State of Connecticut

Child and Family Services Plan
2015 - 2019

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

By:
Department of Children and Families

Joette Katz
Commissioner

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1. GENERAL INFORMATION

State agency administering the programs

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

The Commissioner's Office is responsible for the development of the Child and Family Services Plan (CFSP). The Division of Clinical & Community Support and the Division of Adolescent & Juvenile Services are responsible for oversight of the IV-B programs under the plan, including the Chafee Foster Care Independence Program (See attached Organizational Chart). A copy of the 2015-2019 CFSP is available on the DCF website at http://www.ct.gov/dcf/cwp/view.asp?a=2534&Q=532140. The state contact for the CFSP is Deputy Commissioner Fernando Muñiz (Fernando.Muniz@ct.gov, 860-550-6300).

Mission and Vision

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

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

This mission is grounded in a core set of beliefs that encompass the Department's vision for how to provide services to Connecticut's children and families.

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

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

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

Collaboration

The Department continues to recognize the value and importance of collaboration and consultation with the community to improve outcomes for children, youth and families.

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

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

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

Interagency collaboration between DCF and the Departments of Mental Health and Addiction Services (DMHAS) and Developmental Services (DDS) has been built into the core of the work and will continue to be a priority. In addition to maintaining the existing coordination protocols and processes, it is critical to move the work forward to improve, enhance and expand what can be accomplished.

Some of the priorities and goals over the next 5 years include, but are not limited to:

1. Expanding the New Britain Area Office Life Skills pilot to additional Area Offices and eventually the whole state so that all youth leaving DCF care for DMHAS (and elsewhere) are prepared.
2. Enhance coordination and communication between DCF and DMHAS throughout the transition process by formally tracking and reporting on the use of the DMHAS Transition Action Plan and providing feedback to DCF and DMHAS staff.
3. Update the Memorandum of Agreements to assure they reflect current practice.
4. Enhance transition from DCF to DDS through coordination of benefits transfer, particularly around Medicaid and SSI related issues; this has been identified as a barrier to timely and smooth transitions.
5. Develop practice guides for DCF staff around screening, eligibility, referral and transition to DMHAS and DDS.
6. Development of a more formal transition protocol between DCF and DDS which accounts for the various ways in which a child/youth might transfer from DCF to DDS.

7. Identify 1-3 interagency pilot projects addressing special needs populations for youth who "fall between the cracks" and/or don't meet eligibility criteria of current agencies. This involves working with DDS, DMHAS, CSSD, DSS and the Office of Policy and Management to develop a cross- or multi-agency funding mechanism to assure service availability for these youth.
8. Develop a specific plan for transition of youth to DMHAS and DDS in foster care settings; for DDS this includes a collaboration between the staff working with DDS licensed Community Care Homes and the DCF Foster Care staff to review licensing, rates, provider and family expectations and services offered in each model, develop a system to educate current foster care parents on DDS CCH options and cross-train staff.

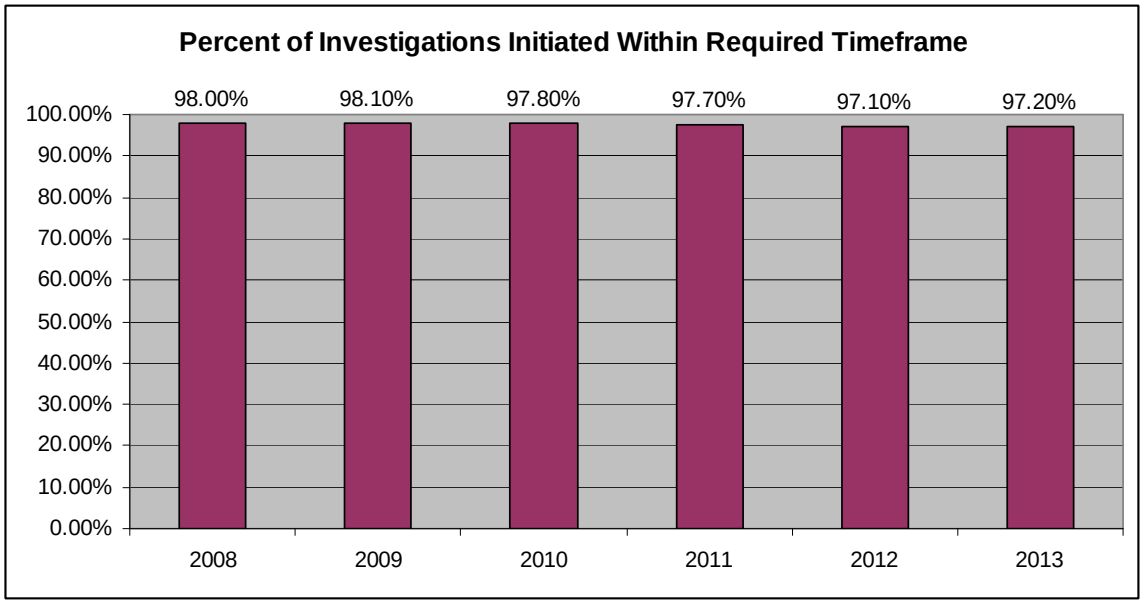
2. ASSESSMENT OF PERFORMANCE

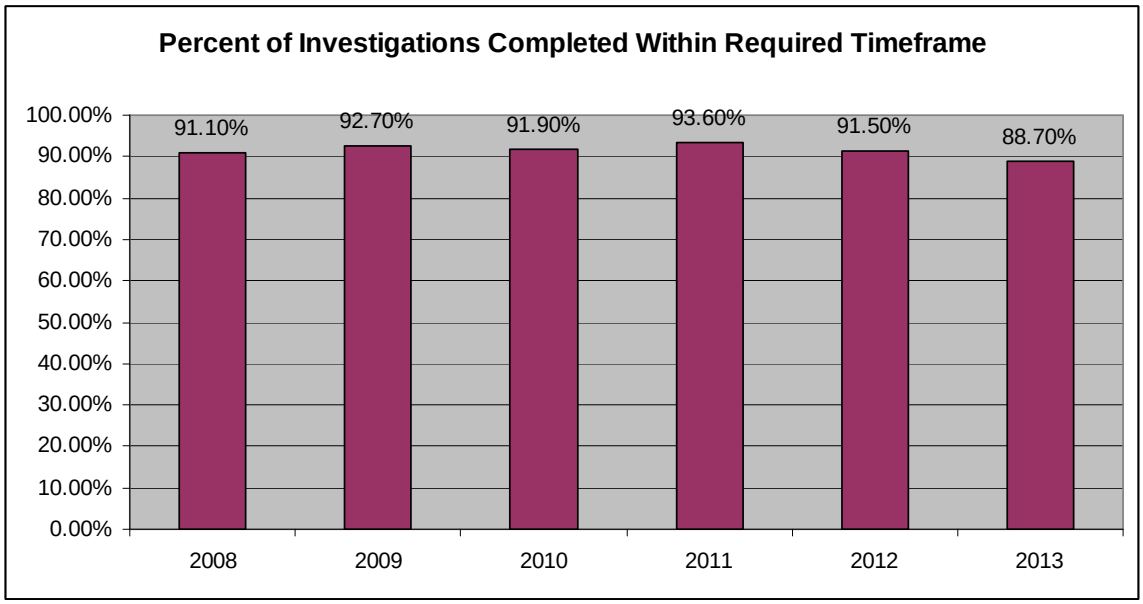
The Connecticut Department of Children and Families has made considerable improvements in all areas of child welfare practice over the past five years. These improvements are attributed to the successful completion of our Program Improvement Plan, which included the implementation of the Strengthening Families Practice Model and the Differential Response System (DRS). It should be noted, however, that implementing DRS has impacted performance on some of our measures due to the diversion of lower risk cases to our community partner agencies.

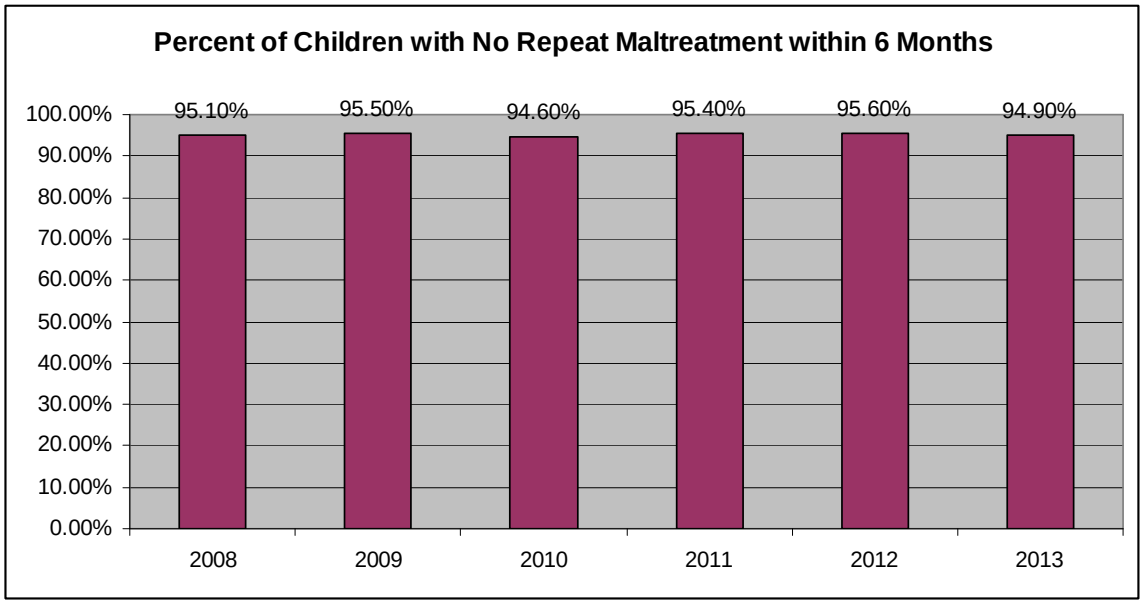
Safety Outcome 1: Children are first and foremost, protected from abuse and neglect

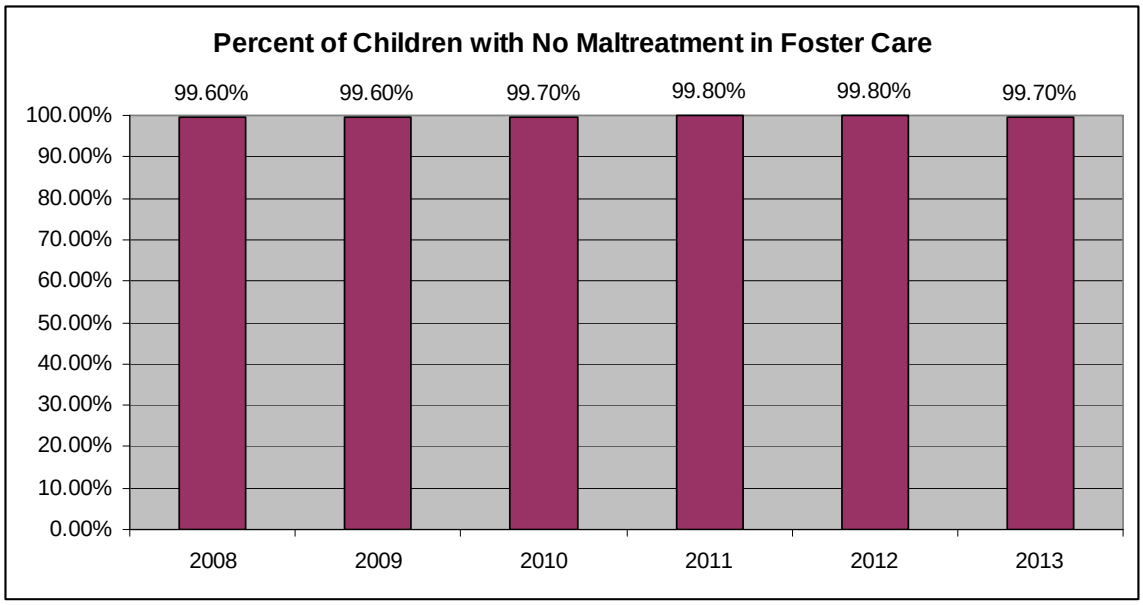
Connecticut was not found to be in substantial conformity with this outcome during the 2008 CFSR. The Department's data profile for Fiscal Years 2006ab and 2007ab, which was used for the CFSR, showed an absence of maltreatment recurrence rate of 92.8%. Our most recent data profile (2012ab) shows that rate has increased to 94.4%, which is close to the national standard of 94.6% and above the national mean of 93.3%.

Although Connecticut did not achieve substantial conformity with Safety Outcome 1, CFSR items 1and 2 (Timeliness of investigations and Repeat maltreatment) were found to be a strength in our practice. This continues to be a strength in our practice, as evidenced by our timely commencement and completion of investigations and our internal measures on repeat maltreatment:




Percent of Investigations Completed Within Required Timeframe
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
91.10%
92.70%
91.90%
93.60%
91.50%
88.70%
2008
2009
2010
2011
2012
2013


Percent of Children with No Repeat Maltreatment within 6 Months
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
95.10%
95.50%
94.60%
95.40%
95.60%
94.90%
2008
2009
2010
2011
2012
2013



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

Connecticut was not found to be in substantial conformity with this outcome during the 2008 CFSR. Only 86% of cases reviewed during the CFSR met the standard for Item 3 (Services to prevent removal) and only 82% met the standard for Item 4 (Risk of harm). Both of these items were included as areas needing improvement in our Program Improvement Plan (PIP).

