child Health and Development Institute of Connecticut, Inc. (CHDI) and The Consultation Center, Inc. at Yale to develop the core components of CONCEPT and a statewide trauma-informed system of care has been built.

Training and support for child welfare staff has been prioritized to cultivate an understanding of childhood trauma and to build strategies around how to support children and families who have experienced adverse circumstances. CTDCF has since adopted the National Child Trauma Stress Network's (NCTSN) Child Welfare Trauma Training Toolkit, training more than 2,500 child welfare staff and implementing a Trauma-Informed Therapeutic Childcare model. Other relevant trauma-informed infrastructure developed as a result of the CONCEPT grant include:

- The development of a trauma screening tool (the Child Trauma Screen) to identify children suffering from trauma and who are in need of services
- The institutionalizing of trauma-informed policies
- Expansion of trauma-informed interventions like TF-CBT and Child and Family Traumatic Stress Intervention (CFTSI)

While there is existing language around delivering trauma-informed care in provider contracts, CTDCF intends to integrate the core tenets developed out of the CONCEPT framework into all Family First contracts including language about trauma training, trauma-informed policy alignment, and trauma-screening. CTDCF will co-create with providers, standard reporting methods and metrics to ensure services are being delivered in a trauma-informed manner.

CTDCF anticipates annual monitoring of this trauma-informed framework in alignment with the existing contract review and continuous quality improvement strategies. This includes asking contracted providers a set of questions to ensure programming includes key trauma-informed activities including:

- Trauma-informed written policies
- Training for staff and families regarding trauma and its impact on youth, families, and communities
- Supervisors equipped to guide case managers on trauma-informed care
- Trauma screening

Implementation Approach

Connecticut utilized a fit and feasibility matrix to determine which EBPs should be selected for its Plan. In terms of feasibility, Connecticut specifically considered levels of evidence, infrastructure and availability in Connecticut, as well as particular details regarding staff qualifications and service delivery. Connecticut has demonstrated a long-standing commitment to implementation of a wide array of EBPs with sustained focus on model fidelity, evaluation, and positive outcomes. This experience will be leveraged in the implementation of Family First.

Connecticut intends to serve its “known-to-DCF” candidacy population as well as families accepted for Voluntary Care Management services first. Furthermore, it will prioritize services with an existing infrastructure in Connecticut for initial implementation.

Well-Established EBPs in Connecticut

MST, FFT, NFP, and PAT are well established in Connecticut's service continuum and have existing provider networks that range from serving three regions of the state to a nearly statewide presence. This will allow Connecticut to build on existing efficiencies while also providing an opportunity for needed expansion. As these programs are already embedded in Connecticut, they have some level of quality assurance and fidelity monitoring in alignment with those developed by the model purveyor. Connecticut plans to initiate Family First implementation by leveraging existing contracts and/or expanding contracts and Memorandum of Understanding (MOU) with sister agencies for those programs primarily supported through other public agencies.

Emerging EBPs in Connecticut

HFA is newer to Connecticut and has a growing provider network which was strengthened and expanded by Connecticut's 2021 Office of Early Childhood in 2021. As the service provider network and quality assurance infrastructure develops as a result of the OEC’s actions, CTDCF will partner with OEC, contracted providers, and the HFA model developers for implementation.

As previously noted, PCIT is not currently funded by any public agencies in Connecticut, but there are a few therapists and community providers offering PCIT throughout the state. Connecticut has been communicating with peer jurisdictions to learn more about their efforts to develop and expand PCIT in

order to build a strong implementation rollout. There are particular training needs and start-up costs associated with PCIT to accommodate the model's two-way mirror and wireless communication device coaching strategy. As available funding allows, CTDCF will begin to support the infrastructure and implementation of services models in our plan that would be new additions to the Connecticut DCF service array.

EBPs new to Connecticut

BSFT does not currently exist in Connecticut, however the Court Support Services Division previously funded BSFT as part of its programing for moderate risk youth involved with the juvenile court system, with four providers and 14 teams across the state at its broadest dissemination. CTDCF intends to learn from those past efforts. As available funding allows, CTDCF will begin to support the infrastructure and implementation of services models in our plan that would be new additions to the Connecticut DCF service array.

Implementation of the Connecticut Prevention Plan will be informed by the ongoing guidance of the Governance Committee, the Implementation Team, and the CQI Workgroup. These teams include representatives from the provider community, sister agencies, families and youth, advisory and advocacy groups, and university partners.

This implementation structure promotes:

- Routine refinements and improvements during implementation planning and rollout
- Identification and (re)allocation of resources as needed
- Timely decision-making around policy- and program-related elements
- Ongoing monitoring of progress towards prioritized outcomes
- Executing and sustaining the desired transformation

Information gathered by the CQI Workgroup will be reviewed to ensure Connecticut's Prevention Plan is aligning with agency and statewide goals. This structure will facilitate the development of collaborative strategies to respond to any organizational or systemic challenges that arise. CTDCF's Continuous Quality Improvement Strategy Section will provide additional information regarding Connecticut's plan to implement Family First services successfully and with fidelity.

Section 4: Child-Specific Prevention Plan

Process for assessing service need

For Connecticut's "known-to-CTDCF" population, there are several tools and resources CTDCF case workers currently use to assess a family's service needs including the Family Strengths and Need Assessments (part of the SDM process), the Protective Factors Survey and the North Carolina Family Assessment Scale for General Services (NCFAS-G). These tools provide insight into strengths, needs, and goals of a family, and the results of the assessments are captured as part of the family's case plan.

For the community pathways population, Connecticut will ensure that the Care Management Entity[4] prioritizes family engagement as the first opportunity to begin understanding the strengths and needs of a family. As previously mentioned, the CME will be expected to conduct an assessment protocol for all families coming through the CME. This will include 1) an evaluation of safety; if there is a safety concern the CME will make a call to the Careline for further evaluation, and 2) an assessment of risks, strengths, and needs to inform case planning, and service matching. CTDCF will dictate within the CME RFP the necessity to use a 'periodic risk assessment' that meets the requirements outlined in the Family First legislation and that incorporates assessment characteristics identified by the Infrastructure, Practice, and Policy subgroup (i.e., tools that facilitate family engagement and trust-building) but will allow the CME to select the specific assessment.

As part of Connecticut's conversations regarding ways to improve collaboration with and empowerment of families, caregivers recommended that workers should establish a connection with the family before conducting formal assessments and noted the importance of focusing on the goals and needs that the family has determined for themselves. Therefore, Connecticut plans to build workforce capacity to use assessments as a tool for enhanced family engagement, in order to authentically partner with families to identify needs and capitalize on family expertise. Connecticut believes that stronger engagement practices will ultimately lead to improved assessment and identification of family needs.

"Wrap CT" was funded in 2006 in Connecticut in order to provide comprehensive mental health care to children and families through the Wraparound evidence-based service delivery model. Connecticut intends to leverage and build upon the existing workforce capacity around Wraparound values and principles in order to improve partnership and assessment of family needs.

Process for developing child-specific prevention plans

Family First requires that each eligible child must have a written prevention plan. For foster care candidates, the prevention plan must include the services to be provided as well as a foster care prevention strategy to ensure the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver. For parenting or pregnant youth in foster care, the prevention plan must list the services to be provided to or on behalf of the youth and describe the foster care prevention strategy for any child born to the youth. The child specific prevention plan will include language that indicates that the child has been identified as being at serious risk of entering foster care and that families' participation in prevention services is designed to prevent foster care entry.

Connecticut's process for developing a child-specific prevention plan aligns with the Department's commitment to a family-centered practice. Prevention plans will:

- Serve as a tool for dialogue and be completed in collaboration with the family
- Be written in language that the family understands
- Demonstrate that the goals are realistic and developed with a thorough understanding of the family's situation

[4] For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families.

For all of the "known-to-CTDCF" target populations, assessment of Family First eligibility as well as the child-specific prevention plan will be captured within Connecticut's child welfare information systems, including CT-LINK, PIE, and/or CT-KIND.

Voluntary Care managers will enter child-specific prevention plans for families receiving voluntary services into their data system, Service Care Connect, and will report the necessary child-specific data elements to CTDCF.

For Connecticut's community pathway population[5], CTDCF anticipates that child specific data will be entered into a community portal and the CME will share the relevant child-specific data elements with CTDCF to ensure Connecticut has the data necessary for Family First claiming and reporting. In the CME RFP, CTDCF will outline clear parameters for data sharing to ensure family data and privacy are protected. Connecticut seeks to build a firewall within its CCWIS system in order to collect the necessary data, but limit exposure of family data throughout the rest of the child welfare data system. Furthermore, families will be asked to consent with these data sharing parameters to ensure transparency and clarity regarding CTDCF's partnership with the CME. Services will be selected, and the child-specific prevention plan will be developed in partnership with the family while drawing on the results of the identified standardized assessment tools.

The completion date of the child-specific prevention plan will be captured in the following data systems:

- "Known-to-CTDCF" populations (i.e., pregnant and parenting youth in foster care, siblings in foster care) will be captured in CT-LINK.
- VCM families will be captured in Service Care Connect.
- Community pathway populations will be captured in a community portal.

For Connecticut's "known-to-CTDCF" population, eligibility will be determined using existing infrastructure at the Careline, reflecting the fact that all families associated with accepted Careline calls will be eligible for Family First. The child-specific prevention plan will be initiated at the Careline, as some demographic information is captured, but will not be completed until the case is assigned to an Investigations or FAR track. As caseworkers and families build a partnership and identify needs and strengths, they will collaboratively select and document appropriate services, including those supported by title IV-B subpart 1 and 2 funding, and finalize the child-specific prevention plans.