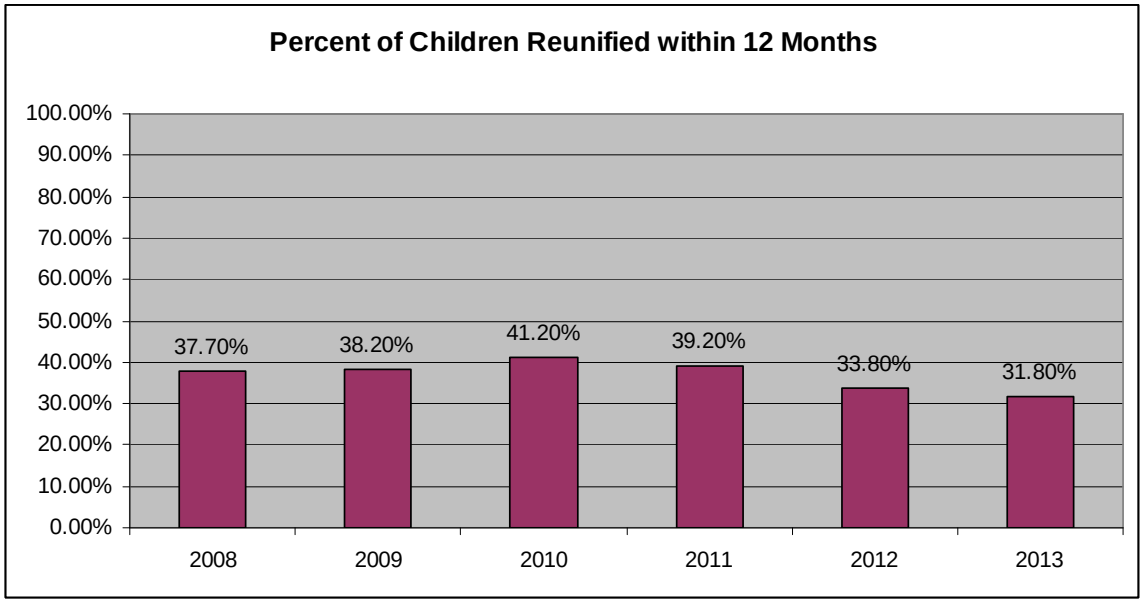
As a result of our successful reforms in recent years, there has been significant improvement in these areas. When Connecticut conducted its first PIP review in September 2010, 84.3% of reviewed cases met the standard for Item 3. Our prospective goal was set at 88.4%. By March 2013, 90.2% of reviewed cases met the standard. Similarly, our performance on Item 4 improved to 82.3% in September 2011 from the baseline of 76.6% set in September 2010. That level of performance was above the prospective goal of 80.5%.

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

Connecticut was not found to be in substantial conformity with this outcome during the 2008 CFSR. Since that time, we have trained all staff in effective case planning practices and in the Strengthening Families Practice Model. These initiatives, along with other change initiatives, have resulted in significant improvements in Connecticut's performance on the four CFSR permanency composites:

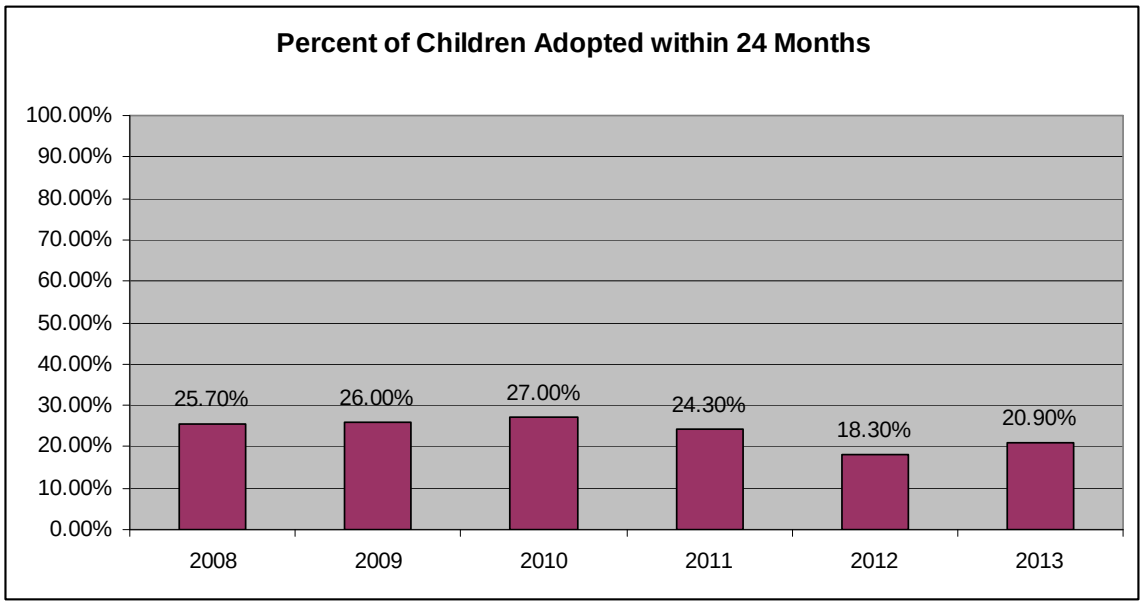
Measure	06b07a Performance	2013ab Performance
Permanency Composite 1: Timeliness and Permanency of Reunification	95.6	100.4
Permanency Composite 2: Timeliness of Adoptions	98.9	112.2
Permanency Composite 3: Permanency for Children and Youth in Foster Care for Long Periods of Time	98.3	123.4
Permanency Composite 4: Placement Stability	99.2	106.2

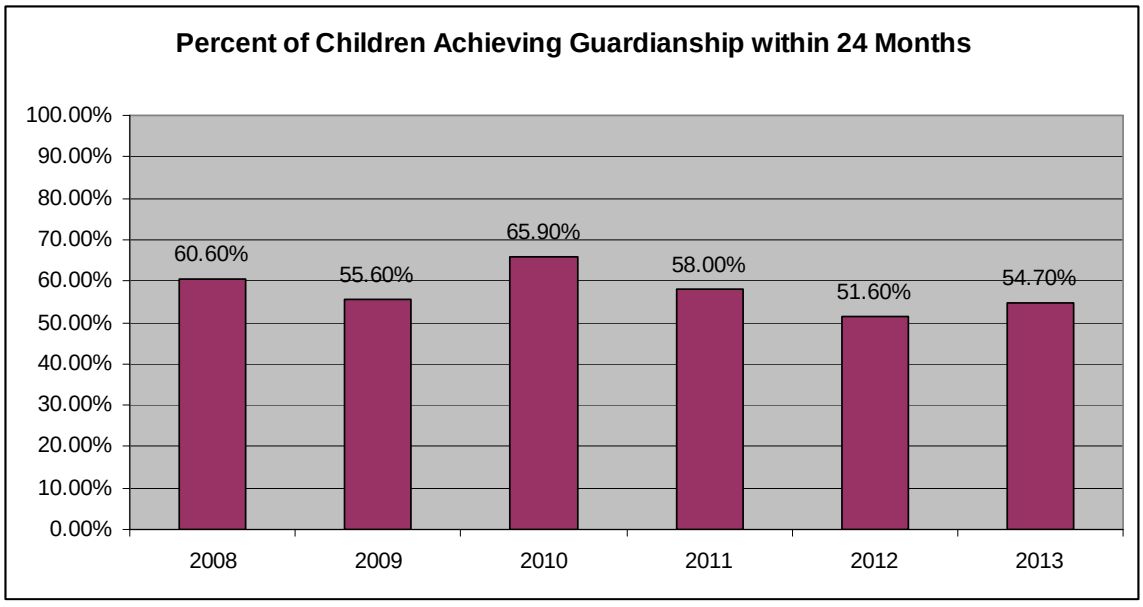
Connecticut's performance is now exceeding the national standard for three of the four composites. Permanency Composite 1 is still a challenge for the Department. Our internal measure for reunification also indicates that this is an area needing improvement:



The decrease in the percentage of children reunified within 12 months can partly be explained by the introduction of DRS and Considered-Removal Team Meetings. Because fewer children are entering care in Connecticut than in the past, the children and families we are serving in foster care have more challenges that make reunification harder to achieve.

We believe these same factors are impacting our performance on achieving adoptions and transfers of guardianship in a timely manner:



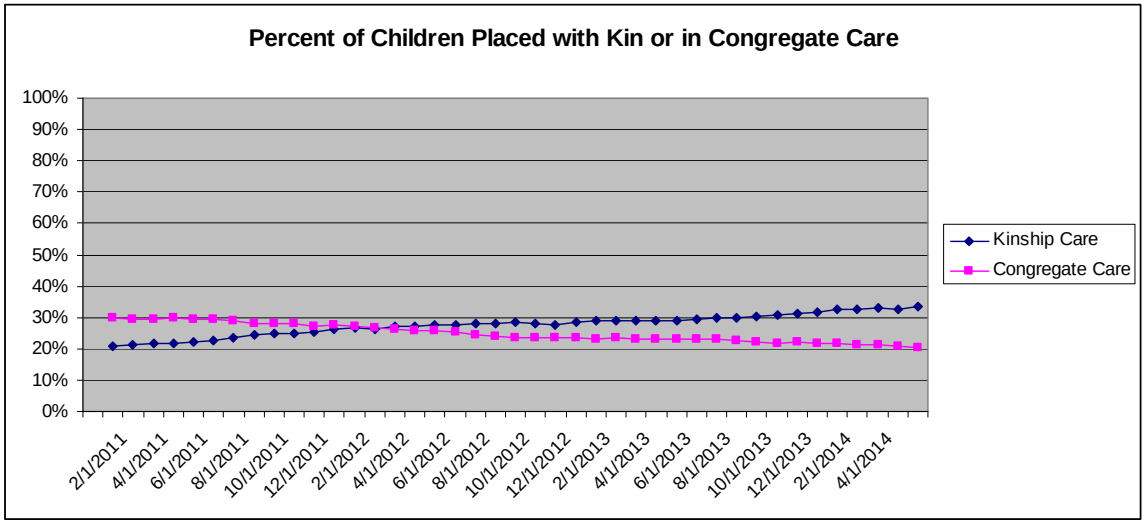


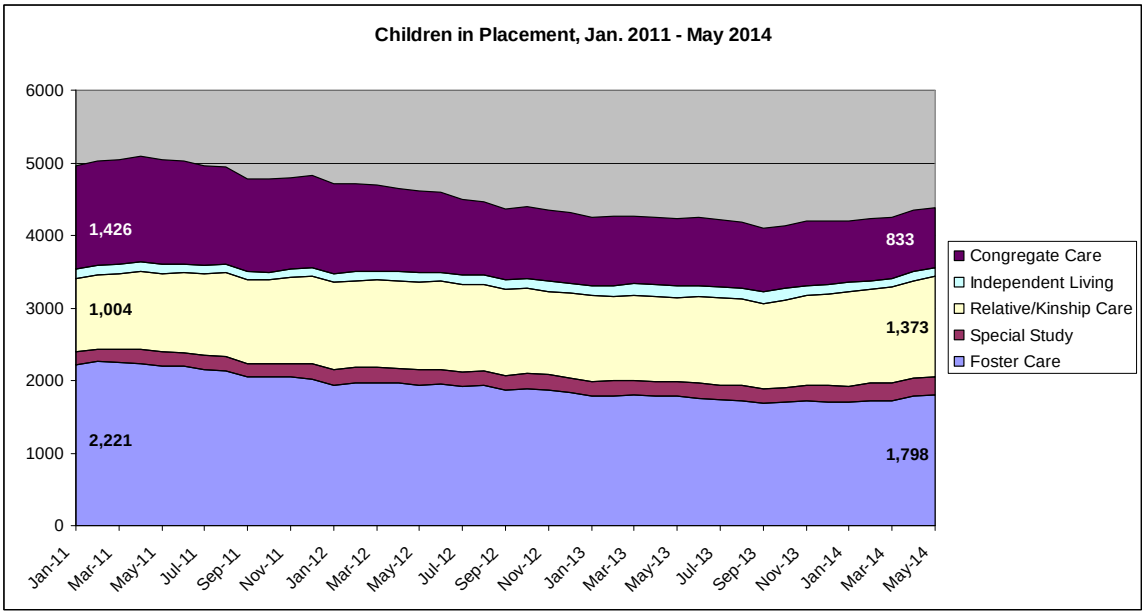
Permanency Outcome 2: The continuity of family relationships is preserved for children.

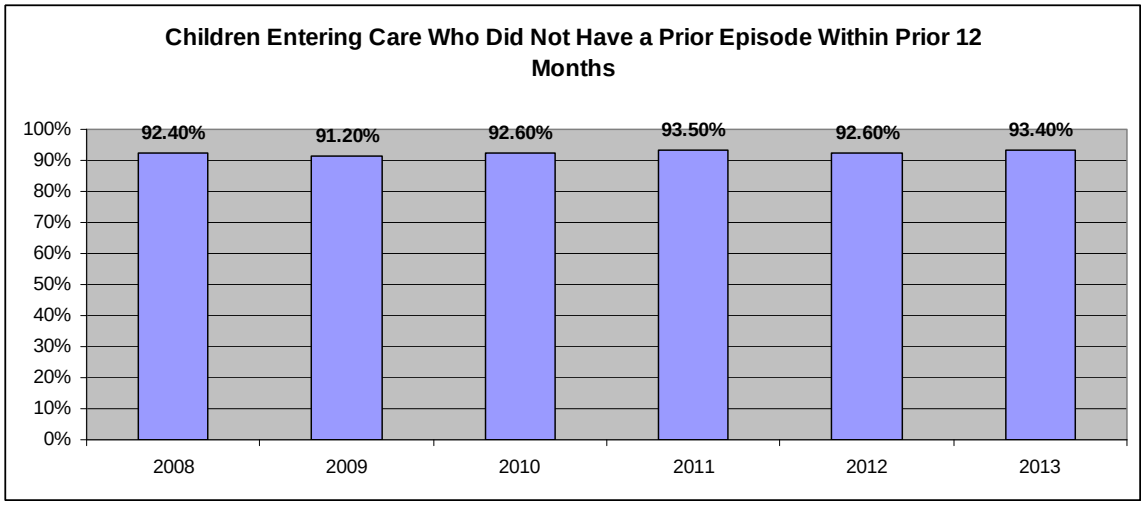
Connecticut was not found to be in substantial conformity with this outcome during the 2008 CFSR. Since that time, the Department has been focusing on improving the continuity of relationships for children by:

- Increasing the percentage of children placed with their own relatives and kin;
- Placing more children with their siblings whenever possible and appropriate;
- Ensuring children who are in care have high quality visits with their parents.