For pregnant and parenting youth in foster care, eligibility will be captured in CT-LINK and the identified services will be documented in the child-specific prevention plan which will be embedded into the youth's case plan. For the candidacy population of siblings of youth in foster care, CTDCF case workers will develop the child-specific prevention plan during intake when all members of the household are assessed.

For the community pathways population, Connecticut plans to integrate the child-specific prevention plan requirements into the assessment protocol conducted by the CME. It is anticipated that child specific data will be entered into a community portal and the CME will share the relevant child-specific data elements with CTDCF. The CME will engage families to assess their risks, needs, and strengths and

[5] For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families.

partner with them to select the appropriate services. Services will be selected in partnership with the family while drawing on the results of the identified standardized assessment tools. The required child-specific data elements will then become integrated into the youth and family's ongoing treatment plan.

For families accepted for VCM, Family First eligibility will be determined by the CTDCF Careline workers. Once services are identified through Beacon Health Options, services and the remaining elements of the child-specific prevention plan will be documented in their electronic system, Service Care Connect.

Case managers will be trained to engage families in conversation about their maltreatment risk factors, including the seriousness of the challenges and circumstances families are facing and the potential impact on the safety of their child(ren). As part of these conversations, case managers will communicate the purpose and intended outcomes of the title IV-E prevention services identified in their child's prevention plan.

For all Family First candidacy populations, Connecticut intends to use a standardized referral process. For the "known-to-CTDCF population," CTDCF will build upon existing referral processes, but plans to provide training to ensure greater uniformity across DCF regions and divisions.

For the community pathways population, Connecticut plans to develop standardized referral processes informed by the same approaches and resources used with the "known-to-CTDCF" populations. In order to develop this form and these processes, CTDCF plans to collaborate with its statewide partners and build upon best practices. The CME will be responsible for filling out referrals with a standardized set of criteria for community pathway families.

For both the "known-to-CTDCF" population and the community pathways population, CTDCF staff and Care Management Entity staff, respectively, will maintain frequent and regular contact with service providers and families to support service provision, assess progress made, and/or support needed adjustments to services, including those supported by title IV-B subpart 1 and 2 funding.

For each child, the candidacy determination date will be documented and tracked by CTDCF. For the "Known-to-CTDCF" populations, CTDCF will monitor case progress through case planning and communication with families, and service providers. Case workers for pregnant and parenting youth and siblings of youth in foster care will be prompted via a tracking process that will leverage administrative case reviews. Case workers will ensure a collaborative meeting between the family and service providers prior to the 12-month mark to discuss whether ongoing services are needed. Following that meeting, CTDCF will make the redetermination decision and will document it in CT-LINK.

For the community pathway population, the assessment protocol will be readministered every 6 months and the child-specific prevention plan will be reviewed every 6 months, or any time a safety or new risk factor is identified, and/or any time services are not having the intended result as reported by the service provider or the family. The CME will have regular contact with youth, families, and service providers regarding the child-specific prevention plan and general progress a family is making. CTDCF will identify what information is needed to make a redetermination decision and, based on the information gathered through the reassessment protocol and the ongoing communication about child specific prevention plan progress, the CME will provide a candidacy re-recommendation to CTDCF at 11 months and CTDCF will make a final candidacy re-determination before 12 months. The CTDCF IV-E

department in conjunction with the Central Office's Behavioral Health and Systems Departments will jointly make approval decisions for re-determination.

Section 5: Monitoring Child Safety

Connecticut sees monitoring child safety as directly tied to effectively assessing family needs and seeks to leverage Family First to prevent safety threats by addressing needs early. Furthermore, Connecticut intends to engage families and their natural supports as essential partners in monitoring, preventing, and addressing family safety concerns.

Initial and ongoing assessments of safety and risk are central to the work of Connecticut's child welfare staff. All of the "known-to-CTDCF" candidates undergo the SDM CT Family Safety and Risk Assessment as part of the intake process. Furthermore, case planning is done collaboratively and in close partnership with children and their families, which typically provides a more comprehensive understanding of the family's circumstances and needs. Case workers also regularly connect with professional partners such as educators, medical providers, and clinicians who are monitoring family safety as well. All safety monitoring is done within Connecticut's safety model, the ABCD Child Safety Practice Model (for further information see Section 1). The ABDC Child Safety Practice Model aims to ensure safety throughout all CTDCF's assessments, responses, services, and operations across the entire child welfare continuum. The ABCD model guides the daily interactions of employees, families, and community members in their work with the Department in conjunction with the standards of practice to achieve safety outcomes. Child and family team meetings are used as a forum for the full child and family team to identify strengths, needs, risk, and/or safety concerns and to collaboratively develop a plan to address risks or concerns as they arise. CTDCF will use these existing practices to ensure child safety for the "known-to-CTDCF" candidates receiving in-home services, including: (1) families with accepted Careline calls, 2) siblings of youth in foster care, or (3) pregnant and parenting youth in foster care. Furthermore, for pregnant and parenting youth in foster care, workers will ensure weekly visits for the first 30 days of foster care, and then move to monthly visits.

For all "known-to-CTDCF" candidates, case workers will continue to leverage these existing engagement and monitoring mechanisms (CFTMs, regular contact, the ABCD Child Safety Practice Model, the SDM tools, etc.) to update each child specific prevention plan and to identify whether a child's risk remains high, and services are still required during the 12-month period receiving Title IV-E prevention services. As with all cases the Department engages in, case workers will make modifications to the child specific prevention plan and will consider alternative strategies throughout the course of the case to ensure children remain safe and families continue to make progress. If at the end of the 12-month period, family risk and/or needs remain high, CTDCF will make a formal redetermination decision for "known-to-CTDCF" families and will ensure the child specific prevention plan and identified Title IV-E services align with current needs and maintain child safety.

The Voluntary Care Management (VCM) program works with families to help connect youth to high needs behavioral health services and support. The engagement process includes an explanation of the program, a review of behavioral health needs, and creating a crisis plan with the family. Crisis plans are developed within the existing plan of care and are in place to ensure that families have identified supports and contacts to connect with should a behavioral health incident occur. Crisis plans serve as a key element within the families' care plan and are revisited at least monthly with the family during

meetings with VCM care managers and the family. Furthermore, like all CTDCF staff, VCM staff are trained in CTDCF's ABCD Child Safety Practice Model to ensure they have the skills needed to prevent and identify child safety issues as they arise.

The VCM program provides authorization for clinical services and meets with providers and families on a regular basis to ensure the appropriate services are in place and that the youth's behavioral health needs are being met. During meetings with the family, the VCM care manager will complete informal assessments of both child risk and safety, and will discuss the family's progress, goals, and any barriers they are experiencing. Additionally, the VCM care manager meets with service providers at least every two months in which they discuss any identified risk or safety concerns, progress towards treatment goals, and, if needed, authorize on-going services. While the average service duration under the VCM program is currently 4-6 month, CTDCF will modify its current contract with Beacon Health Options to ensure that the VCM will make a redetermination recommendation to CTDCF prior to the 12-month period in the circumstance that services continue to be needed. This recommendation will be based on the information gathered through contact with the family and with service providers. The VCM will submit redetermination recommendations and an accompanying rationale to the CTDCF Regional System Program Directors, the current VCM contract monitor, who then will make the final candidacy redetermination decision.

For the community pathways candidacy population[6], the CME will initially evaluate a family's safety using a validated safety assessment tool that will identify whether current, significant, and clearly observable threats exist to the safety of the child or youth. If there is a safety concern, the CME will make a referral to the Careline for further evaluation. CTDCF will require that the CME have regular contact with the family and will conduct informal safety assessments during those contacts. Furthermore, service providers will also conduct informal safety assessments with families at every contact. Both CME and service providers will be mandated reporters and will be trained in CTDCF's safety practice model (ABCD Child Safety Practice Model) in order to ensure a clear understanding of how to identify safety threats and when a call to the Careline is necessary. However, as risks emerge, the CME and service providers will develop safety plans as needed and maintain ongoing communication to ensure families are receiving the services and supports necessary to keep children safely at home. In the event that families are not making progress on their identified risk areas, the CME will reevaluate the appropriateness of services and will consider new referrals. Connecticut is seeking to partner with the CME to facilitate a different experience for families when monitoring child safety. CTDCF believes that through relationship building, regular contact, and crisis planning, when needed, monitoring safety can be a collaborative and empowering experience that keeps children safe while equipping families to sustain safety and stability.

Monitoring the CME:

Because CTDCF is proposing to contract out many of the administrative elements necessary for the implementation of Family First in Connecticut, it is essential that it establishes clear and robust strategies for monitoring the CME. In order to provide adequate oversight of the CME, CTDCF proposes to 1) engage in intensive contract monitoring, 2) administer a well-developed and collaborative CQI

[6] For all aspects of Connecticut's implementation of the community pathways populations, CTDCF will require the partnerships, infrastructure, and resources be in place before contracting with the CME and serving community pathway families.

infrastructure, and 3) develop a shared data system that facilitates both contract monitoring and CQI mechanisms but preserves family privacy.

Contract Monitoring: As with all contracted services, Connecticut will appoint a Program Lead to be responsible for oversight and quality assurance regarding the specific contractual obligations of the CME. At CTDCF, Program Leads are currently responsible for ensuring quality implementation and addressing needed program improvement.

CQI Infrastructure: CTDCF intends to utilize the CQI Implementation Team to support the development of fidelity and outcome measures for the CME (details regarding the CQI implementation team structure can be found in Section 6). While the specific fidelity and outcome measures of the CME would be developed within the CQI implementation team, at a minimum CTDCF will require that the CQI Implementation team operationalize the following elements into fidelity and outcome measures:

1. The development of quality child specific prevention plans;
2. The selection of appropriate services that align with the family's needs;
3. Effective service referral and linkage processes and outcomes;
4. Appropriate monitoring, adjusting, and closing of child specific prevention plans based on the changing needs of families; and
5. Effective ongoing risk and safety monitoring.