From 2011 to 2014, these practices have resulted in a significant increase in the number of children placed with kin and an equally significant decrease in the number of children placed in congregate care settings. The percentage of children placed with relatives or kin increased from 21% in January 2011 to 33% in May 2014. The percentage of children placed in congregate settings decreased from 30% to 20%:



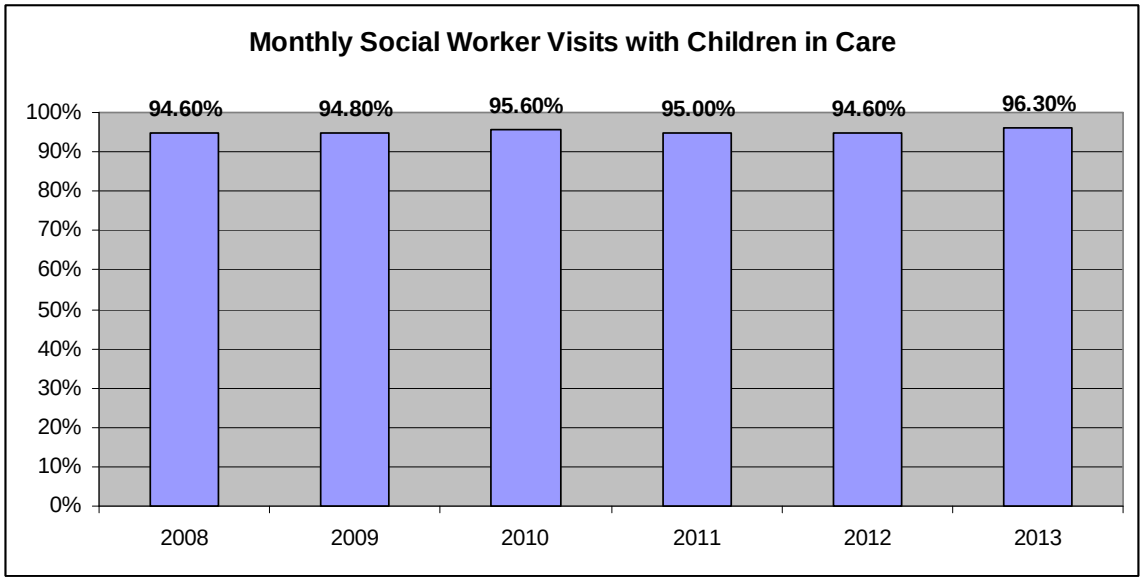


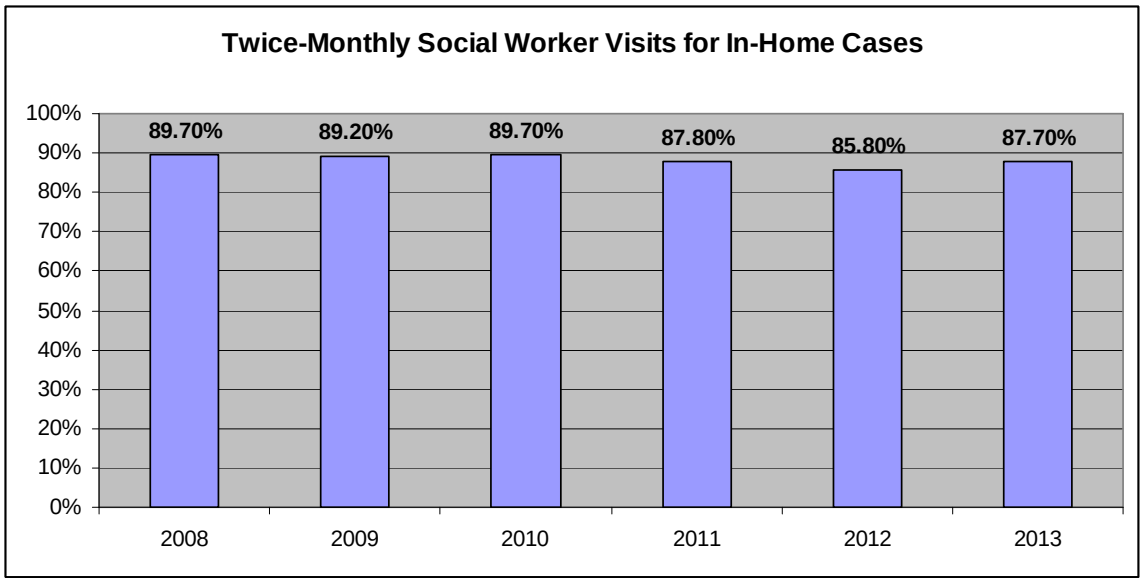


Another promising trend is from the Department's ACR data. The Department's Office of Administrative Case Reviews conducts approximately 14,000 6-month case reviews per year. In the most recent complete quarter (January - March 2014), ACR reviewers found that in 93% of cases the Department did an effective job of promoting the continuity of relationships between children in foster care and their parents.

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

Connecticut was not found to be in substantial conformity with this outcome during the 2008 CFSR. The state has made significant progress in this outcome through the implementation of the Strengthening Families Practice Model, which emphasizes family engagement and purposeful visitation as the core of social work practice. Monthly social worker visits with children in foster care and twice-monthly visits with children being served in-home have consistently exceeded 95% and 85% respectively:





The Department has also emphasized the involvement of parents and children in case planning. However, our most recent data from the Office of Administrative Case Reviews shows that participation in recent ACRs has been low. In the first quarter of 2014, only 52% of mothers, 31% of fathers and 33% of children attended their administrative case review. This is an area the Department will improve through the implementation of Child and Family Team meetings.

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

Connecticut was found to be in substantial conformity with this outcome during the 2008 CFSR. During the on-site review, 95.5% of our cases were rated as a Strength for meeting children's educational needs.

Recently, the Connecticut General Assembly passed Public Act 14-99, which permits sharing of educational information about a foster child with the child's foster parent, DCF social worker and the child's attorney. It also prompts receipt and review of a child's educational records to ensure timely referral for appropriate supports.

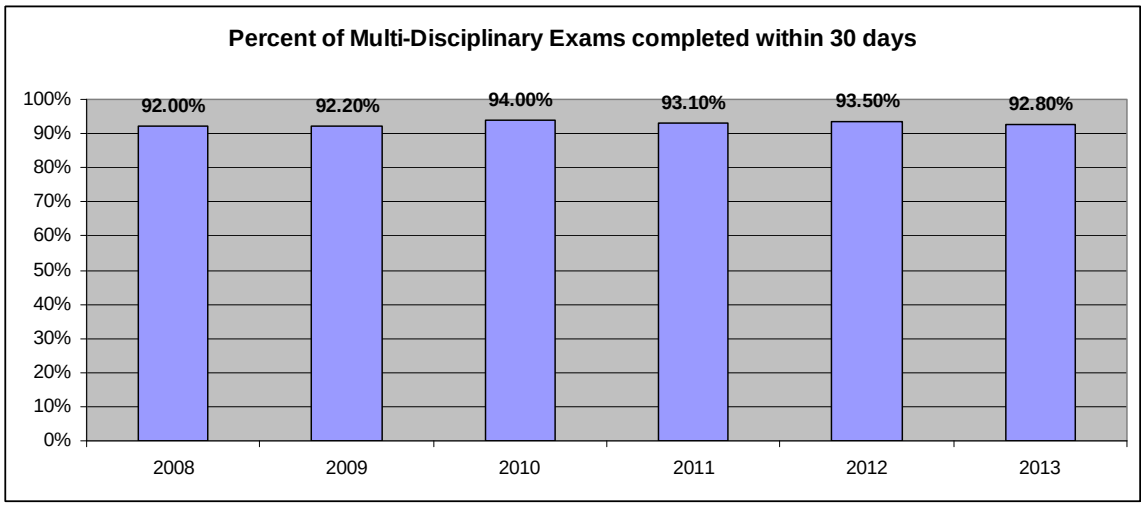
Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

Connecticut was not found to be in substantial conformity with this outcome during the 2008 CFSR. To address this concern, Connecticut implemented the following strategies in our PIP:

- Standardized the Multi-Disciplinary Exam (MDE) documentation and referral process;
- Contracted for the expansion of MDE diagnostic facilities;
- Established a referral protocol to the Birth to Three Program;
- Developed Memoranda of Understanding with other State agencies to enhance interagency coordination of services and referrals for DCF clients;
- Increased medical, behavioral health, substance abuse, and mental health support capacity in area offices through the establishment of Regional Resource Groups of clinicians and nurses to consult on cases.

Connecticut met the target goals for this outcome by the end of the PIP implementation period.

We have continued to make improvements to our Multi-Disciplinary Exams, which are required within 30 days for every child who enters care. Over 90% of children receive the MDE in a timely fashion:



The MDE serves as the foundation for identifying and meeting children's needs. Each child's case plan is based, in part, on needs identified in the MDE. The Office of Administrative Case Review conducts twice-yearly reviews of every child's case plan.
Below are the percentage of cases reviewed that were rated as a Strength in four primary areas of children's needs:

Physical health care - Child	**Error! Hyperlink reference not valid.**
Substance Abuse/ Social Support/ Mental Health - Child	**Error! Hyperlink reference not valid.**

Transition Plan	**Error! Hyperlink reference not valid.**
Permanency	**Error! Hyperlink reference not valid.**

Systemic Factors

Information System

Connecticut was not found to be in substantial conformity with this outcome during the 2008 CFSR. Although the Connecticut is operating a statewide information system from which staff can readily identify children's status and demographic characteristics, concerns were noted regarding the accuracy of information pertaining to the child's placement location and case goals. Connecticut addressed the issues identified during the CFSR and met all of the goals outlined in our Program Improvement plan. However, the LINK system is nearly 20 years old and was recently moved to non-SACWIS status. We are in the process of procuring for a new web-based, mobile case management system that will meet all SACWIS requirements and serve as a better tool for social workers in the field.

Case Review System

Connecticut was not in substantial conformity with the systemic factor of Case Review System during the 2008 CFSR. Although the CFSR determined that Connecticut has a functioning administrative review process for the periodic review of the status of each child at least every 6 months, the following concerns were identified:

- Parents, especially fathers, were not consistently involved in case planning.
- Permanency hearings were not occurring in accordance within the required 12-month timeframe. Connecticut has a State statute that requires a full evidentiary trial if a permanency plan is contested by any party. As noted in the Statewide Assessment and stakeholder interviews, when full evidentiary trials are held, the permanency hearings may not occur in accordance within the required 12-month timeframe.
- There is inconsistency in implementation of the process for TPR in accordance with ASFA requirements.
- The State is not consistent with regard to notifying foster parents, pre-adoptive parents, and relative caregivers about court hearings involving the children in their care or in notifying them of the right to be heard in court hearings.

To address these concerns, Connecticut implemented the following strategies in its PIP:

- DCF adopted a family conferencing model as a mechanism for engaging parents and relatives in case planning. Training was provided to all area offices on family conferencing, case planning, and concurrent planning.
- To ensure that efforts were made to involve parents in case planning and to meet the requirements for TPR, when relevant, the State provided training and guidelines to caseworkers regarding the use of all possible search options for locating absent or noncustodial parents.
- To improve the timeliness of court hearings and consistent implementation of ASFA requirements, the State implemented MAP meetings bringing together legal, medical,

behavioral health, and child protection staff to identify outstanding issues that need to be addressed before filing the permanency plan.

While these changes made significant improvements to our case review system, we still experience challenges in participation at the ACR meetings. In the first quarter of 2014, only 52% of mothers, 31% of fathers and 33% of children attended their administrative case review. This is an area the Department will improve through the implementation of Child and Family Team meetings.

Quality Assurance System

Connecticut was in substantial conformity with this systemic factor during the 2008 CFSR. The key findings of the CFSR were the following:

- The State has in place effective licensing standards and policies to ensure that children in foster care are provided quality services.
- The State has a clearly identifiable and functioning QA system that addresses key practice areas and provides feedback on key findings. However, stakeholders expressed concerns regarding the number of QA processes and the lack of meaningful integration of these processes.

Since the CFSR, Connecticut made additional improvements to our quality assurance system. Quality Assurance / Quality Improvement now report to the Chief of Quality and Planning in the Commissioner's Office. DCF also re-established a statewide Quality Improvement Council as a forum for standardizing quality improvement processes across the state. Finally, we continue to develop more management reports to support practice improvement and have invested in additional analytic capacity by adding additional staff to the Office for Research and Evaluation.

Staff Training

Connecticut was in substantial conformity with this systemic factor during the 2008 CFSR. The CFSR determined that the Connecticut provides initial training for staff that is sufficient to prepare them for the duties required by their jobs. The CFSR also determined that the State's training program for foster and adoptive caregivers is generally effective in addressing the skills and knowledge necessary for them to parent the children in their care.

Despite these areas of strength, ongoing staff training was rated as an ANI. Although a range of ongoing training opportunities are provided and State policy requires that staff receive 5 days of in-service training per year, attendance at training was not tracked well and there are no consequences if staff do not meet the 5-day requirement. In addition, stakeholders reported that many staff members found it difficult to access training because of a lack of time and funds for travel and the fact that many classes fill up quickly.

Since the 2008 CFSR, Connecticut implemented a new system for tracking staff training. Managers can now receive reports on which staff have not completed the annual training requirements. Additional in-service trainings have been added to the training catalog, and a satellite Training Academy location has been added to increase access for all staff.

Service Array

Connecticut was in substantial conformity with this systemic factor during the 2008 CFSR. Key findings of the CFSR were the following:

- The State has an array services to assess and address the needs of children and families.
- The availability of flexible funds and wraparound services enable the agency to individualize services to meet the unique needs of children and families.
- Although improvements in service accessibility have been made since the 2002 CFSR, the accessibility of services still varies across the State, and long waiting lists for services are reported in many areas.

Connecticut has continued to build on its existing strengths in this area by expanding community-based services and reducing its reliance on congregate care.

Agency Responsiveness to the Community

Connecticut was in substantial conformity with this systemic factor during the 2008 CFSR. Key findings for this factor in the CFSR were the following:

- DCF engages in ongoing consultation to develop and update the CFSP through various surveys, special studies, and collaborative efforts with internal and external partners.
- The State consults with community stakeholders to update the CFSP annually and develop the Annual Progress and Services Report (APSR).
- The State has mechanisms in place to ensure coordination of services and benefits.

DCF has continued to engage in these practices and to expand opportunities for stakeholder input. Each of the six DCF regions has a Regional Advisory Council (RAC) comprised of providers, parents and other community members. The RACs have representation at the State Advisory Council, which advises the Commissioner on major policy issues impacting the child welfare system. The Department also has regular meetings with the service provider associations to discuss the evolving landscape of the service array and to identify opportunities to partner in the future.

Foster and Adoptive Parent Licensing, Recruitment, and Retention

Connecticut was in substantial conformity with this systemic factor during the 2008 CFSR. Key findings of the CFSR were the following:

- DCF has established and implemented clear standards for approving foster family homes and licensing child care institutions.
- The Department applies consistent standards for all licensed child-placing agencies, child care institutions, and foster family homes.
- The State is in compliance with the Federal requirements for criminal background clearances and safety requirements for prospective foster and adoptive parents.
- DCF has in place a process for the use of cross-jurisdictional resources.
- Although the State has many recruitment efforts in place, there is a lack of adequate follow-up to responses from potential resource parents, resulting in a lack of sufficient foster and adoptive family homes.

In order to address the concern regarding a lack of sufficient foster and adoptive homes, the Department sought consultation from the Annie E. Casey Child Welfare Strategy to develop foster parent recruitment and retention plans for each region. Additionally, the increased focus on placing

children with their relatives and kin has decreased the demand for non-relative foster parents. There are currently 423 fewer children placed with non-relative foster parents than there were in January 2011.

3. PLAN FOR IMPROVEMENT

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

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

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

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

Objectives	**Measures of Progress**	**Interim Benchmarks and Timetable**
1. The number of children in foster care will be reduced by 25% through continued implementation of Considered-Removal Team Meetings (CRTM).	• Number of children in placement • Number of CRTM held • Number of children diverted from placement • Number of children returned within 6 months of entering care	• By June 2015, the number of children in care will be reduced by 5% • By June 2017, the number of children in care will be reduced by 15% • By June 2019, the number of children in care will be reduced by 25%
2. The in-home service array will be expanded and strengthened to support keeping children with their family of origin.	• Development of a trauma-informed continuum of services designed to ensure children remain with their family of origin.	• By June 2017, trauma-informed services will be available in all DCF regions • By June 2019,
3. Forty percent of all initial placements and 30% of overall	• Percent of children initially placed with relatives/kin	• By June 2015, 40% of all initial placements and 30%

placements will be with relatives and kin.	• Percent of all children in placement with relatives/kin	of overall placements will be with relatives and kin
4. An adequate array of foster home placements is available for children who cannot be placed with their own families.	• Number of available foster home beds per child who needs a non-relative home	• By June 2015, 100 additional foster homes will be licensed • By June 2017, 200 additional foster will be licensed • By June 2019, 400 additional foster homes will be licensed

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

Objectives	**Measures of Progress**	**Interim Benchmarks and Timetable**
1. Children entering care will achieve their permanency goal in a timely manner as measured by entry-cohort reports for reunification, adoption and transfer of guardianship.	• Percent of children reunified within 12 months of entering care • Percent of children adopted within 24 months of entering care • Percent of children whose guardianship is transferred within 24 months of entering care	• By June 2017, at least 60% of children whose goal is reunification will be reunified within 12 months • By June 2017, at least 32% of children whose goal is adoption will be adopted within 24 months • By June 2017, at least 70% of children whose goal is Transfer of Guardianship will be have a TOG within 24 months
2. Permanency Teaming will be implemented to improve the likelihood of permanency for all children and to reduce the use of APPLA by 50%.	• The number and percentage of children in placement with an APPLA goal	• By June 2017, the use of APPLA will be reduced by 25% • By June 2019, the use of APPLA will be reduced by 50%
3. The number of youth aging out of care without legal or relational permanency will be reduced by 50%.	• The number and percentage of youth aging out of care	• By June 2017, the number of youth aging out of care without legal or relational permanency will be reduced by 25% • By June 2019, the number of youth aging out of care without legal or relational permanency will be reduced by 50%

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

Objectives	**Measures of Progress**	**Interim Benchmarks and Timetable**
1. The number of children placed in	• The percentage of children	• By June 2015, congregate

congregate care settings will be no more than 10% of the population of children in placement.	and youth in placement who are in a congregate setting • Length of stay • Treatment goals & objectives achieved in a timely manner	care will be no more than 15% of children in placement • By June 2017, congregate care will be no more than 10% of children in placement
2. All congregate care settings have extensive family involvement as part of the treatment process.	• The number and percentage of children whose family is actively involved in treatment	• By June 2015, all congregate care settings have extensive family involvement as part of the treatment process.

Staff Training, Technical Assistance and Evaluation

See Section 10 (Targeted Plans within the CFSP - Staff Training Plan).

Implementation Supports

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

4. SERVICES

Child and Family Services Continuum

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

Prevention • Prevention • Early Intervention • Diversion	**Treatment** • Community Based Treatment • Foster care • Out of home treatment • Inpatient Treatment		**Aftercare** • Transition • Aftercare • Life Skills • Vocational support
Early Childhood Services	Care Coordination	Extended Day Treatment	Community Based Life Skills
High-Risk Infant Program	Care Giver Support Services	Therapeutic Foster Care	Work/Learn Youth Program
Juvenile Criminal Diversion	Community Emergency Services	Family Based Recovery (FBR)	SWETP
Mental Health Consultation to Childcare	Crisis Stabilization	Multisystemic Therapy (MST)	Supportive Housing for Families
Parent Project	Child First Early Childhood Services	Multisystemic Therapy for Transition Aged Youth	PASS Group Homes
	EMPS-Crisis Intervention Service	Multisystemic Therapy-Family Integrated Transitions	
	Family Advocacy	Reentry and Family Treatment (RAFT)	
	Family and Community Ties Foster Care	MST- Building Stronger Families	
	Family Enrichment Services	MST- Problem Sexual Behavior	
	Reconnecting Families	Juvenile Justice Intermediate Evaluations	
	Foster Care Clinics	Juvenile Sexual Treatment	
	Foster Parent Support for Medically Complex	IICAPS	
	Integrated Family Violence Services	Juvenile Justice Intermediate Evaluations	
	Intensive Community Based Treatment	Juvenile Sexual Treatment	
	Intensive Family Preservation	Multi-Dimensional Treatment Foster Care	
	Functional Family Therapy	Solnit Children's Psychiatric Center	
	Multidimensional Family Therapy	Residential Treatment Centers	
		Therapeutic Group Homes	
		Safe and STAR Homes	

Service Coordination

Connecticut's service array is coordinated through committees that oversee the development of new services and the re-procurement process for existing services:

- Community-Based Outcomes Workgroup - This workgroup is responsible for ensuring every contract in Connecticut's child welfare service array has measurable child and family outcomes. The group meets every two weeks to review current services, modify existing scopes of service and make recommendations for the development of new services when gaps are identified in the state.

- Strategic Finance Committee - This Committee is responsible for managing the procurement process, including approving Requests for Proposals and making decisions about how to invest our resources to improve the service array.

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

Service Description

DESCRIPTION - STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM

Staff Positions: The Albert J. Solnit Psychiatric Center North Campus is a facility run by the Connecticut Department of Children and Families. It provides brief treatment, residential care and educational instruction for abused and neglected children between the ages of 10 and 18 from all across the state. It offers complete multidisciplinary medical and mental health assessments for those children under its care. Individual services are designed to meet the children's unique needs and to facilitate and support community placements when clinically indicated. The grant helps support multiple positions including Children's Services Assistants, Lead Children Services Workers and a secretarial position for a facility administrator.
Area Office – Office Assistant Positions: In an effort to enhance our service delivery to families and achieve more timely permanency for children, three part time Office Assistants were hired to provide support to the staff in the Meriden and Norwalk Area Offices to help coordinate our case planning efforts by scheduling and facilitating the coordination of family conferences, conducting relative searches for children in care in order to identify and locate potential relative resources, and assure grandparent and relative notification as required.

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

student intern to assist our ORE staff to update the disproportionality and disparate outcomes data from fall 2013 to present. This intern was hired through the UCONN School of Public Administration.

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

Personnel - Administrative Positions**:** The grant supports a full time administrative position within the Division of Grant and Contracts Management, an Accountant who provides fiscal management and oversight of the child welfare grants, and a full-time Program Manager who provides managerial oversight of multiple federal child welfare related grants and oversees the development and implementation of key child welfare initiatives.

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

DCF contracts with the Connections, Inc. to provide intensive case management services to assist families to develop and utilize a network of services in the following areas: economic (financial support, employment assistance), social (housing, transportation, family support, parenting education, child care) and health (medical/mental health care for adult and child, relapse prevention, and domestic/child/substance abuse issues). The Connections, Inc. has nine sub-contracted agencies to provide these services statewide. Permanent housing is established through DCF's partnership with the Department of Social Services (DSS). The DSS provides a Housing Choice Voucher (formally "Section 8" - federal program) or Rental Assistance Program (RAP-state program) Certificate. DCF's Supportive Housing for Families Model has been recognized as a promising model of housing assistance and family support by the Child Welfare League of America, The National Alliance to End Homelessness and the National Center for Social Research. This additional federal funding is used to develop a specialized unit to assess and serve the waitlisted reunification families who have children less than five years of age in order to expedite permanency.

Triple P America: Federal funds were allocated to the Positive Parenting Program (Triple P) to offer two week-long Level 4 Standard and Standard Teen Triple P trainings in FFY 2013-2014. A total of 33 new Triple P staff members were trained and accredited. This allocation supports ongoing training opportunities for provider staff to ensure no interruption in the provision of services. Triple P is an evidenced-based model that provides in-home parent education curriculum along with support and guidance so that parents will become resourceful problem solvers and be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths.

Parents with Cognitive Limitations: Federal funding was used to help support a two day international conference held in Mystic, CT on parents with cognitive limitations developed by The Association for Successful Parenting and the Department. Highlights included the following:

- attendance of 200 participants each day;
- a panel of State Leader presenters that included the Commissioners of Department of Developmental Services and the Department of Children and Families and the Chief Justice of the CT Supreme Court;

- presenters who came as far away as Iceland;
- a family panel consisting of parents and their teens/young adult children to present and respond to questions;
- a very strong presence of families among the attendees.

Five additional training opportunities will be held that will be open to providers and DCF staff. By the end of September, over 150 additional people will have been trained.

UCONN MOA: See description for JRA Consulting.

Travel/Conferences: Federal funding was used to support travel and registration fees for staff to attend various conferences, including but not limited to Differential Response, Infant-Mental Health, and Human Trafficking.

KJMB Solutions: KJMB Solutions is a technology consulting firm specializing in web application development, database development, networking consultation, quality assurance services, and secure web application hosting. In June 2011, the Corporation for Standards and Outcomes disbanded and the staff involved in developing CT's data collection and reporting system established their own company called KJMB Solutions. Programs and Services Data Collection and Reporting System (PSDCRS), is a web-based application that allows the department to gather and evaluate client and program level outcomes. This contract is being supported by both state and federal funding.

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

Reconnecting Families Program: This program is primarily home-based, designed to engage, support and intervene with family members through a short-term, intensive service model in order to promote and effect successful reunification and reduce the risk for further abuse and neglect.

Since April 2008, the 10 contractors selected through a competitive procurement continue to provide this service statewide. This program is being supported by both state and federal funds. This past year, the Department decreased the funding level for the program statewide in order to reduce the federal allocation. Additionally, the service is being redesigned and a new service type is being created, adding therapeutic visitation. An RFP is scheduled for release in June 2014.

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

Collaboratives have been established to serve all the Area Offices.

Each collaborative has an executive board that provides support and direction to the collaborative. A staff person from the Office of Foster Care and Adoption (OFAS) leads the Community Collaboratives and meets with the coordinators bi-weekly and approves all financial reimbursements. The coordinator from each collaborative maintains contact with families from the date of inquiry up to licensing or withdrawal and gathers information about their decision to withdraw.

Foster Care Consumer Advocacy: The Office of Foster Care and Adoption Services (OFAS) has contracted with FAVOR, Inc., a statewide family advocacy organization, to support foster families' caring of children with complex behavioral health needs and to assist them in navigating the service system. The goal of this program is to increase placement stability and improve foster family retention. This position has, in partnership with FAVOR's other family advocates, directly supports therapeutic and DCF foster parents and provides family advocacy support to post-adoptive families.

The services that are available through this program are as follows:

- Empowerment of foster families through education and support to enable them to assume a lead role in the planning and delivery of the foster children's behavioral health treatment;
- Support to foster families, including attendance at Child Specific Teams, Administrative Case Reviews, Pupil Planning Teams, Treatment Planning Conferences and Court hearings, etc;
- Information sharing with foster families that will help in identifying and accessing available services;
- Connection to services, initiating referrals, as appropriate;
- Ensuring foster parent's receipt of the skills and encouragement required to ensure they or their children with Serious Emotional Disturbances (SED) have a primary role in local and statewide activities and initiatives concerning the children's behavioral health system; and
- Ensuring foster families' participation in case planning for their child(ren).

While the goals for each family are individualized, the standard objectives that guide the course of the work with the foster families are as follows:

- Team building;
- Incorporation of natural supports;
- Enhancing shared communication and open dialogue;
- Improving connectedness to community; and
- Expanding knowledge and skills related to caring for children with behavioral and mental health needs.

The Department intends to pursue procurement for family advocacy services. This component will be included in the RFP.

Adoption Enhancements: The Department of Children and Families contracts with the University of Connecticut Health Center to provide post-adoption services to families who have adopted children from DCF's custody. It also provides service to relative families who have come from the state's subsidized guardianship program. Within available funding, services may be provided to families who have adopted privately or who have adopted internationally. This program is based on an employee assistance model, i.e., to provide limited interventions and/or make referrals to local services for families experiencing a variety of problems that may or may not be directly related to adoption. This service is free of charge to families. The AAP has four community case managers based in the four major cities in the state. The Community Case manager also provides in home assessment of the family's needs and assists in coordination of appropriate services. AAP also manages the post finalization services from a program that DCF offers for children following adoption finalization. Within the context of PPSP, each child adopted from DCF's foster care system is eligible for an additional 100 hours of support services from 21 Connecticut Child Placing Agencies. This program is funded by both state and federal funds.

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

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

Adopt a Social Work Program: This statewide program assists children and families (birth, foster and adoptive) that are DCF involved through voluntary services, support, and donation of goods as well as to help families' secure needed resources.

Populations at Greatest Risk of Maltreatment

Analysis of the Department's SACWIS data indicates that children ages 0 -3 are at the greatest risk for maltreatment. Data for the period of State Fiscal Year 2007 - State Fiscal Year 2011, show that the abuse and neglect substantiation rates, per thousand, for children ages 0 -3, averaged 18.79. The average rate for ages 4-17 was considerably lower at 10.58. During SFY 2012, the substantiation rate for children 0-3 was 17.5. For the same period, the rate for children ages 4-17 was 9.43. The SFY 2012 data further indicate that African American and Hispanic children, ages 0 -3, have an increased rate of neglect: with substantiation rates of 37.5% and 34.4%, respectively.