The Program Lead will meet regularly with the CME to review data based on the specific outcome and fidelity measures designed by the CQI Implementation team and embedded in the CME contract. If deficits are identified, the Program Lead will meet with the CME to collaboratively identify strategies to improve fidelity and outcome measures.

Section 6: Evaluation Strategy and Waiver Request

At this time, Connecticut is seeking a federal evaluation waiver for each of the seven "well-supported" programs included in this Prevention Plan (i.e., FFT, MST, BSFT, PCIT, NFP, PAT, & HFA). In the future, Connecticut intends to pursue an evaluation for the three "promising" and "supported" EBPs named in this Prevention Plan (i.e., MDFT, TF-CBT, and Triple P), to continue to review additional services added to the Clearinghouse, and to consider whether any existing services in Connecticut have the evidentiary support to be considered for an Independent Systematic Review. Connecticut also intends to seek partnerships with data, research, and implementation experts to ensure continuous quality improvement efforts are identified and implemented for each EBP selected in this Prevention Plan.

Evaluation Waivers for Well-Supported Interventions

Connecticut is requesting an evaluation waiver for all EBPs selected in this Prevention Plan. The Family First Prevention Services Act suggests that an evaluation waiver is allowed for EBPs rated "well-supported" on the Clearinghouse as long as jurisdictions are able to meet the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II), as these programs already have a body of evidence demonstrating effectiveness. Connecticut is seeking evaluation waivers for Functional Family Therapy (FFT), Multisystemic Therapy (MST), Brief Strategic Family Therapy (BSFT), Parent Child Interaction Therapy (PCIT), Nurse Family Partnership (NFP), and Parents as Teachers (PAT), and Healthy Families America (HFA) as identified in *Table 12.*

Table 12. Connecticut evaluation waiver request and future evaluation plans

Evidence-Based Program	*CQI (evaluation waiver request)*	*Planned/Future Evaluation*
Functional Family Therapy	√	
Multisystemic Family	√	
Brief Strategic Family Therapy	√	
Parent Child Interaction Therapy	√	
Healthy Families America	√	
Nurse Family Partnership	√	
Parents as Teachers	√	
Multidimensional Family Therapy		√
Trauma-Focused Cognitive Behavioral Therapy		√
Triple P		√

Each of these EBPs has empirical evidence demonstrating positive outcomes in one of the domains highlighted by the Clearinghouse: child safety, child permanency, child well-being and/or adult well-being.

Connecticut is requesting an evaluation waiver for all "well-supported" EBPs selected for its Prevention Plan because each has met the following criteria:

1. Compelling **evidence of improved outcomes** related to child permanency, child safety, child well-being, and adult well-being
2. Research demonstrating **effectiveness and applicability across diverse populations**--Connecticut children and families come from diverse cultural, ethnic, and linguistic backgrounds which makes wide applicability an important characteristic of EBPs selected for the Connecticut Prevention Plan
3. **Evidence of alignment with a number of Connecticut's candidacy populations**. An important element of fidelity is ensuring that only children and families that meet the eligibility criteria of a specific EBP are referred to that service.

Below is the compiled evidence and waiver justification:

Evidence Review for Well-Supported EBPs

EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Functional Family Therapy (FFT)	FFT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of nine eligible studies indicating favorable effects on child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated FFT as "supported" with medium relevance for child welfare in the outcome areas of behavioral management programs for adolescents in child welfare, disruptive behavior treatment of children and adolescents and substance abuse treatment of adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Well-Being* - *Improved behavioral and emotional functioning* FFT has proven outcomes of addressing child behavioral and emotional needs and improving adolescent depression (Celinska, 2013; Slesnick, 2009). - *Reduced adolescent substance use* One study demonstrated that FFT resulted in reduced adolescent drug and alcohol use (Slesnick 2009). - *Reduced delinquent behavior* Research indicates that FFT reduces delinquent behavior specifically resulting in fewer out of home placements for delinquency and a reduction in reconvictions for property offense (Celinksa, 2018; Darnell, 2015).	Research indicates that FFT is effective with racially diverse populations. FFT has demonstrated positive outcomes in multiple countries and across various states in rural, suburban, and urban settings. Specifically, participants in the 2009 Slesnick study included adolescents and families that were predominantly non-white including Latino, African American and American Indian/Alaska Native youth. Another Clearinghouse-referenced study (Darnell, 2015) demonstrated that FFT resulted in decreased reentry into out-of-home placements for predominantly Latino and African American youth. As mentioned in Section 3, FFT in Connecticut has demonstrated positive	**Families accepted for VCM Services** - Research indicates that FFT can result in improved child behavioral and emotional functioning which is the primary reason youth are referred for VCM services (Celinska, 2013; Slesnick, 2009). **Siblings of youth in foster care** - Because FFT addresses issues within the family context, it is reasonable to conclude that siblings of youth in foster care that are experiencing emotional or behavioral difficulties may benefit from FFT. **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of a substance use disorder, or a behavioral or emotional challenge, there is evidence FFT could address those underlying behaviors (Celinska, 2013; Slesnick, 2009). **Youth who have been referred to a diversion program or who have been arrested** - Research indicates that FFT can result in reduction in delinquent behavior (Celinksa, 2018; Darnell, 2015).

	Adult Well-Being - *Improved family functioning* One study demonstrated that FFT contributed to the improvement of family functioning by reducing family conflict (Slesnick, 2009). As mentioned in Section 3, FFT in Connecticut has demonstrated positive outcomes for reduced out-of-home placement (as measured by remaining in home during the duration of services), reduced delinquency (as measured by no arrests during the duration of services) and improved educational engagement (as measured by remaining in school during the duration of services).	outcomes for communities of color.	**Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Research indicates that FFT can result in a reduced adolescent substance use.
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Multisystemic Therapy (MST)	MST was rated "well-supported" by the Prevention Services Clearinghouse based on the review of 16 eligible studies indicating favorable effects on child permanency as well as child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated MST as "well- supported" with medium relevance for child welfare in the outcome areas of alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment of children and adolescents, and substance abuse treatment of adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Permanency:* - *Reduced out-of-home placement*	Like FFT, MST has demonstrated positive outcomes in multiple countries and various states in a variety of service delivery settings. A number of studies reviewed by the Clearinghouse demonstrate that MST was provided to multi-ethnic, predominately African American, populations and was found to be effective in reducing delinquency-related outcomes including re-arrest rates, time incarcerated, and self-reported offenses	**Families accepted for VCM Services** - Research indicates that MST can result in improved child behavioral and emotional functioning which is the primary reason youth are referred for VCM services (Asscher, 2013; Dekovic, 2012; and Fonagy, 2018). **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of a substance use disorder, or a behavioral or emotional challenge, there is evidence MST could address those underlying behaviors (Asscher, 2013; Dekovic, 2012; and Fonagy, 2018). **Youth who have been referred to a diversion program or who have been arrested**

	MST has been shown to significantly reduce out-of-home placement for youth with problematic behaviors (Vidal, 2017). *Child Well-Being:* - *Improved behavioral and emotional functioning* Multiple studies demonstrate the MST is effective at improving adolescent emotional functioning and both internalizing and externalizing behaviors of adolescents, including antisocial or violent behaviors (Asscher, 2013, 2014; Dekovic, 2012; Fonagy 2018; Henggeler, 1997; Manders, 2013; and Ogden, 2004). - *Reduced delinquent behavior* Evidence indicates that MST is effective at reducing a range of delinquent behaviors including property offenses, subsequent arrests and adjudications, and violent and non-violent crimes (Asscher, 2013, 2014; Borduin, 1995; Butler, 2011; Fonagy, 2018; Henggeler, 1993, 1997; and Vidal, 2017). - *Reduced substance-use* One study indicated that MST is effective at reducing adolescent substance misuse (Fonagy, 2018). *Adult Well-Being:* - *Improved positive parenting practices* Several studies reviewed by the Clearinghouse demonstrate that MST contributed to improvements in positive parenting practices such as positive discipline, increased parental involvement, improvements in monitoring and supervision, and reductions in inconsistent discipline (Asscher, 2013; Dekovic, 2012; and Fonagy, 2018). - *Improved parent/caregiver mental or emotional health* MST has also demonstrated improvement in parent/caregiver mental and emotional health (Borduin, 1995; Fonagy, 2018).	(Borduin, 1995; Henggeler,1991).	- Research indicates that MST can result in a reduction in delinquent behaviors (Asscher, 2013, 2014; Borduin, 1995; Butler, 2011; Fonagy, 2018; Henggeler, 1993, 1997; and Vidal, 2017). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Research indicates that MST can result in reduced adolescent substance use (Fonagy, 2018).

	- *Improved family functioning* MST has been shown to contribute to overall improvements in family functioning, family satisfaction, family cohesion, and family communication (Bourdin, 1995; Fonagy, 2018). As mentioned in Section 3, MST in Connecticut has demonstrated positive outcomes for reduced out-of-home placement (as measured by remaining in home during the duration of services), reduced delinquency (as measured by no arrests during the duration of services) and improved educational engagement (as measured by remaining in school during the duration of services).		
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Brief Strategic Family Therapy (BSFT)	BSFT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of five eligible studies indicating favorable effects on child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated BSFT as "supported" with medium relevance for child welfare in the outcome area of substance abuse treatment of adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Well-Being* - *Reduced delinquent behavior* One study demonstrated that participants in BSFT improved behavioral and emotional functioning by reducing externalizing behaviors. The study also showed reductions in delinquent behaviors such as	BSFT was developed to respond to the cultural/contextual factors that influence youth behavior problems and has promising outcomes with communities of color and Spanish-speaking communities. The study participants of Horigian (2015) were 44% Hispanic/Latino adolescents and 23% African American youth; this study demonstrated positive outcomes in terms of reducing delinquent behaviors by reducing externalizing behaviors. The	**Families accepted for VCM Services** - Research indicates that BSFT can result in improved child behavioral and emotional functioning by reducing externalizing behaviors which is the primary reason youth are referred for VCM services (Horigian, 2015). **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of externalizing behavioral, BSFT could address those behaviors (Horigian, 2015). **Youth who have been referred to a diversion program or who have been arrested** - Research indicates that BSFT can result in a reduction in delinquent behaviors (Horigian, 2015).

	the number of lifetime and past year arrests and incarcerations (Horigian, 2015). *Adult Well-Being* - *Improved family functioning* One study showed that BSFT resulted in overall improvements in family functioning (Santisteban, 2003).	study participants of Santisteban (2003) were predominately Hispanic/Latino youth from various nationalities and demonstrated positive outcomes in family functioning.	
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Parent Child Interaction Therapy (PCIT)	PCIT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of 21 eligible studies indicating favorable effects on child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated PCIT as "well-supported" with medium relevance for child welfare in the outcome areas of disruptive behavior treatment (child and adolescent) and parent training programs that address behavior problems in child and adolescents. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Well-Being* - *Improved behavioral & emotional functioning* Studies demonstrate that participation in PCIT improves child behavioral and emotional functioning including child compliance, internalizing and externalizing behaviors, and overall reduction in problematic behaviors (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009, Schuhmann, 1998; and Thomas, 2011). *Adult Well-Being*	Evidence suggests that PCIT has demonstrated positive outcomes for children from diverse backgrounds (Capage, Bennett, & McNeil, 2001; Chadwick Center on Children and Families, 2004; McCabe, 2005). While PCIT was originally evaluated with predominately white children and families, it has since been evaluated with communities of color and has demonstrated positive effects with various populations including African American families (Fernandez, Butler, & Eyberg, 2011), American Indian/Alaska Native families (Bigfoot & Funderburk, 2011) and Latino and Spanish-speaking families (Borrego, Anhalt, Terao,	**Families accepted for VCM Services** - Research indicates that PCIT can result in improved child behavioral and emotional functioning which is the primary reason youth are referred for VCM services (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009; Schuhmann, 1998; and Thomas, 2011). **Children who are chronically absent from preschool/school or who are truant** - In circumstances where truancy is a result of a behavioral or emotional challenge, there is evidence PCIT could address those underlying behaviors (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009; Schuhmann, 1998; and Thomas, 2011). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - PCIT has been shown effective for children with a wide range of underlying

	- *Improved positive parenting practices* Multiple studies show that PCIT enhances positive parenting behaviors including supporting parents to use encouraging commands and praise, enhancing effective child- and parent-led play skills, and reducing the frequency of corporal punishment (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; McCabe, 2009; & Thomas, 2011). - *Improved parent/caregiver mental or emotional health* Two studies demonstrated that PCIT reduced parental stress, depression and anxiety (Leung, 2015, 2017).	Vargas, & Urquiza, 2006; McCabe & Yeh, 2009).	problems and psychological needs, such as ADHD (Leung, 2017), autism (Solomon, 2008), intellectual and developmental disabilities (Bagner, 2007), and disruptive behavior (Abrahamse, 2016). **Children who have exited to permanency** - PCIT has also demonstrated positive outcomes with children who have experienced maltreatment (Thomas, 2011).
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Nurse Family Partnerships (NFP)	NFP was rated "well-supported" by the Prevention Services Clearinghouse based on the review of 10 eligible studies indicating favorable effects on child safety and child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated NFP as "well-supported" with medium relevance for child welfare in the outcome areas of home visiting programs for child well-being, home visiting programs for prevention of child abuse and neglect, prevention of child abuse and neglect (primary) programs, and teen pregnancy services. <u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Safety* - *Reduced child welfare administrative reports* One study demonstrated that NFP reduced the likelihood of CPS reports (Mejdoubi, 2015). *Child Well-Being* - *Improved cognitive functions and abilities*	While NFP was initially evaluated with predominately white families, subsequent evaluations demonstrated positive outcomes for children from diverse backgrounds, specifically African American families (Kitzman, 1997) and Latino and Spanish-speaking families (Olds, 2002). In Connecticut, 15% of mothers receiving NFP in 2019 were Black or African American and 36% were Hispanic or Latino.	**Pregnant or parenting youth in foster care** - NFP could be offered to expectant or new mothers in foster care. **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Studies indicate that NFP can improve child cognitive functioning and abilities as well as their physical and developmental health (Kitzman, 1997; Robling, 2016; & Thorland, 2017). **Substance-exposed infants** - Since NFP has demonstrated outcomes for child health and cognitive functioning, NFP could be a good match for substance exposed infants (Kitzman, 1997; Robling, 2016; & Thorland, 2017). Furthermore, NFP has demonstrated outcomes for young mothers with health risk factors,

	A number of studies demonstrated that NFP resulted in enhanced child cognitive functions and abilities, specifically regarding improved visual attention and reduced language development concerns (Kitzman, 1997; Robling, 2016; Thorland, 2017). - *Improved physical development and health* A number of studies demonstrated that NFP resulted in enhanced child physical development and health including reduced yeast infections, fewer pre-term and early term births, and fewer instances of very low birth weight (Kitzman, 1997; Robling, 2016; & Thorland, 2017). *Adult Well-Being* - *Improved economic and housing stability* At least one study demonstrated that participation in NFP increased economic stability, specifically increasing the likelihood of a caregiver employment after birth (Olds, 2002). As mentioned in Section 3, NFP has demonstrated positive outcomes in Connecticut specifically related to improved physical development and health as well as improved economic and housing stability.		including those exhibiting behaviors such as alcohol and tobacco use. One study found that pregnant women who smoked and received NFP were more likely to quit smoking than women in the control group. Alcohol and tobacco cessation may have implications for other substance use disorders (Matone et al., 2012). **Unstably housed/homeless youth and their families** - While NFP would not be the only treatment or intervention needed for families experiencing homelessness, one study indicated NFP can increase economic and housing stability (Olds, 2002).
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations
Parents as Teachers (PAT)	PAT was rated "well-supported" by the Prevention Services Clearinghouse based on the review of six eligible studies indicating favorable effects on child safety and child and adult well-being outcomes. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated PAT as "promising" with medium relevance for child welfare in the outcome areas of home visiting programs for child well-being and prevention of child abuse and neglect (primary) programs.	PAT has demonstrated positive outcomes across the United States and in other countries. PAT was designed to be delivered to a diverse population of families, demonstrating efficacy with predominately Latina mothers (Wagner,	**Pregnant or parenting youth in foster care** - PAT could be offered to expectant or new mothers in foster care (Casey, 2018). **Children who are chronically absent from preschool/school or who are truant** - When participating in PAT, parents are taught to detect developmental delays earlier in their children and parents are

	<u>Favorable outcomes identified by the Prevention Services Clearinghouse:</u> *Child Safety* - *Reduced child welfare administrative reports* One study demonstrated that participation in PAT has been shown to increase child safety by reducing the occurrence of substantiated incidents of abuse and neglect. Specifically, there was a 22% decreased likelihood of substantiated cases of child maltreatment as reported by CPS for PAT families compared to non-PAT families (Chaiyachati, 2018). *Child Well-Being* - *Improved social functioning* PAT demonstrates favorable and statistically significant improvements on child social functioning including children scoring at or above their chronological age on the Self-Help Development Scale (Wagner, 1999). - *Improved cognitive functions and abilities* Two studies demonstrate that PAT improves child cognitive functions and abilities, specifically in regard to expressive language and general cognitive development (Neuhauser, 2018; Wagner, 1999). One of the studies reviewed by the Prevention Services Clearinghouse, was conducted in Connecticut with 7,386 participants between 2008-2011. This evaluation demonstrates that PAT already has positive outcomes in Connecticut, specifically related to reducing the occurrence of substantiated cases of child maltreatment (Chaiyachati, 2018).	1999) as well as African American mothers (Wagner, 2002).	better able to support school readiness and success (Neuhauser, 2018; Wagner, 1999). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - Studies indicate that participation in PAT results in improved social functioning and improved cognitive functions and abilities for children as parents are taught to recognize and respond to developmental or health issues (Neuhauser, 2018; Wagner, 1999).
EBP	Clearinghouse Outcomes	Effectiveness with Diverse Communities	Alignment with Candidacy Populations