To address these concerns, the Department expanded the Child First contracts to ensure every office has access to services for this population. In 2013, in addition to the 6 existing sites for Child First (Bridgeport, Hartford, New London County, New Haven, Norwalk and Waterbury), three additional locations were added (Middlesex County, Stamford, and Northeast CT). Research demonstrates that risks to the development of young children as well as the risks for child abuse and neglect include maternal depression, substance abuse, domestic violence, and homelessness. The Child First model directly addresses these risks through (1) comprehensive assessment and treatment planning for the parent/child relationship and supports to the whole family, and (2) a home-based, parent-child intervention which builds the nurturing relationship, protects the developing brain, and optimizes child social-emotional development, learning, and health. The primary method of treatment is the use of Trauma Informed Child-Parent Psychotherapy, as developed by Dr. Alicia Lieberman, in order to strengthen the attachment between the parent and child in order to decrease risk and increase the capacity of parents to nurture and support their children's development. Therefore, the child's developing brain is protected from the devastating effects of trauma. The model includes broad collaboration among early childhood and adult providers, parents, and other stakeholders, which promotes an integrated system of community-based services and supports.

In addition to this service, Child FIRST providers have been trained to enter data into the Programs and Services Data Collection and Reporting System (PSDCRS) so that child and family outcomes can be measured. Presently, 51% of children served within the Child First program are presently involved with the Department. Of those children, there was a decrease of DCF involvement by 33% over a three year period (by parent report).

Additionally, the DCF/Headstart Partnership has increased collaboration and has helped to ensure children are connected to quality early care, education, programming, and support.

The High Risk Infants Program is a service for pregnant, incarcerated mothers who are at the Janet E. York Correctional Institution (YCI) in Niantic, CT. This service provides assessment, prenatal education,

birth planning, case management, medical care, and referrals for pregnant women who will deliver babies while incarcerated, those who will deliver a baby shortly after being released from YCI, and services for post-partum mothers who remain incarcerated following the birth of their children.

The case manager for the program is affiliated with Lawrence and Memorial Hospital in New London, CT, where all incarcerated mothers will deliver their babies. This service offers a complete individual baseline assessment of each referred pregnant inmate a care plan for the safe placement of her newborn infant if the mother remains incarcerated through her delivery. The service also provides a child protective services background check of all potential alternative caretakers identified by the pregnant incarcerated mother. In addition, the case manager provides referrals for follow-up health care, including services such as WIC, Healthy Start, Birth to Three, and Help Me Grow to mothers or extended family who will be caring for the infant. Also offered is a weekly support group for post partum inmates.

Quarterly advisory board meetings are held between L&M Hospital, DCF, YCI, and the Child Advocate's office to discuss the inmate mother's and infant's needs and program improvement. The purpose of this Board is to coordinate services and develop solutions for this target population across the child welfare, hospital and correctional systems.

The purpose of this service is to decrease involvement with Child Protection and place infants with family. In 2012, there were 22 infants born to incarcerated mothers at YCI, and 13 infants were placed in DCF foster care upon birth (59%). However, in 2013, there was a remarkable improvement in these numbers as 21 infants were born to incarcerated mothers at YCI, and only 8 were placed in DCF foster care (38%).

Services for Children Under the Age of Five

Over the next five years, the Department will continue to focus on decreasing length of stay in foster care and increasing timeliness to permanency for children under the age of five. We will be implementing Permanency Child and Family Teaming as a model for case planning across Connecticut. We anticipate this method for engaging children and families will improve the likelihood that young children will achieve more timely permanency. Additionally, we will continue to invest in Child First and other early childhood services that will support families caring for young children.

Services for Children Adopted from Other Countries

DCF does not have specific services for children adopted from other countries. These children and their families have access to the array of services available trough the DCF Voluntary Services Program if the children meet eligibility criteria.

5. CONSULTATION AND COORDINATION BETWEEN STATES AND TRIBES

Connecticut currently has two federally recognized tribes: the Mashantucket-Pequot Tribal Nation (MPTN) and the Mohegan Tribe (MT). Consultation between the State and the two tribes has remained consistent with minimal change in recent years. Connecticut and the tribes will not be engaging in a formal planning process over the next five years to improve or maintain compliance with ICWA, as no issues have been noted by either the tribes or the state.

Activity with the tribes is most often fostered after an accepted or non-accepted child maltreatment report to the State's CARELINE.

The CARELINE screens for MPTN involvement according to case addresses that exist on their reservation. Because the reservation is relatively small, the roads are few and easily indexed. If the case address is noted as a reservation MPTN address, the report is non-accepted and the CARELINE takes the lead in notifying the tribe of the report. The tribe then chooses to investigate according to its own policies and procedures, with its own established CPS resources. The State is not involved in these circumstances. There are other circumstances in which the tribal member has an address off-reservation; in these cases the State does intervene and provides immediate notice to the Tribe of the report.

Contrary to the MPTN, the Mohegan Tribe does not have any members living on a formal reservation/tribal land. As such, all reports taken and accepted by the CARELINE are investigated by the State and the MT provided notice. All CT tribe (non-reservation) reports are most often serviced by the Norwich Area Office in DCF 's Region 3. Every accepted report of child abuse and neglect serviced through each Area Office of DCF is screened upon initial face to face contact for race and ethnicity demographics. Within this inquiry, each family member is specifically screened for Indian heritage consistent with ICWA. Tribal affiliation is also screened and noted at this time. Results are stored in the State SACWIS system (LINK).

In 2012, the State implemented a two-track system for the handling of child maltreatment reports. Formally known as DRS (Differential Response System), complaints of abuse and neglect may be assigned a Family Assessment Response (FAR) or a traditional investigation. Reports with ICWA considerations may be assigned to either track, dependent on severity and policy considerations.

Most ICWA activity has centered on the State's resident tribes. On occasion there is activity regarding tribes in the neighboring states of Rhode Island, Massachusetts, and New York. Also notable is the practice of both casinos to exercise Native American hiring preference in their gaming and hospitality enterprise; this has resulted in many (and all required) ICWA notices to be filed with Tribes across the nation and BIA. While there is ICWA activity, no data is available to demonstrate compliance. Information on compliance is available in narrative form in individual client records.

There is a longstanding Memorandum of Understanding between the State and the MT. Efforts to effect a similar agreement with the MPTN have not come to fruition.

Monthly meetings were often held between the MT and the State. As of late, these meetings have been more sporadic due to less volume. The content of the meetings is oriented to the Memorandum of Understanding. This includes case specific discussion of State interventions with MT members. The State notifies the MT of all accepted reports regarding their members. Discussion is held in a confidential meeting at tribal offices. The meetings are also used as an opportunity to advise the Tribe of new State initiatives; recent past and present discussions have included Structured Decision making, Differential Response System for child maltreatment reports, and Child and Family Team Meetings for Considered Removals.

Regarding the MPTN, while no formal arrangement is in place for regular meetings, there is a well noted single point of contact, Director of Child Protection. The State continues to have a positive working relationship with the Director.

As noted above, the State screens for ICWA compliance with demographic inventories/interviews at the point of all DRS activity. There are additional checkpoints that also capture/create safeguards for identification/notifications. These include genograms completed with families (at investigation or FAR) and revised by ongoing State social workers in the formulation and revision of case plans; internal multidisciplinary assessments for permanency (MAPS) in which State legal and Social work staff discuss cases in which legal intervention has transpired; as well as canvassing of all parties once court involved.

Consistent with ICWA, all tribes are notified of State legal activity in writing, by USPS certified mail. For the States' two local tribes, as a courtesy, telephone notice precedes written notification.

Common practice for State proceedings finds representatives of the two local tribes present, at least for initial proceedings. Neither tribe has a developed system of resources (foster/host homes/group care) that allows for a divergent path from State care, should removal from home become necessary. In 2013, the State adopted Child and Family Team meetings for Considered Removals; in advance of a possible entry into State care, these meetings allow for families to address safety concerns and a remediation plan with their own resource system present at the discussion table. For tribal families, there is explicit instruction offered by the State that the family is welcome to invite tribal resources to the forum. To date there have been no meetings that resulted in the State needing to remove tribal children.

Jurisdiction with the proceedings occurs with exclusivity to the State court system. The MT does not seek to transfer cases to its own court network and prefers to partner with the State in the Superior Court for Juvenile Matters. Conversely, the MPTN often exercises the option of jurisdiction moving to its court network.

There have been no ICWA compliance issues identified with the MPTN or MTN over the last five years. The last large scale training Statewide relative to ICWA was a day long event sponsored on site by the MPTN. Some DCF area offices have undertaken recent training efforts on ICWA. Newly hired Social Workers are trained on ICWA during pre-service training. There are present considerations to have statewide refresher training for the next fiscal year.

There has not been in the last year, or during the last five years, any negotiations with the two tribes in state specifically as it relates to determining eligibility, benefits and services and ensuring fair and equitable treatment for Indian youth under the Chafee Foster Care Independence Program (CFCIP). However, tribal youth are eligible for all of the same Chafee and Independent Living services as any other youth in Connecticut. Also, in accordance with the requirements of the Chafee program, all youth in DCF care who are at least sixteen years old, including Indian youth, are provided with a copy of their credit report at least annually.

A copy of the State's most recent Annual Report will be provided to the tribes post submission.

6. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM (CFCIP)

Agency Administering CFCIP (section 477(b)(2) of the Act)

See Section 1 (General Information)

Description of Program Design and Delivery

Connecticut DCF maintains a broad service array for adolescents in foster care through the Chafee Foster Care Independence Program. These services include:

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

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

Community-Based Life Skills: The department currently contracts with 15 community service providers to provide community life skills to DCF committed youth placed in community settings. Since 2008, this 12 month program model utilizes Ansell-Casey Life Skills. It provides youth age 15 and older who are residing in foster care with the life skills necessary to successfully transition to adulthood.

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

- *Our Piece of the Pie* (OPP): A comprehensive work/learn model located in Hartford that helps youth access and attain a combination of educational, employment and personal development opportunities that promote success. OPP is in the process of opening a second Work/Learn site in Norwich. This site began accepting referrals in June, 2012 and accommodates up to 35 youth.

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

Wilderness School: The grant helps support the operating costs of the Wilderness School. The Wilderness School is a prevention, intervention, and transition program for adolescents from Connecticut. The

Wilderness School offers high impact wilderness programs intended to foster positive youth development. Designed as a journey experience, the program is based upon the philosophies of experiential learning and is considered therapeutic for the participant. Studies have documented the Wilderness School's impact upon the self esteem, personal responsibility, and interpersonal skill enhancement of adolescents attending the program.

Aptitude/personality/interest assessment and Career Matching is a new service designed to assess a youth's academic strengths and challenges while considering their personality style and passion for a specific career choice. These assessments are assisting youth in choosing trades and college majors where they are most likely to find success.

Health and Wellness Initiative: This program spans our congregate care network offering programs that enhance physical fitness through sports camps, gym memberships, dance with the Connecticut Ballet, Fitness Camps with the Center of the Tribe Fit Choice and the Heavy Hitters Boxing exercises. In addition to the above noted movement approaches the health and wellness focus has provided nutritional training and awareness for congregate care staff and youth. This work has resulted in guidelines and continuing instruction to ensure internalization of the new framework.

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

Summer Youth Employment Program: The Department established a Memorandum of Agreement (MOA) with the Connecticut Department of Labor and in partnership with the five regional Workforce Investment Boards to enhance access to summer youth employment opportunities for youth involved with the Department. This Memorandum facilitates the transfer of funds to programs operated by the contractors of each of the five Workforce Investment Boards. These Boards sub-contract with local businesses and government agencies to provide 6-week on the job employment training programs that include academic instruction, career awareness and work readiness training, career competency training, worksite selection and development, oversight of program activities to ensure developmental focus and other services to help prepare youth for a career. A portion of the funding is set aside to ensure that youth who want to continue past the 6-week period have the opportunity to do so. Funding is available during the entire fiscal year for this purpose.

The Rite of Passage Program is designed to educate young women about the essential elements of growing into strong, confident, competent women. Twenty-four youth participated in this educational journey, meeting each Saturday with a community of women who brought them forward in their understanding of self, their relationship to others and their status in the world. They participated in a series of classes, events and a final cross-over ceremony.

DCF Youth Music and Arts Academy: This program motivates youth to develop their innate ability to excel in the arts. There is a curriculum regarding the music industry that is presented to each cohort as well as a lab experience in which youth develop and hone their individual and group talents.

Over the course of the next year, the Department will be closely examining the services offered under the Chafee program to determine the level of need in the state. Because the population of adolescents with an APPLA goal is expected to continue to decline, the Department will be making adjustments to the service array. Also, we anticipate adding services to support older youth who achieve permanency in years two through five of this plan.

Serving Youth Across the State

Connecticut is a state-administered child welfare agency with six regions. Contracting for services is a centralized function that ensures services are available across the state to all youth. Unique services can also be purchased locally through wrap-around funding if there are local gaps in the service array for youth.

Connecticut's Chafee services serve youth through the age of 21. We have statutory authority to keep young people voluntarily in the care of DCF past their 18th birthdays and have recently expanded the services that are available to transition-aged youth. These services include room and board, which in Connecticut is defined as the amount of funding allotted to cover an individual's basic living expenses, including housing, food, clothing and personal supplies. There are no systemic barriers in the state that preclude us from serving youth of various ages and at various states of achieving independence.

In the 2015-2019 implementation period, DCF will be adopting a new independent living assessment tool that is currently in use by the adult Department of Mental Health and Addiction Services (DMHAS). This tool will be administered to all youth before they participate in Independent Living Skills training and post-training to gauge the effectiveness of the training and the youth's readiness for independent living.

DCF utilizes both state and ETV funds to provide services to youth who have left foster care for kinship guardianship or adoption after attaining the age of 16. Through ETV funds, DCF oversees a grant program that provides up to $5,000.00 per academic year to youth involved in a post-secondary program. In accordance with the Chafee ETV Program, DCF utilizes the cost of attending an institution of higher education (as defined in section 472 of the Higher Education Act) to determine costs allowable under the Connecticut ETV program. DCF will continue to oversee the state's ETV program in the upcoming planning period.