Healthy Families America (HFA)	*Child Safety:* - *Reduced self-report of maltreatment* Participation in HFA has resulted in an increase to child safety due to a reduction in neglectful parenting behaviors, frequency of minor physical aggression, psychological aggression and frequency of severe and very severe physical abuse (Duggan, 2004; Mitchell-Herzfeld, 2005). *Child Well-Being:* - *Improved behavioral and emotional functioning* HFA has been shown to improve behavioral and emotional functioning by reducing both internalizing and externalizing behaviors (Caldera, 2007). - *Improved cognitive functions and abilities* HFA has proven efficacy in its ability to improve child cognitive functions and abilities as exhibited by an increase in scores on an infant mental health development index (Caldera, 2007). - *Reduced delinquent behavior* One study suggested that HFA results in reduced delinquent behavior, measured by a reduction in children skipping school (DuMont, 2010). - *Improved educational achievement and attainment* HFA has been shown to result in improved educational achievement and attainment, specifically measured by the learning children retain in 1st grade (Kirkland, 2012). *Adult Well-Being* - *Improved positive parenting practices* HFA has proven outcomes related to improved positive parenting practices evidenced by observations of parents guiding their children through various tasks (DuMont, 2008). - *Improved parent/caregiver mental or emotional health*	Research indicates that HFA is an effective intervention for families from diverse backgrounds. One study demonstrated that HFA is effective in reducing adverse birth outcomes for socially disadvantaged pregnant women; two thirds of those participants were Black or Hispanic women (Lee, 2009). Furthermore, another study found that pregnant American Indian adolescents who received HFA had significantly better outcomes including higher parent knowledge scores and maternal involvement scores as compared to mothers in the control group (Barlow, 2006).	**Pregnant and parenting youth in foster care** - HFA could be offered to expectant or new mothers in foster care (Jacobs, Easterbrooks, Bumgarner, Raskin, Fosse, & Fauth, 2015). **Children who are chronically absent from preschool/school or who are truant** - Not only does HFA have proven outcomes for improved educational achievement and attainment (Kirkland, 2012), it also demonstrates an improvement in child behavioral and emotional functioning, child cognitive functions and abilities, and positive parenting practices; all of which could address underlying contributors to chronically absent children (Caldera, 2007; Dumont 2008). **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting** - HFA has demonstrated outcomes that could address both child emotional and behavioral functioning (Caldera, 2007) and parent/caregiver mental or emotional health (Duggan, 2004; Duggan, 2007; McFarlane, 2013). **Families experiencing IPV** - HFA has proven outcomes for mothers with reported instances of intimate partner violence; specifically, mothers receiving HFA reported lower rates of physical assault victimization and significantly lower rates of perpetration

	Participation in HFA has resulted in improved parental mental health and decreased stress (Duggan, 2004; Duggan, 2007; McFarlane, 2013). - *Improved family functioning* HFA has demonstrated positive outcomes in family functioning and reductions in domestic violence (Bair-Merritt, 2010). HFA has been successfully implemented in Massachusetts and a number of the studies reviewed by the Clearinghouse were completed in Massachusetts (Easterbrooks, 2012, 2013; Jacobs, 2015, 2016; Tufts Interdisciplinary Evaluation Research, 2017). Connecticut and Massachusetts have geographical, regional, and demographic similarities; for example, in 2010, 88% of Connecticut's residents lived in cities and 92% of Massachusetts' residents lived in cities. These similarities and others suggest that implementation of HFA in Connecticut may be successful based on its success in Massachusetts.		relative to the control group (Bair-Merritt, 2010).

Continuous Quality Improvement (CQI) Strategy

CTDCF will partner with an experienced CQI entity to enhance CQI strategies for the "well-supported" evidence-based programs included in Connecticut's Prevention Plan as well as the activities of the Care Management Entity. CTDCF will also collaborate with the Office of Early Childhood, the current administrator of the early childhood home visiting programs in Connecticut's Prevention Plan (i.e., NFP, PAT, and HFA). Relatedly, CTDCF will work with the Court Support Services Division, the current MST contract holder in Connecticut. CTDCF intends to collaborate with a number of other partners including university colleagues, model developers, contracted providers, and youth and families with lived expertise.

CQI processes will be guided by *A Measurement Framework for Implementing and Evaluating Prevention Services (Framework)* developed by Chapin Hall at the University of Chicago (2020). The *Framework* identifies metrics to better understand the **reach** of the selected prevention services, to monitor the **fidelity and quality** of the selected prevention services and determine whether the EBP-specific **outcomes** and the overall Connecticut Family First **outcomes** are being achieved in order to course correct if needed.

Evaluation and CQI questions for Connecticut's Well-Supported EBPs

Informed by the *Framework,* CTDCF has developed a list of cross-cutting research questions that will be applied to all EBPs in Connecticut's Prevention Plan. All evaluation and CQI questions will be examined from the standpoint of racial equity; Connecticut plans to engage a diverse set of stakeholders and data to ensure it approaches Family First CQI with racial justice at the forefront.

A. Cross-EBP evaluation and CQI questions related to **reach**:
    a. Are Connecticut's Family First candidate children/families being identified and referred to prevention services?
    b. Are referred children/families enrolling in prevention services once they are referred?
    c. What are the characteristics of the Family First candidate children/families receiving prevention services and how/do they differ from referred children/families that are not receiving services? (i.e., is Connecticut equitably serving referred children/families referred to services)
    d. What is the length of time between referral to services and when children/families actually start services?
    e. What is the duration and intensity of children/families' prevention services involvement?
    f. How often do children/families complete services?
    g. Is there regional variation in referrals, service receipt, and service completion?
B. Cross-EBP evaluation and CQI questions related to **fidelity and quality**:
    a. Do the Family First candidate families being referred to prevention services meet the specific EBP eligibility requirements?
    b. To what extent are prevention services being delivered as outlined by the EBP model developers and associated manual/curriculum, (i.e., are service being delivered with fidelity to the model)?
    c. Are the same number of service sessions as outlined in the EBP model being delivered to Family First candidate families?
    d. Are prevention services being delivered with quality?

C. EBP-Specific Fidelity and Outcome Measures

1. Functional Family Therapy (FFT)
    a. Fidelity Measures

FFT has robust and well-established fidelity monitoring infrastructure. FFT provides training to teams of therapists plus consultation and practice to support model fidelity. All existing and any future Connecticut FFT providers have completed or will complete the three phases of development and training necessary for fidelity: 1) clinical training, 2) supervisor training, and 3) the maintenance phase.

FFT fidelity is assessed using various sources and from multiple perspectives from the family, supervisors, and therapists themselves. Clinical Services System (CSS) is FFT's web-based system used to monitor program fidelity based on the fidelity and dissemination adherence scores. Therapist fidelity is measured in part through the Weekly Supervision Checklist and the Global Therapist Ratings. The checklist is completed for each week's consultation and contains ratings for each case staffed for every therapist by supervisors after every staffing. Over the course of a year a therapist may receive up to 50 ratings providing critical information about therapists' adherence and competence for FFT. Periodically, the FFT supervisor rates each therapist overall adherence and competence in FFT which results in the Global Therapist Rating.

FFT fidelity monitoring will include completion of assessments which include pre posts, process, and outcome measures, along with fidelity rating of staffing and consultations with supervisors.

    b. Outcome Measures

EBP	Favorable Outcomes	Current CT Outcome Measures	Data Source(s)
FFT	• Reduction of youth substance use; • Reduction of youth delinquent behaviors; • Improvement of youth emotional and behavioral functioning; and • Improvement of family functioning.	• Percentage of youth, siblings, and caregivers who remain in the community. • Percentage of cases without an intensification of referral problems. • Percentage of youth attending school. • Percentage of youth without law violations. • Percentage of families without safety incidents.	• DCF Provider Information Exchange (PIE) • Clinical Services System (CSS)

2. Multisystemic Therapy (MST)
    a. Fidelity Measures

MST has a rigorous fidelity monitoring infrastructure and includes measures for both the therapist and the supervisor. The Therapist Adherence Measure Revised (TAM-R) is a 28-item measure that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. The TAM-R is administered monthly. The Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists (CEBC).

b. Outcome Measures

EBP	Favorable Outcomes	Current CT Outcome Measures	Data Source(s)
MST	• Reduction of out-of-home placement; • Reduction of youth substance use; • Reduction of youth delinquent behaviors; • Improved youth emotional and behavioral functioning; • Increased positive parenting practices; • Improved parent/caregiver mental and emotional health; and • Improved family functioning.	• % of youth living at home • % of youth with no new arrests • % of youth in school/working	• DCF LINK (current SACWIS) and eventually CT-KIND (future CCWIS) • DCF PIE • MSTI Data Collection Service collecting the Therapist and Supervisor Adherence Measures

3. Brief Strategic Family Therapy (BSFT)

a. Fidelity Measures

According to the CEBC, sites seeking to implement BSFT are required to demonstrate readiness for integrating the EBP into their organization. Because there are no active sites in Connecticut organizations seeking to implement will need to participate in the pretraining Organizational Readiness process in order to orient the staff with the essentials of the model. BSFT therapists are assessed after each session using the BSFT Adherence Certification Checklist which is based upon ratings of filmed clinical session. This tool is designed to assess how adept a practitioner is at implementing BSFT and to provide feedback that can be used to increase clinical skills and fidelity to the model. Initial ratings will be provided by the BSFT Institute Faculty until Connecticut providers develop their own BSFT Certified Supervisors.

b. Outcome Measures

EBP	Favorable Outcomes	Data Source(s)
BSFT	• Reduction of youth delinquent behaviors;	• BSFT Family Therapy Training Institute collecting the

	• Improved youth emotional and behavioral functioning; • Reduction of parent/caregiver substance use; and • Improved family functioning.	Adherence Certification Checklist data • DCF PIE (when providers are identified)

4. Parent-Child Interaction Therapy (PCIT)
    a. Fidelity Measures

PCIT has clinical fidelity tools as part of the standard PCIT protocols. More detailed research measures of therapist competency and fidelity have been developed for studying skill acquisition and fidelity and are available upon request. Because there are limited PCIT providers in Connecticut, CTDCF will require that PCIT providers are trained and meet all core competencies or have the PCIT International certification. In order to maintain fidelity to the model, PCIT providers will use a fidelity checklist for each session and will use specific parent handouts and the Eyberg Child Behavior Inventory (ECBI). CTDCF will require that PCIT providers ensure their room equipment is in good working order and PCIT providers participate in continuing education.

    b. Outcome Measures

EBP	Favorable Outcomes	Data Source(s)
PCIT	• Improved child behavioral and emotional functioning • Improved positive parenting practices • Improved parent/caregiver mental or emotional health	• PCIT Fidelity Checklist • Eyberg Child Behavior Inventory (ECBI) • DCF PIE (when providers are identified)

5. Nurse Family Partnership (NFP)
    a. Fidelity Measures

The two NFP providers that CT OEC already contracts with have completed the key pre-implementation steps necessary to implement NFP to fidelity. If CT DCF and CT OEC determine additional providers are necessary to meet the needs of children and families in CT, they will ensure all pre-implementation activities are completed. All nurses and their supervisors participating in a 9-month comprehensive training program to learn how to conduct in-home visits and engaging in ongoing education and training occurs for both new nurse home visitors and supervisors. Supervisors receive ongoing consultation to monitor and support the nurse home visitors.