DCF utilizes state funds to provide for financial assistance to youth who were adopted through the department's foster care program before the youth's eighteenth birthday. The state provides financial assistance for any youth adopted from foster care after December 31, 2004, regardless of age at the time of adoption. This financial assistance is solely to provide support for youth enrolling in a post-secondary program that is an accredited college, university, or institution of higher learning. Presently, the state caps the allowable amount of financial assistance in this program at an amount equivalent to the cost of tuition, fees, room and board at the state's public university. Youth may attend an institution of their choice, as long as it meets the criteria noted above. Youth and their families are responsible for any costs incurred beyond the allowable determined funding level. This support is included in the adoption subsidy agreement.

SERVICE COORDINATION WITH FEDERAL AND STATE PROGRAMS:

The Education Practice Improvement Committee (EPIC) was formed In May 2010 to examine the educational outcomes of children and youth under the care and supervision of the Department of Children and Families (DCF) and to recommend practice changes to improve these outcomes. Its purpose was anchored in the child welfare principle that the well-being of a child includes his/her education success and in the education principle that parental/guardian involvement directly impacts a child's education success.

The membership of the EPIC committee included representatives from multiple areas within DCF including representatives from Education Services, Area offices, Parole Services, Consulting Psychologists, the Connecticut Juvenile Training School, Legal Services, Quality Improvement and Prevention. It also had members from outside of the agency including representatives from the CT State Department of Education and the Connecticut Association of Private Special Education Programs.

EPIC Meeting activities included:

1. A review of literature specifically related to the following topics: the educational outcomes of foster care youth; the impact of underperforming schools on foster care youth; the significance of learning to reading by grade three, the Connecticut State Department of Education's Comprehensive Plan for Education; Connecticut's position statement on Early Childhood Education, and Public Act 10-111, Education Reform;
2. The identification of DCF's strengths regarding the education of children and youth under its care and supervision;
3. The identification of factors that impact the educational outcomes of DCF's children and youth;
4. Discussion of possible practice changes related to the factors identified as impacting educational outcomes;
5. Initial recommendations for practice change;
6. Recommendations regarding the future membership, work and timelines of the committee.

Based upon the committee's multiple perspectives, it identified the following to be current strengths of DCF related to the education of children and youth under its care and supervision:

1. The agency's commitment to education;
2. Its participation in the Early Childhood Partnership that helps prevent youth from being expelled from pre-school;
3. DCF's Headstart Partnership;
4. Its significant work regarding trauma and its impact on the education of children;
5. Its policy, practices and supports for the provision of post-secondary education opportunities for older adolescents who have been in care and who will be transitioning out of care;
6. The provision of comprehensive education services through the Unified School District #2 (USD #2) to all students who reside in DCF facilities and whose treatment needs require that they be educated within the facility;
7. The educational case management for students within USD #2 including those students who are no-nexus and who are placed in private residential treatment facilities and under the jurisdiction of USD #2;
8. The education consultants who provide consultation services to the DCF regional offices;
9. The Circle of Security Parent Program;
10. The provision of educators in the PASS group homes.

The literature describes children and youth who are abused and neglected as "vulnerable children". These children have poor academic success, behavior challenges and a low high school graduation rate. The committee recognizes that there are numerous factors that contribute to the educational difficulties of children and youth who are under the care and supervision of DCF. It did, however, highlight the following factors as ones that it believes have a significant impact on educational outcomes:

1. Experiencing multiple placements is a consistent factor in decreased academic achievement and in increased behavioral difficulty;
2. Receiving complete and accurate education records by DCF and/or the receiving school is essential to a child's timely access to school and appropriate education placement;
3. Identifying and notifying the responsible local education agency (LEA) in a timely and accurate way significantly enhances the child's timely access to free school privileges;

4. Incorporating educational planning as part of a child's discharge planning expedites both the placement and the child's receipt of an appropriate education. Without such planning the scenario of school districts not having a planning and placement team (PPT) meeting until the child is placed and the child not being able to be placed until the education program is in place is frequent and delays the child's placement or access to education;
5. The lack of understanding by educators of the effects of trauma on the education of children and youth can result in the child's early disruption in an educational placement;
6. Difficulty with acquiring data on the educational achievement/outcomes of children and youth under the care and supervision of DCF compromises the ability of DCF and the State Department of Education to identify systems issues impacting the education of DCF children and youth;
7. Differences in LEA's requirements for credits and graduation requirements combined with the multiple placement factor may lead to delayed graduation for some youth resulting in an increased likelihood of dropping out;
8. The lack of a universal pre-school education for all children in Connecticut disadvantages children who enter the care of DCF as many have not experienced a high quality pre-school education that serves as the basis of future achievement;
9. The lack of a consistent adult in each DCF child's life who is responsible for the oversight of the child's educational performance results in a lack of focus on education and an intermittent review of a child's educational progress;
10. Children entering DCF care often have entered kindergarten late or have been retained due to attendance or failure issues, both of which result in over-aged and under-credited youth then prone to dropping out;
11. DCF youth returning from residential treatment centers are often not prepared for regular schools;
12. Vulnerable children struggle with literacy. Children need to learn to read by grade three because at grade four they need to read to learn. Not learning to read by grade three is a strong predictor of poor future achievement.

The committee posited that the consideration of practice changes directly related to the factors identified as those that impact educational outcomes will result in improved educational outcomes for children and youth under the care and supervision of DCF. The committee recommended examining practice change for all of the factors listed above but acknowledged that the scope of this work was vast. The committee also acknowledged that some practice change is already occurring as part of the agency's current work. For example, DCF's implementation of the Education Stability Act is significantly addressing the "multiple placements" factor and its current review of the 603 notification form, policy and practice for notifying LEAs should assist in addressing the "notifying LEAs" issue.

The committee believed that there are critical points in the life of a case and critical ages/grades when specific actions must be taken by the DCF social worker. Towards this end, the committee met monthly through September 2011, at which time it developed a document entitled "Critical Points in the Educational Life of a Child". This document is designed for social workers, identifying the educational milestones in a child's life from birth through post-secondary education. It lists the particular age, the educational milestone and how to determine whether the milestone was achieved. The goal of this document is to provide social workers with a practice guide to be used in the assessment of a child's educational progress at each of the identified critical points in the educational life of a child.

The document, "Critical Points in the Educational Life of a Child", is currently being piloted as part of the agency's implementation of its federal educational stability grant. It is being used in addition to modified versions of the child welfare and teacher screening tools developed by the State of Pennsylvania. This pilot is occurring in the Waterbury Public Schools in collaboration with DCF's Waterbury Area Office.

Determining Eligibility for Benefits and Services (section 477(b)(2)(E) of the Act)

Eligibility for the services in the Chafee program in Connecticut is based on age and permanency goal. All youth ages 13 and up with a permanency goal of APPLA are eligible to access the benefits and services in the program until they reach the age of majority. Youth who are temporarily residing out of state are not denied access to the benefits and services in the program.

Cooperation in National Evaluations
Connecticut DCF will cooperate in any national evaluations of the effects of the programs in achieving the purposes of CFCIP.

Education and Training Vouchers (ETV) Program

DCF provides a comprehensive service delivery system to support youth who have aged out of foster care system. DCF offers youth (at age 18) the opportunity to continue to receive DCF services. Key to the continued receipt of service is the youth's voluntary agreement to comply with DCF policy to participate in an approved educational program. Upon enrollment in a post -secondary educational or training program, the department continues to provide services for youth. According to policy, the Department will fund up to the equivalent of cost of attendance at an identified in-state university (covers tuition, room and board, books and fees) at an approved Post Secondary Institution of the student's choice. The department plans to continue providing these supports to youth who have aged out of foster care.

Connecticut will be meeting with the Youth Advisory Boards and the State Advisory Council to establish goals and outcomes for the ETV program. Specific meetings on this program did not happen prior to the development of the 2015-2019 CFSP.

Consultation with Tribes (section 477(b)(3)G))

See Section 5 (Consultation and Coordination Between States and Tribes)

CFCIP Program Improvement Efforts

The Department has a strong network of Youth Advisory Boards (YABs) that operate in each of its six regions. The YABs are comprised of young people in the Department's care who meet on a regular basis to provide feedback and recommendations about DCF's service array and practices. Representatives from the regional YABs convene quarterly at a statewide meeting with senior leaders at the Department, including the Commissioner. Over the next five years, we will continue to use this structure to gather input from the young people in our care about the service array available to them.

CFCIP Training

See Section 10 (Targeted Plans within the CFSP - Staff Training Plan).

National Youth in Transition Database

The NYTD Survey data is being reviewed to determine where the department can provide specific information/training to our staff, youth and stakeholders that will better assist foster youth with a more successful transition to adulthood. One example is with health insurance. Current foster youth need to know their present health care plan and, that for the vast majority of them, that coverage will continue until their 26 birthday. When the department is surveying former foster youth who report having no health care coverage, the department must make youth aware of their current coverage and possible continued eligibility and how to access this benefit.

Additionally, survey data provides the department with information that may lead to additional program development and/or program modification. One example is with employment. Low employment (part/full time) rates, especially for older youth in care, needs to be addressed in order for youth to have better outcomes. Employment training programs funded by the department need to be reviewed for utilization and outcome data and additional employment training opportunities need to be explored for youth to leave care with both work experience and a savings account.

Lastly, review of the survey data has yielded information that has alerted the department for the need to clarify for staff and youth, questions on the actual survey that will lead to more accurate data collection. An example is with the question that asks if the youth is in foster care. Depending on the staff and/or youth's definition of "foster care" the resulting data may be very inaccurate.

NYTD Independent Living Services data is available but unfortunately is not being used for service delivery improvements nor being shared with stakeholders. Data elements collected for this report are based on several Adolescent Services Payment codes attached to youth that are available in LINK (see attachment) and do not include many services that are paid for by the department through contracts.

DCF Contracts for many independent living services that provide one or more of the elements identified in the "Independent Living Services" data report and these are not reflected in this data, thus negatively skewing the number and type of services youth receive.

The department will continue to collect high-quality data by providing technical assistance and training to the staff who are assisting youth with completing the surveys so more accurate data can be gathered.

The department is in the process of redesigning the State SACWIS and if possible, the new system will allow for additional services to be captured in order to better capture the many independent living services provided to foster youth.

Lastly, the department will expand the number of staff who are assisting current staff with survey completion and outreaching to former foster youth for survey completion. The department will provide more information on continued health care coverage, re-entry into department services

and other critical resources available to former foster youth as part of the outreach efforts to youth who left care.

The department will have a link on their internet website for current and former foster youth to access information, policy, programs and services that will assist them as they transition into adulthood.

The department has designed a service delivery system that allows youth to receive independent living services across the state. Contracts are based on youth population data the department obtains and allocates resources accordingly. Each region has access to independent living services such as One on One Mentoring, Community Based Life Skills, case management for youth in Community Housing Assistance Program (CHAP), and the Work to Learn Programs. Transitional living is available in many areas of the state but not available in each of the regions at this time.

The department offers several options for health education and risk prevention as part of the federal Personal Responsibility Education Program (PREP) grant. These services are offered across the state to all youth in care in all the various settings where they reside. These programs include information and training on a range of topics including: reproductive health and education; risk reduction and prevention; and healthy relationships and living.

Academic support, education and training opportunities are also available statewide. Youth are eligible for tutoring, remediation services as well as summer bridge programs and post secondary education and training. Eligible youth may attend any college, university or vocational training program in or out of state and receive yearly funding equivalent to the State University rate.

The department also has Regional Youth Advisory Boards and a Statewide Youth Advisory Board that meets regularly to address the needs of youth in care. These boards allow the department to hear directly from the consumers what their current needs are and to react and adjust programming accordingly.

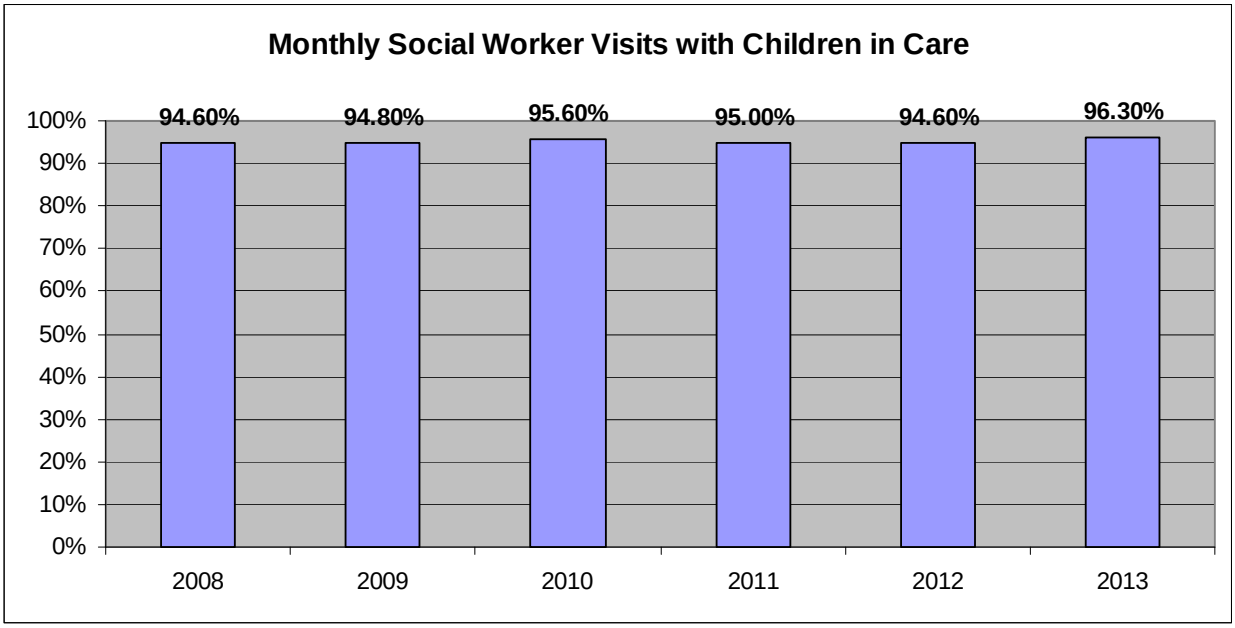
Medical Coverage for Former Foster Youth

The Medical Assistance Unit (MAU), within the Revenue Enhancement Office, is responsible for placing all children in DCF care on an appropriate medical coverage. Since January 2014, when the provision in the Affordable Care Act was implemented, the MAU has been working with DSS (the state Medicaid agency) to place these eligible youths on what is now known as an MO9 coverage. This medical category entitles youths to medical coverage to age 26 - as long as they remain a resident of Connecticut. This medical coverage does require an annual redetermination that is done by the MAU and the youth is not required to participate in this.

For those youth who passed from DCF care prior to January 2014, they can register on Connecticut's accesshealthct.gov website. For those youths who do so, and who indicate that they were in foster care with Connecticut's DCF on their 18th birthday, DSS contacts the MAU to determine if the applying youths meet all other criteria before they are awarded an MO9 coverage. Connecticut DSS does not provide the above-referenced medical coverage to individuals under this eligibility group from any other state but Connecticut.

7. MONTHLY CASEWORKER VISIT FORMULA GRANTS AND STANDARDS FOR CASEWORKER VISITS

The Department's standard is that each child in care be visited at least once per month. The Department's staff have been very successful in meeting this standard over time:



In addition to the policy standard on frequency of visits, the Department has also trained all social work staff in effective visitation techniques through a training entitled "Purposeful Visits." This training covers how to prepare for an effective visit, what kinds of topics and questions to use during a visit and making visitation the core of our engagement with young people.

In the next five years, the Department will use funds from the Monthly Caseworker Visit Grant to continue to improve our assessment tools, provide additional training on visitation and assessment and support activities that social workers and youth can do together to improve their working relationships.

8. ADOPTION INCENTIVE PAYMENTS

The Department completed 503 adoptions in 2011. Because of these excellent efforts, the Department received over $300,000.00 in Adoption Incentive Grant money from the Federal Government.

A number of activities and events have already occurred over the past year and are planned moving forward to support Adoption throughout the year while utilizing the Adoption Incentive Grant money. Some of those activities are as follows:

- Promoting November as National Adoption Month while hosting significant statewide events to bring awareness of the need for adoptive homes. The activities included purchasing radio advertisements, the Bells of Hope Project, and countless open houses across the State.
- Promoting Connecticut Adoption Day that occurred on November 26th during which 6 Probate Courts opened their doors to adoption proceedings for members of the media to highlight the adoption process.
- Sponsoring post adoption trainings and seminars pertaining to the topics of attachment, trauma, parenting, disruptions, self care and other issues featuring expert guest speakers in each of the 5 Areas around the State.
- Hosting adoption nights around the State whereby current foster and adoptive parents bring a family they believe would be an excellent resource for the department to hear guest speakers, including youth placed in care, talk about their experiences and the need for additional homes.
- Purchasing Department logos, banners, and giveaways to promote foster care and adoption at statewide events.
- Promoting the Heart Gallery across the State, which highlights the 20+ children freed for adoption but for whom the Agency has not found a permanent home.
- Contract with the author of PRIDE, Donna Petrus, to conduct 3 day training on the updated PRIDE curriculum and 2 day training on home study assessments. This training would be for DCF and private provider agencies.
- Purchase the updated Parent Resources Information, Development, and Education (PRIDE) license in order to be able to use the updated version of this training curriculum for our foster and adoptive parents. Currently, the Department's PRIDE curriculum is outdated. PRIDE is the training curriculum the State of Connecticut uses for all of our foster and adoptive parents Statewide to prepare them for being a licensed provider.
- Contract with Dr. Joseph Crumbley who is a national expert on the dynamics of relative foster care placements and what is necessary to insure a long term, stable home for children. Dr. Crumbley will present at a DCF sponsored conference entitled “Kinship care”.
- Collaboration with Center for Children's Advocacy to design, edit and re-produce the "I Will Speak Up for Myself: Legal Rights in Foster Care" book and accompanying video to be given/shown to all 12-17 year old youth in care. This project has received previous funding from DCF over the past number of years and includes private funding from Casey Family Services and the Annie E. Casey Foundation.
- Provide funding for the 2012 "Adolescent Permanency Conference". Similar to last year's event, adolescents Statewide would come together to hear motivational speakers, attend workshops and network together regarding the themes of adoption and permanency while in DCF care.
- Provide funding to the Connecticut Association of Foster and Adoptive Parents to cover the increase in open adoption agreements not currently covered by their contract, which need to be mediated between adoptive parents, relatives and birth families.

- Purchase population projects data which will provide greater efficiency to project foster care needs around the state and assist with Geographic Information Systems (GIS).
- Provide funding to Post Latino Inc. to develop and run radio and television advertising in the Latino community.
- Purchase Environmental Systems Research Institute Inc. consultation to further enhance the Geographic Information Systems (GIS) development.

9. CHILD WELFARE DEMONSTRATION ACTIVITIES

Connecticut has no Child Welfare Demonstration Activities.

10. TARGETED PLANS WITHIN THE CFSP

HEALTH OVERSIGHT AND COORDINATION PLAN

Connecticut's Department of Children and Families (DCF) continues to work to develop a comprehensive system of care that helps ensure its mission that children grow up'"healthy, safe, smart and strong". Guided by CWLA, AAP and AACAP best practices, DCF's efforts focus on establishing a community-based system of health care services and support. Developed in 2012, the Health & Wellness framework highlights six strategies to guide decision-making. They include: adopting state and national policy standards; improving case practice and care coordination; advancing community-based systems of care; addressing Connecticut's health equity plan including issues of racial justice; improving information technology and data analytics; and ensuring strategic communications continue to guide development. The six strategies, along with DCF's broader Strategic Plan and more recently developed 2014 Performance Expectations, help guide agency activities. Additionally, success and sustainability require effective collaboration and partnering with other state agencies including the state's Departments of Public Health (DPH), Social Services (DSS), Mental Health and Substance Abuse Services (DHMAS) and Developmental Services (DDS). DCF is also working with the American Academy of Pediatrics (AAP) Connecticut Chapter, American Academy of Child and Adolescent Psychiatrists (AACAP) Connecticut Council and community providers including hospitals, clinics and private providers. Collaboration with families served by the Department and with foster parents is being enhanced through partnerships with CT Association of Foster and Adoptive Parents (CAFAP) and DPH's Medical Home Advisory Council (MHAC) whose Family Experiences section will be convening a workgroup to advise DCF in achieving this five-year plan.

Connecticut's five-year Health Oversight and Coordination Plan builds on the principles outlined above and on strategic partnerships. The below activities are the route to achieve the agency's goals as well as meeting "Fostering Connections" expectations. The efforts focus on three components: 1) program development, 2) policy and practice: development, refinement, implementation and education, and 3) outcomes and results based accountability (RBA): data development and continuous quality improvement.

As described below DCF relies on both internal and external professionals to achieve the goals of improving outcomes and optimizing the health of children in care. Key internal resources include:

- Regional resource group (RRG) nurses who are available in each DCF Area Office (AO) and Region to support offices in addressing child specific issues as well as AO education and support;

- Central Office nurses who in additional to supporting AOs provide training to foster parents and congregate care facilities on safe medication administration and caring for children with complex medical needs;
- Health Advocates who assist with issues relating to insurance and accessing services;
- Regional Psychiatrists who provide case specific consultation and inform agency planning on mental/behavioral health;
- Substance Abuse experts who support both child specific and AO practice;
- Psychologists and Clinical Social Workers with expertise in trauma;
- Centralized Medication Consent Unit (CMCU) APRNs and RNs who oversee all psychotropic medications for children in care (additional detail below); and
- Clinicians in the RRGs who assist with planning for children with behavioral health needs.

Health & Wellness Policy and Practice Guide: Translating Policy into Practice

DCF has recently revised and enhanced its Health and Wellness policy and practice guide to improve outcomes for children in care. As in the past, the guide sets expectations for routine care and health supervision informed by the AAP's "Fostering Health" guidelines and CWLA's "Standards of Excellence for Health Care Services for Children in Out-of-Home Care". These standards continue to include:

- An initial health screen;
- A multidisciplinary evaluation (MDE) before 30 days;
- Ongoing routine health care consistent with Medicaid EPSDT and AAP Bright Futures;
- Medication Oversight and Psychotropic Medication Consent;
- Health Passport;
- Care of children with complex medical needs.

Strategies for improving outcomes and achieving the goals of policy and practice include the following activities and initiatives:

- Education:
  - Providing education on the revised Health & Wellness policy and practice guide:
    - Area Office staff training will be provided through a partnership between RRG nurses and Central Office Health & Wellness Division staff;
    - Partner with CAFAP to provide training to foster parents on the revised policy and practice guide through the already developed "Fostering Health for Children in Foster Care" curriculum that will become part of their pre-licensure training. The training has been reviewed by foster parents through a piloted presentation. CAFAP will assist with monitoring to ensure that the training meets foster parent needs and will assist with any needed modifications to the training based on feedback;
  - Providing education to DCF staff about pediatric health issues especially those areas affecting children in foster care. Topics include: routine health care and supervision including EPSDT screening, immunizations, dental care, trauma, child development, and human trafficking with a goal of ensuring that AO staff receive ongoing routine training and updates on topics important to children in foster care and child welfare. Standardized curricula will be developed by DCF's nursing Community of Practice (COP) with training scheduling and regional specificity of content managed by DCF's Regional Rescourc Group (RRG) nurses;
  - Developing SharePoint "library of trainings" including power points and resources.
- Continuing the partnership with DSS to ensure children receive timely quality health services:
  - Health Advocates and Medical Assistance Unit continue to ensure that all children in DCF's care are enrolled in Medicaid;

    - Through a Memorandum of Understanding with Community Health Network [note: CHN is DSS's ASO for medical care] develop a mechanism for using claims data to track receipt of routine and disease-specific health services that can inform the child's case plan and Administrative Case Review.
- Consulting with medical and nonmedical professionals is essential to best outcomes for children and families. DCF's participation in workgroups and committees facilitates communication and collaboration on programs and processes affecting children in its care. Formal and informal communication are facilitated through partnerships with stakeholders. Recently intensified efforts are occurring to partner with professionals in pediatrics and psychiatry. Specific strategies for ensuring consultation:
    - Work of nursing COP to standardize nursing practice and optimize use of RRG nurses and CO nurses and supports. DCF's Change Management initiative involves a number of COPs focused on developing strategies and recommendations which will help achieve agency goals;
    - Continued availability of Regional Psychiatrists and the Director of Pediatrics for direct consultation on child-specific issues and program development;
    - Maintenance of the Medical Review Board (MRB), which provides recommendations to the Commissioner in matters concerning the medical care and treatment of children in the care and custody of DCF when their health situations are exceptionally complex or present other ethical and/or legal issues;
    - Continued participation in workgroup and committees. Examples include: DPH Medical Home Advisory Council (MHAC), Medicaid Program Oversight Committee (MAPOC), Hartford Care Coordination Collaborative (HCCC), and Psychotropic Medication Advisory Council (PMAC).

DCF's Enhanced Multidisciplinary Evaluations (MDEs)

DCF began requiring a Multidisciplinary Evaluation (MDE) within 30 days for children entering care in 1985. Over time this process has evolved from a pilot project to a statewide contracted service. MDEs include medical, dental, mental health and developmental components and are performed by contracted providers serving each of the agency's Regions and Area Offices. In the last year, DCF and its MDE clinic contracted providers collaborated on the development of a protocol aimed at enhancing the MDE experience and product. Monthly meetings led to the revision of policy and practice to ensure that the process best supports children, caregivers and biological parents and leads to a quality report that informs case planning. Specific strategies included in the new MDE practice guide:

- Standardization of the MDE report across the all MDE providers;
- Expansion of MDE criteria to include all children entering care including those re-entering DCF and, if appropriate, voluntary services;
- Expansion and standardization of mental health and developmental screens including Ages and Stages, screening for Fetal Alcohol Syndrome Disorder, and trauma screening;
- Standardization of recommendations to facilitate their integration into a child's case plan and utilization at ACR;
- Protocols for ensuring communication of MDE summary findings and recommendations to a child's primary care provider (PCP) and his/her placement/caregiver;
- Rigorous QI/QA system with RBA outcomes and the development of a mechanism for standardized data collection;
- Training of AO staff by DCF MDE champions and MDE clinic providers.

Plans for continued support and enhancement of the MDE include the following steps:

- Implementation of the revised and enhanced MDE practice guide;

- Provide training and education to AO staff about the new guide and how it supports and improves planning for children in care. MDE contracted providers and representatives from DCF AO and Central Office have worked together on the development of training material and will partner in presentations to AO staff;
- Continue with quarterly MDE meetings of MDE clinic providers and DCF representatives;
- Implement data collection and QA mechanisms and toolkit with yearly QA team reviews of each MDE clinic and AO practice. Components of QA team review include review of randomly selected MDE reports and care plans to assess quality of assessment and recommendations and the incorporation of latter into the case plan;
- Potential re-procurement of MDE clinics based on information gathered from reviews over the next one to two years.

<u>The Development of Regional Systems of Care: Partnership with Connecticut's Chapter of the American Academy of Pediatrics (AAP)</u>

DCF is collaborating with the CT Chapter of AAP on an initiative to develop regional systems of care. The goal is to ensure that all children in DCF care have access to "Medical Homes" familiar with the unique needs of children in foster care. Rather than developing special stand alone foster care clinics, this community based system of providers reflects recognition that the majority of children in DCF care remain in their community and are best served by providers familiar with them and their families. It is also consistent with DCF policy that supports maintaining a child's primary care provider whenever possible. Beginning in spring 2014, AAP will identify "Pediatric Champions" from practices throughout the state interested in partnering with DCF. Together with AAP Chapter and DCF leadership, Pediatric Champions and AO Pediatric Liaisons will meet toward building relationships and developing strategies for best meeting the needs of children based on clear expectations and best practices. Components of the project include:

- Development of 'regional teams' chaired by Champions from both pediatric practices and DCF AOs;
- Attention to partnerships with DSS' identified Person-Centered Medical Homes (PCMH) as key collaborators in this initiative as all children in DCF are eligible for inclusion in this important initiative;
- Shared training about respective best practices in Pediatrics and DCF/Child Welfare including, e.g., Medical Home, Strengthening Families;
- Identification of clear expectations;
- Development of protocols of practice which include mechanisms for communication and consultation;
- Development of regional templates for care which outline specific AO/Provider Practice steps for achieving required health care including an initial medical screen; completion and review of MDE with incorporation into case plans; ongoing routine medical care consistent with national best practices; maintenance of health records including DCF health summary;
- Engagement of caregivers and biological parents in planning;
- Development of measures and RBA outcomes;
- Development of mechanism for supporting Pediatric practice partners including potential AAP Maintenance of Certification (MOC). Pediatricians are required to completed the MOC to maintain their subspecialty certification,

"Healthy Mouths, Healthy Kids" Initiative

The "Healthy Mouths, Healthy Kids" initiative is a cooperative interagency project among DCF, DSS and the Connecticut Dental Health Partnership [note: CTDHP is DSS' ASO for dental care]. The objective of the project is to ensure that children in DCF care receive oral health care services at an established dental home beginning at age one but no later than age three to achieve optimal oral health. Through regular oral health evaluations the prevalence of dental disease and adverse oral habits can be reduced. This also will be accomplished through routine dental check-ups every six months.