NFP fidelity requires adherence to all 19 of the NFP Model Elements. Nurses collect client and home visit data as specified by the NFP National Service Office's (NSO) national database who then reports data back to agencies to assess and support implementation Agencies use these reports to monitor, identify and improve variances, and assure fidelity to the NFP model.

    b. Outcome Measures

EBP	Favorable Outcomes	Data Source(s)
NFP	• Reduced child welfare administrative reports; • Improved cognitive functions and abilities; • Improved physical development and health; • Improved economic and housing stability.	• NFP National Service Office collection of the 19 NFP Model Elements • OEC currently collects data; CTDCF will seek data sharing agreement in order to access necessary data elements

6. Parents as Teachers (PAT)

The PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report (CEBC). The PAT National Center monitors fidelity through the data collected within these annual reviews.

The PAT National Center provides technical assistance via state assigned National Center TA providers to any organization implementing PAT that requests assistance. This state-based TA includes support with fidelity monitoring culminating in an annual report. PAT providers are required to meet specific CQI measures known as the 21 Essential Requirements. If the provider does not meet certain benchmark percentages of the Essential Requirements, they must complete a "Success Plan" outlining how they will improve to meet benchmarks, participate in rapid CQI processes, and undergo technical assistance with an assigned PAT staff member. The provider becomes a "Provisional Affiliate" until minimum benchmark measures are met. Providers that meet at least 75% of PAT Quality Standards are recognized as exemplary "Blue Ribbon Affiliates", recognizing that these providers are delivering high-quality services to children and families. 10 of Connecticut's providers have already been named "Blue Ribbon Affiliates".

The PAT National Center expects affiliate providers to engage in CQI of service delivery and operations on an ongoing basis including: tracking and evaluating service delivery and outcomes, along with monitoring staff requirements such supervision, training and workload. All current and future Connecticut PAT providers will be expected adhere to these parameters.

c. Outcome measures

EBP	Favorable Outcomes	Data Source(s)
PAT	• Reduction in reports of child maltreatment; • Improvement in child social functioning; and • Improvement in child cognitive functions and abilities.	• PAT National Center collection of the 21 Essential Requirements • OEC currently collects data; CTDCF will seek data sharing agreement in order to access necessary data elements

7. Healthy Families America (HFA)

According to the CEBC, Prospective HFA providers are required to submit an implementation plan outlining their capacity to implement the model requirements. Providers are granted consultation phone calls to help identify implementation readiness and are provided with HFA Site Development guides. Furthermore, new providers are offered a 3-day Implementation Training by the HFA National Office as well as ongoing implementation support. The current HFA providers in Connecticut have completed these prerequisites and new sites will be required to follow the same protocol.

HFA requires local HFA providers to follow the HFA Best Practice Standards and to demonstrate fidelity to the standards demonstrated through periodic accreditation site visits. The HFA Best Practice Standards are both a guide to model implementation and the fidelity tool used to measure adherence to model requirements. There are 153 standards that providers are rated on and ultimately help measure the current degree of fidelity to the model. All HFA providers are required to complete a self-study of current site policy and practice. An external and objective peer review team uses this self-study along with a multi-day site visit to determine the sites rating (of exceeding, meeting or not yet meeting) for each standard.

Ongoing technical assistance, staff training, and periodic site visits are components of formal implementation support provided by the HFA National Office and serve as key elements of fidelity monitoring. For practice standards that providers are not in adherence with the HFA National Office provides CQI guidance and support to ensure fidelity and alignment with model.

b. Outcome measures

EBP	Favorable Outcomes	Current CT Outcome Measures	Data Source(s)
HFA	• Reduction in reports of child maltreatment; • Improvement in child behavioral and emotional functioning; • Improvement in child cognitive functions and abilities; • Reduction of delinquent behavior; • Increased educational achievement and attainment; • Increased positive parenting practices; • Improvement of parent/caregiver mental or emotional health; and • Improvement of family functioning.	• GED or high school completed • Median household income range • Housing status • Use of financial assistance (food stamps, Medicaid, TANF, and WIC)	• HFA National Office collection of compliance with HFA Best Practice Standards Fidelity Tool • OEC currently collects data; CTDCF will seek data sharing agreement in order to access necessary data elements

D. Cross-EBP research questions related to **outcomes**:
    a. Well-being
        i. Do children/families that receive prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (*this will be tailored to the EBP-specific program goals*)?
        ii. Do children/families that complete prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (*this will be tailored to the EBP-specific program goals*)?
    b. Safety
        i. Does receipt of prevention services reduce maltreatment? Are children referred or re-referred for suspected child maltreatment within 12 months of the child-specific prevention plan start date? Within 24 months?
        ii. Does prevention service completion reduce maltreatment? Are children referred or re-referred for suspected child maltreatment within 12 months of EBP service completion? Within 24 months?
    c. Permanency
        i. Does receipt of prevention services reduce foster care entry? Do children enter foster care within 12 months of the child-specific prevention plan start date? Within 24 months?
        ii. Does completion of prevention services reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?
    d. Racial Equity
        i. Are prevention services reducing the racial and ethnic disparities in Connecticut's substantiated cases or foster care entry rate?
        ii. Are Connecticut families of color experiencing better mental health, substance abuse, and parenting outcomes as prescribed by each EBP?
        iii. Are there differences in how families experience prevention services provision across racial and ethnic groups?

CQI Implementation Team Structure

CTDCF has developed a rich infrastructure for collaborative program design, implementation, data sharing and service delivery statewide. This infrastructure includes Memoranda of Understanding (MOUs) between EBP model developers, other state agencies, the CT Judicial Branch, academic centers, and a network of community adolescent and family behavioral health providers serving every region of the state. CTDCF will leverage this infrastructure to build its Family First Implementation team as well as its CQI Workgroup. Connecticut will work with its Governance Committee and the emergent Implementation team in order to make decisions around CQI in Connecticut. These teams will include representatives from the provider community, sister agencies, families and youth, advisory and advocacy groups, and university partners.

Intended Family First CQI leads and partners

Internally, the CTDCF Bureau of Strategic Planning will lead the CQI Workgroup and CQI efforts in Connecticut in partnership with internal and external groups mentioned below. Like all other Family

First workgroups, Connecticut intends to engage partners to co-lead and participate in the CQI Workgroup. The Bureau Chief of Strategic Planning and her team will coordinate the CQI Workgroup and will meet quarterly to review data reports, plan and monitor improvement goals, and address challenges identified by stakeholders. The CQI team will then report to the Governance Committee and Implementation Team with their findings.

Below are the internal and external partners CTDCF intends to engage for its CQI Workgroup and efforts.

- The *Bureau of Strategic Planning* encompasses *Quality Improvement (QI), Quality Assurance (QA), and Performance Management (PM):* QI includes all efforts to provide strategies for improvement of the practice; QA provides ongoing review of CTDCF practice; PM includes the provision of performance data and oversight of the overarching performance goals and outcomes for the agency. The Bureau will be responsible for leading and coordinating the CQI strategy and providing the monitoring and management of the well-supported interventions. These responsibilities will include cleansing, analyzing, and reporting data on EBPs and other evaluation and CQI questions described above, as well as engaging EBP providers and other stakeholders in quality improvement activities that address concerns discovered in the evaluation findings.

- *CTDCF Program Leads:* Primarily responsible for the oversight and quality assurance regarding the specific contracted services and ensuring quality implementation and needed program improvement. Program Leads will work with EBP model developers to identify and develop reports on specific outcomes.

- The *Academy for Workforce Development:* Primarily responsible for training and support of field practices that advance the goals of high-quality assessment, referral, case planning, and service delivery in Connecticut.

- *Connecticut Office of Early Childhood:* Primary contractor for home visiting EBPs, and therefore will provide insights and guidance on CQI for HFA, PAT, and NFP.

- *Court Support Services Division:* Contractor for EBPs associated with delinquency and therefore will provide insights and guidance on CQI for FFT, MST, and BSFT.

- *Community pathway partners:* Potential community pathway referral sources (i.e., schools, police departments/fire departments/EMS, courts, healthcare providers, sister agencies, and community- or faith-based organizations, etc.) will provide insight into the referral process and the ability to connect families with Family First services through the care management entity.

- *Contracted provider organizations:* Primary responsibility for implementing Connecticut's prevention services in coordination with CTDCF, OEC, and CSSD. Ongoing responsibilities will include collecting and reporting intervention-specific fidelity monitoring and outcome data and implementing performance improvement activities.

- *Model developers/trainers:* Primarily responsible for training and support of providers implementing Family First EBPs.

- *Youth and Families:* Primary responsibility for providing feedback on service delivery and receipt.

Current CQI strategies

CTDCF intends to build upon the internal and external CQI strategies and frameworks as a starting place for its Family First CQI structure. Below are ongoing strategies Connecticut currently employs to ensure performance and outcome monitoring:

- *Service Development Plan and Corrective Action Plan*: CTDCF utilizes a standardized performance management process that relies on collaborative implementation of a Service Development Plan (SDP) when deficiencies in a program are identified. If the SDP fails to correct the deficiency, a formal Corrective Action Plan is implemented along with the CTDCF Contract Division.

- *Contracted Services*: All contracted services in Connecticut have performance expectations and specific outcomes. The performance and outcome data collected are utilized to assess progress towards intended outcomes for Connecticut's families, and to assess whether services are achieving intended benefits. CTDCF Program Leads meet with provider agencies regularly to review data based on the specific outcome and model fidelity measures that are outlined in contracts. If deficits are identified in the performance expectations and outcomes, the Program Leads along with the model developers meet with agencies to collaboratively identify strategies to improve outcome measures. If continued challenges exist, programs could be placed on a Corrective Action Plan, up to and including termination if the deficiencies fail to be corrected.

- *Training and TA*: CTDCF has a longstanding practice of contracting with model developers for training and technical assistance to ensure model fidelity. CTDCF currently has contracts with all model developers for EBPs currently in place.

- *Data collection*: All EBP models and CTDCF require data systems that collect information on clients served. In addition, the EBP models require information on staff training and progress toward certification in the model. These data include staff participation in initial and booster training sessions, any necessary technical assistance, documentation of sessions (submission of recorded sessions); and track the content, frequency and duration of sessions. For each EBP fidelity reviews are conducted that analyze all the data collected. These reviews typically include CTDCF Program Leads, the EBP model developer, and providers. CTDCF conducts two levels of reviews: system reviews and individual provider reviews. System fidelity reviews look at these data in aggregate, while the fidelity review of the individual program looks at provider specific data. CTDCF, in partnership with the EBP model developer, will combine these data into dashboard reports and share with providers to inform discussion during fidelity review meetings that occur quarterly.

Data sources:

Data reporting is an essential function of the CTDCF Bureau for Strategic Planning and includes provision of data from Connecticut's LINK, Results-Oriented Management (ROM) Reports, Provider Information Exchange (PIE), and CT-KIND systems.

CT-LINK: LINK is CTDCF's statewide automated child welfare information system (SACWIS), which is being updated to the current federal requirements for child welfare information systems

(CCWIS) and will become *CT-KIND*. LINK is CTDCF's system of record utilized by staff to document and record case related activity as well as to reflect and record engagement activities and other data.

ROM: The Results-Oriented Management (ROM) Reports system was built and maintained by the University of Kansas (KU) School of Social Welfare, in conjunction with CTDCF Strategic Planning and Information Systems staff. The system is available to CTDCF staff and contains a collection of automated reports concerning the safety, permanency and well-being of the children that we serve. The system allows staff to view pending work as well as trends in performance over time, and comparisons of unit performance.

PIE: The PIE system is utilized by CTDCF and providers as the data and reporting solution for community-based programs across CTDCF mandate areas, including the EBPs identified in this plan that currently exist (additional EBPs identified in this plan that are not currently in existence will also be added to the PIE system). PIE provides key outcome data regarding our families and service provision and allows staff to assess utilization of services, assess and monitor service quality, and manage programs and contracts with data. PIE includes data for behavioral health programs, child placement programs, and child welfare programs as well as data regarding non-CTDCF clients for some programs as well. The PIE system can produce quantitative data, and qualitative data can be obtained from the Program Leads, Systems Program Directors, CTDCF staff, and the providers as well.

Data reporting is further informed by CTDCF's Statistician who can provide complex analysis of agency data. Qualitative data can be obtained from LINK records in combination with record review and interviews and/or focus groups.

CTDCF and the EBP model developers use web-based HIPAA and HITECH compliant databases to record client specific information, to aggregate this information across the network, and to develop reports that document system functioning, as well as individual services and outcomes to monitor program fidelity.

In addition, EBP model developers have their own web-based systems where they collect from providers information related to the type of services clients receive, frequency, content and duration of sessions; EBP skills utilized in sessions; and outcomes data. Connecticut will modify contracts as needed to ensure all necessary quality improvement data is being collected from each provider, including the data reported to model developers. Connecticut intends to utilize these data systems and others to inform its CQI efforts

Section 7: Child Welfare Workforce Training and Support

Connecticut is well poised and committed to ensuring that quality, effective, and efficient services are provided to children and families throughout the state. To demonstrate this commitment, Connecticut places an emphasis on training support for the CTDCF child welfare and provider workforce so that they are expertly trained on a competency-based, trauma informed curriculum that encompasses best practice through an intentional racial justice lens.

Ensuring that the workforce has a comprehensive understanding of being trauma informed not only supports a well-developed workplace but also reinforces the important professional development

perspectives of caregivers with lived experience. As discussed earlier in this plan, community conversations were held with caregivers throughout the state. Among the many identified cross-cutting themes was the need for the workforce to demonstrate a deeper understanding of trauma and the impact it has on children and families.

Caregivers also expressed that in addition to a strong trauma-informed knowledge base, ensuring that the workforce understands the importance of being genuine, flexible, and understanding is key to positive relationship building which leads to positive outcomes for children, youth, families and communities.

Commitment to the caregiver voice and the comprehensive development of the workforce further illustrates Connecticut's prime positioning to leverage Family First. CTDCF provides training through the Academy for Workforce Development, which prepares caseworkers to understand the specific details of Family First and available EBPs. This training is vital as caseworkers are invaluable in the process of identifying, referring, and supporting services available to Connecticut's children and families.

EBP provider workforce

To support implementation of Family First, the EBP provider workforce will be trained on the unique EBP model requirements, to ensure fidelity and long-term sustainability. To that end, the Department recognizes that having a lead entity for EBP workforce training is critical particularly for the ongoing support and coaching that is needed for fidelity. The Department plans to contract with an outside entity to partner in this task, as available funding allows.

For monitoring purposes, the Program Leads will meet with provider agencies regularly to review data based on the specific outcome measures and model fidelity measures that are outlined in CTDCF EBP contracts.

Child welfare agency workforce

Through the Academy for Workforce Development (the Academy), the Department currently offers a robust training curriculum of pre-service training, in-service training, mandatory trainings, simulation training and leadership development training for its child welfare workforce. These trainings are designed to ensure that the workforce is equipped with the requisite skills and knowledge needed to support a prevention-oriented system. Each training category offers a cadre of courses that are trauma informed, competency-based and reflective of the Department's commitment to racial justice. Courses are also intentionally aligned with skill building opportunities to demonstrate on the job learning through practical applications.

For example, pre-service offerings for new child welfare staff include a two-day trauma training, behavioral health training, a two-day Structured Decision Making (SDM) training and a course focused on effectively engaging families, to name a few. In-service or ongoing course offerings are ever evolving to meet the diverse training needs of the workforce. Key among the many in-service courses currently offered to support Family First are: Assessing Safety and Risk during the interview process, SDM Safety Planning and Critical Thinking Skills.

To ensure workforce readiness for Family First, the Department plans to develop and launch a Family First Overview training that introduces both new hires in pre-service training and ongoing caseworkers in in-service training to the Family First legislation as well as practice and outcome implications. More specifically, the overview training will introduce a clear process for understanding service eligibility for

known-to-CTDCF Family First candidates; and address the newly developed Child Safety Practice Model, the development of child specific prevention plans, the program and service array, and using risk and safety assessments (the SDM tool). The overview training will also further contextualize family engagement in the assessment process, and will be augmented through periodic CTDCF communication strategies, self-guided training opportunities, infographics, micro-learning collaboratives with a coaching component and reinforcement in other Department wide mandatory training opportunities.

The Academy will ensure that the overview training is reinforced through a series of periodic supplemental trainings. To ensure that a prevention lens is embedded in practice, supplemental trainings will be designed to reinforce skill development in translating the need for services or supports, especially needs to prevent safety issues. The supplemental trainings will also serve to reiterate clear and uniform practices around consistent and clear documentation.

These competency-based trainings will be assessed continually by the Academy in partnership with CTDCF area office leadership. The Academy will take the lead in augmenting the training content to better increase the competency level of staff to ensure increased familiarity with the requirements of Family First. As additional training is needed, supervisors will engage coaching tools and techniques to strengthen practice proficiency in their staff. Adjustments to trainings will be addressed to support the needs of the workforce. Skill building related to racial justice outcomes and work with specialized populations, including those with intellectual developmental disabilities or with autism spectrum disorder, will be enhanced by employing quality improvement strategies, such as case reviews. Adjustments will be made when needed to promote quality casework and increased caseworker time dedicated to achieving positive outcomes for children, youth, and families.

Voluntary Care Management agency workforce

To ensure that all VCM employees have an accurate and in-depth understanding of Family First legislation and its impact on their work, CTDCF will modify the existing contract with Beacon Health Options to include mandatory Family First-specific training to orient all new staff. These trainings will cover a number of topics, but will at a minimum cover skills and strategies needed to develop, adjust, and monitor child specific prevention plans including strategies for identifying the information needed to make a candidacy redetermination recommendation to CTDCF. As previously mentioned, VCM workers also will be trained in the ABCD Child Safety Practice Model. These training required for VCM workers will be competency-based and in the interim, will be provided through the existing Community Academy (formerly known as the 'Provider Academy' and housed within the Academy of Workforce Development). However, after the curriculum and resources have been developed, CTDCF plans to share this material with Beacon and it will become part of the VCM contractual responsibility to ensure staff are equipped to adhere to Family First requirements. In order to facilitate this transition in responsibility, CTDCF will also develop a train-the-trainer model for Family First trainings to ensure quality. Furthermore, Beacon Health Options is contractually obligated to provide ongoing staff development and education to VCM staff that cover areas like trauma-informed care, case management, service referral, etc.

Community Pathway workforce

Similar to the VCM training strategy, CTDCF intends to outline clear guidelines in the CME RFP around the skills and competencies necessary within the CME workforce. The CME will be responsible for providing ongoing staff development and education, however like with the VCM, CTDCF will require and coordinate mandatory Family First orientation trainings including skills and strategies needed to

develop, adjust, and monitor child specific prevention plans including strategies for identifying the information needed to make a candidacy redetermination recommendation to CTDCF. Because the initial Family First trainings will be provided through the existing Community Academy, CTDCF plans to implement a train-the-trainer model and share the curriculum and training resources with the CME in order to ensure training quality.

Section 8: Prevention Caseloads

Identifying an appropriate caseload size is one important aspect of equipping CTDCF staff to support families in achieving positive outcomes. As Connecticut transforms into a system of well-being, family engagement and effective case management become even more paramount to successful prevention or intervention services.

Connecticut has developed weighted caseload standards, designed to tailor social worker caseloads based on the circumstances of a case or a family.

Below are Connecticut's maximum caseload standards with the targeted 75% of caseload goals per category:

- Investigators: 17:1; (*12.75:1, 75% of caseload)*
- In-home treatment workers: 15:1; (*11.25:1, 75% of caseload)*
- Adoption and Adolescent specialty workers: 20:1; (*15:1, 75% of caseload)*
- Social workers with a mixed caseload cannot exceed the maximum weighted caseload derived from these caseload standards

For Connecticut's "known-to-CTDCF" population, the caseload standard for social workers with Family First prevention cases will align with the weighted caseload standards determined by the particular circumstances of each candidacy population (e.g., pregnant and parenting youth in foster care likely would be assigned to Adolescent Specialty Workers who have a targeted caseload of 15:1).

For Connecticut's Voluntary Care Management (VCM) population, the caseload is dictated both for the VCM overall and for individual case managers. The VCM will serve a minimum of 260 nonduplicated families each year. Each VCM care manager will serve between 10 and 30 families at any one time. In addition to the care managers, each case will have the supervisory support of a clinical supervisor who will provide oversight and feedback as needed. Additionally, a clinical liaison will aid in referrals to services, service follow-ups, and data entry. Finally, a claim processor will assist in entering and processing claims and adjustments.

For CT's community pathway population, CT will work with the CME to determine appropriate caseload sizes based on the experience levels and expected activities of the staff working with families receiving Family First prevention services. CTDCF anticipates at least three key roles within the CME including 1) Assessment Specialist responsible for assessing families and making candidacy recommendations to CTDCF, 2) Care Coordinators responsible for the ongoing case management of Family First candidates, and 3) Clinical Supervisors to provide guidance and support to these other two positions. CTDCF intends to work with the CME to develop a minimum expected annual caseload as well as a caseload range for each CME staff. This will depend on how quickly the community pathway can be established and the level of needs identified among the families the CME is serving.

As Connecticut works to prioritize in-home service delivery alongside family stabilization and preservation, CTDCF will continue to review current strategies and seek opportunities to improve the ways in which the system effectively engages and partners with families.

Section 9: Assurances on Prevention Plan Reporting

Connecticut provides an assurance in Attachment I that CTDCF will report to the Secretary the required information and data regarding the provision of services and programs included in Connecticut's Title IV-E Prevention Plan. Data will be reported as specified in federal guidance (Children's Bureau 2019, 2020). See Attachment I, State Title IV-E Prevention Program Reporting Assurance.

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APPENDICES

APPENDIX A: CT Candidacy Population Identified Population Needs

1. **Families with accepted Careline calls**
   Identified population needs:
   a. Reducing trauma reaction
   b. Reducing substance use
   c. Addressing behavioral health needs
   d. Maternal depression
   e. Behavioral health needs of and parenting strategies for children with special health care needs or developmental or intellectual disabilities
   f. Increasing supports within the natural ecology
   g. Parenting skill focus (to reduce abuse)
   h. Reducing family violence
   i. Pre-natal treatment for mothers

2. **Pregnant and parenting youth in foster care**
   Identified population needs:
   a. Appropriately matched for this developmental stage
   b. Promotes independent living skill development
   c. Assists with long-term planning (e.g. education, employment)
   d. Promotes self-sufficiency
   e. Promotes youth connections (social network and community supports)
   f. Needs assessment and connection to services/resources (e.g. mental health or substance use treatment; entitlements; healthcare)
   g. Supports youth in finding and maintaining stable housing
   h. Parenting education (milestones, prenatal care, caring for newborn/infant)
   i. Added assessment of need and coordination of care for medical, pediatric, childcare, early childhood resources, etc.
   j. Good pregnancy outcome
   k. Promotes healthy attachment/bonding and infant health/mental health

3. **Siblings of children in foster care**
   Identified population needs:
   a. Reducing trauma reaction
   b. Addressing grief and loss concerns
   c. Treating anxiety due to separation and other relational issues
   d. Strengthening attachment and bonding of meaningful relationships
   e. Addressing behavioral health needs

4. **Families who have been accepted for VCM Services**
   Identified population needs:
   a. Reducing trauma reaction
   b. Addressing grief and loss concerns
   c. Treating anxiety due to separation and other relational issues
   d. Strengthening attachment and bonding of meaningful relationships
   e. Addressing behavioral health needs

5. **Youth that have exited foster care**
   Identified population needs:
   a. Appropriately matched for this developmental stage
   b. Promotes Independent living skill development
   c. Assists with long-term planning (e.g. education, employment)
   d. Promotes self-sufficiency
   e. Promotes youth connections (social network and community supports)
   f. Needs assessment and connection to services/resources (e.g. mental health or substance use treatment; entitlements; healthcare)
   g. Supports youth in finding and maintaining stable housing

6. **Children who are chronically absent from preschool/school or are truant from school**
   Identified population needs:
   a. Improved school attendance;
   b. improved academic performance;
   c. reduced disciplinary action in school (arrest, suspension);
   d. improved relationship with parents/caregivers;
   e. connection to pro-social peers and activities;
   f. reduced drug/alcohol use (where this is identified as a concern)

7. **Children with incarcerated parents**
   Identified population needs:
   a. Reducing trauma reaction
   b. Need for space within prisons to promote parent-child visits that are child friendly
   c. Addressing behavioral health needs
   d. Need for transportation for visits during incarceration
   e. More programs targeting dads
   f. Including transitional housing programs for dads with kids

8. **Trafficked youth**
   Identified population needs:
   a. Youth will have supportive caregivers/adults they are connected to
   b. Youth will be connected to prosocial peers and activities
   c. Youth will demonstrate reduced symptoms related to trauma
   d. Youth will be connected to educational and/or vocational activities (school and/or work) with defined goals (and strategy) for future
   e. Youth's basic needs are met
   f. Youth proficient in multiple life skills domains

9. **Families experiencing interpersonal violence**
   Identified population needs:
   a. Reducing trauma reaction
   b. Parenting skills
   c. Parental acceptance or responsiveness
   d. Increased non-violent parent and child bond
   e. Decreased parental depression
   f. Increased child resiliency

g. Increased child self-regulation
h. Reduced internalizing for children
i. Increased problem solving and adaptive functioning abilities in children

10. **Youth who have been referred to a Juvenile Review Board, a Youth Service Bureau, or another diversion program; or who have been arrested**
    Identified population needs:
    a. Improved school attendance
    b. Improved academic performance
    c. Reduced disciplinary action in school (arrest, suspension)
    d. Improved relationship with parents/caregivers
    e. Connection to pro-social peers and activities
    f. Reduced drug/alcohol use (where this is an identified concern)
    g. Youth following rules at home and in community
    h. Improved positive parenting strategies

11. **Caregivers with a substance use disorder that impacts parenting**
    Identified population needs:
    a. Abstinence/decreased use AND
    b. Stable mental health
    c. Attunement with child's needs both physical and emotional and developing attachment
    d. Peer support
    e. Capacity to care for family
    f. Increased education or job training
    g. Increased employment
    h. Housing stability in a "drug-free' environment
    i. Health care for all family members
    j. Integration into the community
    k. Wraparound services to provide ongoing stability

12. **Caregivers or children who have a substance use disorder, mental health condition, or disability that impacts parenting**
    Identified population needs:
    a. Stable mental health
    b. Attunement with child's needs both physical and emotional and developing attachment
    c. Peer support
    d. Capacity to care for family
    e. Increased education or job training
    f. Increased employment
    g. Housing stability in a "drug-free' environment
    h. Health care for all family members
    i. Integration into the community
    j. Wraparound services to provide ongoing stability

13. **Caregivers who have a child with a substance use disorder and is in need of services**

Identified population needs:

a. Abstinence/decreased use AND
b. Stable mental health
c. Engagement with prosocial peers and activities
d. Attending school and succeeding
e. Enhanced family relationships – Living within family unit
f. Enhance parenting skills to monitor and guide teens
g. Lack of criminal involvement
h. Stable housing

14. **Caregivers who have a child with a mental health condition or physical/intellectual/developmental disabilities**

Identified population needs:

a. Stable mental health
b. Engagement with prosocial peers and activities
c. Attending school and succeeding
d. Enhanced family relationships – Living within family unit
e. Enhance parenting skills to monitor and guide teens
f. Lack of criminal involvement
g. Stable housing

15. **Substance exposed infants as defined by the state CAPTA notification protocol**

Identified population needs:

a. Healthy child development:
    i. Social-emotional
    ii. Cognitive
    iii. Language
    iv. Physical
b. Safe environment
c. Nurturing, responsive parent-child relationship with secure attachment
d. Stimulating environment
e. Stable and secure housing
f. Physical health
g. Caregivers who do not abuse substances