There are two parts to this project:

1. DCF Health Advocates and CTDHP collaborated on the development of a presentation to heighten awareness of AO staff about the oral health needs of children in DCF care. The presentation is a total of 15 minutes: 8-10 minutes of content followed by a brief question and answer period. Information is also provided on resources available to AO staff;
2. The goal of the second part of the project is to assist AOs by providing them with data about specific children on their caseload who have not received recommended dental care. A database developed through an MOU with CTDHP will identify children who are overdue for routine dental care (not having had a dental check-up every six months). The database identifies the date of the last exam and dental office name and phone number. DCF Health Advocates will provide AOs with data specific to their offices as well as be available to assist social workers and facilitate referrals to CTDHP as needed.

Quarterly data first became available from the database at the beginning of April 2014. It identified children in care over the age of three who are overdue for dental care follow-up. As of the end of March 2014 there were 1,414 children or 57% of children, age three and up, who were identified as overdue for routine dental check-ups. This rate is similar to that of the CT Medicaid population overall. The goal over the next two years is to reach 85% of the children in DCF's having routine dental check-up every six months.

The 'Healthy Mouths, Healthy Kids' project plan includes:

- Completing initial education of AO staff (completed May 2014) and provide yearly updates;
- Implementing quarterly AO data sharing activities beginning May, 2014;
- Expanding training to foster parents and other placements;
- Ongoing data assessment and problem solving at both AO and state levels with modifications or revisions of project plan if needed in order to achieve goals.

DPH Medical Home Care Coordination Collaboratives (HCCC)

For the last four years DCF has been a member of the CT Hartford Care Coordination Collaborative (HCCC), a DPH-funded medical home initiative focused on care coordination, efficiency and a holistic approach to health and well-being. The HCCC mission is to serve families and child health care providers in the great Hartford area by:

- Identifying and maximizing the full range of resources available;
- Supporting care coordinators in obtaining the care and services needed by children and their families.

The HCCC also seeks to understand health and human service delivery systems in order to: promote wellness, support the medical home, assist families in negotiating these systems and document the gaps and barriers that families experience. Participants from DCF include Hartford AO social workers and

RRG nurses, Health Advocates and members of the Central Office Medically Complex Unit. Community-based participants include: representatives from CHN, the Behavioral Health Partnership (BHP), and the CTDHP (DSS's Medicaid ASOs for medical, mental health and dental care). Additional partners include CT Family Support Network, Connecticut Children's Medical Center's Special Kids Support Center (SKSC) and the United Way 2-1-1/Child Development Infoline (CDI). Discussions from these meetings have:

- Led to the identification of resources and strategies to improve services to better meet the needs of children and families in DCF care;
- Facilitated communication across sectors that have provided effective and efficient linkage to services for children and families;
- Resulted in the development of partnerships that assist beyond the collaborative.

This year DPH has sought to add four additional Regional Care Collaboratives through the Request for Proposals procurement process. The plan is to model these additional collaboratives after the HCCC. The new collaboratives will serve the other Medical Home Initiative (MHI) regions of the state. DCF's Central Office Medically Complex unit nurses and Health Advocates will assist AOs in identifying social workers and RRG nurses to join in these new collaboratives once established, thus facilitating care coordination for children and families served by DCF.

Future strategies include:

- Continued participation by CO and AO representatives on the HCCC;
- Have local AO and health advocates join the four new Regional Care Collaboratives once they are identified. Ensure local AO and Health Advocate participation;
- Partner with Regional Care Collaboratives to develop shared care coordination models across agencies.

ACCESS-Mental Health CT

ACCESS-MH CT is a model that will provide telephonic psychiatric consultations by child and adolescent psychiatrists to Primary Care Physicians in the state for all children under 19 years of age regardless of insurance coverage. The program allows for face-to-face consultations when a telephone consultation with a child psychiatrist and/or clinician is not able to completely address the PCP's questions. This program is scheduled to begin in June 2014. Three "hub" providers have been contracted to provide the services; the program will be managed by ValueOptions with DCF oversight. Each hub will be comprised of a child psychiatrist, behavioral health clinician, family peer specialist and a care coordinator. The hours of operation will be from 9 a.m. - 5 p.m. Monday through Friday.

Performance Measures:

1. 80% of all PCPs will receive information and an invitation to enroll by June 30, 2014; of the targeted 80%, 50% will enroll by September 30, 2014;
2. 85% of the enrolled PCPs who have used the system will be satisfied that the system was useful and helpful;
3. 90% of the enrolled PCPs who have not used the system will receive follow-up outreach to assess why the PCP has not yet used the service;
4. Data collection will also include total number of calls made to each hub, number of face-to-face child psychiatry consultations per hub, and the percent of children who were able to be maintained with care provided by the PCP following a consultation.

Centralized Medication Consent Unit (CMCU)

The CMCU, staffed by nurse practitioners, child psychiatrists, and a registered nurse, is responsible for making decisions on all psychotropic medications recommended by a provider for a DCF-committed child/youth. In addition the unit maintains the policies, practice requirements and guidelines regarding the use of all psychotropic medications in DCF-committed children. These guidelines and requirements are developed in collaboration with the Psychotropic Medication Advisory Council (PMAC), a DCF-organized council composed of public and private physicians, clinicians, nurses, family members and pharmacists. PMAC meets regularly to: recommend psychotropic medication dosing and monitoring guidelines and requirements; collect and review adverse drug reaction reports; and beginning in 2014, conduct routine pharmacy utilization reviews.

Next Steps:

1. The medication request forms are being updated to include DSM 5 and the new mandatory monitoring requirements;
2. The CMCU website is being updated;
3. Drug utilization studies will be reviewed in PMAC and any ramifications for DCF policies/protocols will be managed by the CMCU staff;
4. As ACCESS-MH CT begins consulting with PCPs on psychotropic medication management issues, CMCU will work closely with the consultation teams to ensure that the requirements for DCF-committed youth are instituted.

Health Information and Documentation: The "Health Passport" and Health Reports

It is important that DCF maintains current health records for all children in its care and that they are readily available to best support children. The revised policy and practice guide requires that all placements maintain current health passports which consist of a Health Summary, Report of Health Visits, the child's Medicaid Insurance Card, a copy of the Consent for Routine Care with the instruction sheets explaining the DCF consent process, immunization records and a log of provider visits. As developed, the Health Passport system, including the process for updates through the report of health visits forms, facilitates the monitoring and oversight of all aspects of a child's health including medication details. Representatives from CT AAP assisted with the drafting of the content of the Health Passport and enthusiastically supported the implementation of this tool through the DCF collaborative 'Regional Systems of Care' initiative described above. As envisioned, the new Statewide Automated Child Welfare Information System (SACWIS) system will further support documentation through inclusion of a "health report" system that captures the elements of the Health Passport including the health summary, report of health visit, and immunization record. DCF is in the process of developing criteria and identifying vendors; it is anticipated that the new SACWIS system will be available in the next 18 months. Pending availability of this new system, DCF nurses will support AO staff in better utilizing and updating the existing LINK (SACWIS) systems Medical Alert template which can be expanded to include information contained in the Health Summary. The expectation is that all placements will have a readily accessible, portable copy of the Health Passport which accompanies the child on every visit and whenever he/she travels.

The foundation of the Health Passport is the "Health Summary," which builds on work of Health Resource and Services Administration's (HRSA) Maternal Child Health Bureau Title V aimed at improving outcomes for children and youth with special health care needs (CYSHCN). Notably, the AAP considers all children in foster care to be children with special health needs. The goal of the Health Summary is to provide a format for capturing information about a child's current medical issues, treatments, medications, as well as provider names and contact information. As with CYSHCN, the goal

is to ensure that children get the care they need. AO social workers and nurses are responsible for ensuring that the health summary is current.

The "Report of Health Visit" completed by providers at each health visit informs the placement and AO social worker of any changes in care. Changes in care may require further follow-up, modification of the "health summary" or other action steps. Completed for all health visits, the Report of Health Visit ensures that DCF is informed of all changes and permits tracking of medications, referrals, status of conditions and any necessary follow-up.

The DCF plan for enhancing medical information and documentation includes:

- Educating stakeholders about the Health Passport including immediate strategies for using the existing Medical Alert;
- Informing DCF planning on the new SACWIS/LINK program and planned "Health Report". Elements include:
  - Incorporation of Health Passport elements including Health Summary and Report of Health Visits;
  - A secure portal to permit community providers to make updates to the Health Report and Report of Health Visits;
- Completing development of a data development plan that will ensure a mechanism of ongoing tracking of child specific health information and population health data and outcomes;
- Work with AAP-DCF Regional Care Initiative partners to develop tools for data collection that will permit child, AO and state level review.

DISASTER PLAN

There have been no changes in the Department's Disaster Plan.

The Careline is the central location that responds to emergency and disaster situations after hours and on weekends. There were two disasters that occurred this past year; a Hurricane on November 5, 2012 and a blizzard in February 2013. Both storms rendered many people without power and a lengthy clean up operation conducted by state, city, town and private contracted workers. The state of Connecticut brought in other contractors from other states to assist.

Prior to both storms, the Area Office staff, Foster Care Director, and Licensing Division reached out to foster families and Congregate Care settings to proactively plan with them in the event that they had to evacuate their location. Foster parents as well as our Safe Home, STAR programs and residential facilities were advised to contact the Careline to report any issues/concerns with their programs. This is a standard operating practice regardless of an emergency. The Careline then sends emails to all staff that are involved with the family/child(ren). The Careline discusses their plans for relocation to ensure safety of the placement staff and the children. This year the Careline added a logging system to track the foster home relocations and follow up. Additionally, DCF Risk Management team tracked the congregate care settings relocation plans.

During the first disaster (Hurricane), some DCF area office locations were impacted as they were without power and had some building damage. The second disaster (Blizzard), brought several feet of snow in places and it took some time to remove snow from all the parking areas to allow for staff to return to work. This was a complicated process as the resources to clean up the parking lots were being utilized in other parts of the state. The state was closed for business for two days. In actuality it was a six day storm from start through cleanup with a state Holiday in the middle. Based on the previous year's storms, relocation plans were discussed in advance and planning was coordinated more smoothly. Area offices are required to invoke the Business Continuity Plan (BCP) when they lose power or have an emergency.

All facilities are required to have BCP's. All facilities are required to report any disruption in services to the Careline or the Risk Management Division through their Significant Event reporting system. In the last two storms, Risk Management continued to play a key role in collecting and disseminating information about power outages at the facilities.

Licensing sent emails to providers immediately after and in the two weeks following the storms, requesting updates regarding power outages. During the Hurricane, it was noted that there had been considerable progress with regard to communication between Agencies/foster homes/providers, and the Department, subsequent to the weather emergencies of the previous year. While there were multiple power outages, facilities reported to the Careline in a timely manner, and kept the Department apprised of relocation, needs, and progress with power restoration. While there were multiple reports, the pre-planning resulted in ongoing communication through the Careline and Risk Management.

During the record breaking Blizzard, there was only one Therapeutic Foster Home that reported a power outage, resulting in disruption. However, the Department assisted in locating and securing generators and other resources for foster homes, in an effort to minimize the disruption and trauma to children/families. In each of these instances, the ability to receive prior knowledge of these storms resulted in the Department's proactive position, minimizing the need for reactionary response.

As a result of the previous year's storms, DCF was able to secure funds to purchase generators for facilities and foster parents who require them to meet the needs of congregate settings and medically complex children. Notification was sent to providers about the availability of these funds.

TRAINING PLAN

DCF operates an internal Workforce Development Academy with the primary responsibility of offering pre-service training, in-service training, coaching

Post Masters Certificate Program
The goal of the Certificate Program is to train child welfare professionals, community mental health providers, adoption services providers and private practitioners to establish a cadre of adoption competent professionals in the community who can then offer post adoption services with clinical expertise to children and families, particularly those who have adopted through the Department of Children & Families (DCF).

The Certificate Program is a collaboration between the UConn School of Social Work (UConn), Southern CT State University (Southern), DCF, and the Adoption Assistance Program at the UConn Health Center. Ten class sessions are held monthly from October to June and alternate between the two universities. The program focuses on cutting edge practices used on a national level to improve services to children and families dealing with a myriad of issues related to permanency. Cross training between DCF staff and providers also creates an opportunity for collaboration and the creation of a shared vision of practice. The feedback from this training program is overwhelmingly positive and has received national attention. The Center for Adoption Support and Education recently requested that this model be used as a demonstration site for the implementation of Training for Adoption Competencies program in an effort to create national standards for training on adoption.

MSW Field Program
The program began in 2004 in response to a need for additional staff development opportunities for those DCF employees seeking an MSW degree. The program is a replacement for the SWIP (Social Work Internship Program), which is now defunct. First and second year students as well as advanced standing students have benefited from the program. Priority is given to students seeking their second-year field placement. The intent of the program is to foster support of our social workers by allowing them to meet their university requirements for 20 hours of field instruction within their regular forty hour work week. In essence, no additional field instruction hours are required outside of the regular work week.

A major component of the program is that it allows the social workers to use their place of employment as their field instruction, while maintaining their current caseload within their current unit. A field instructor outside of the student's chain of command is utilized to ensure a separation of work and learning responsibilities. This supports the agency standard of limiting shifting caseloads. It also benefits the families and children served as they are able to maintain continuity of social workers. Finally, it benefits the social worker as he/she is given the opportunity to keep the caseload they are familiar with yet learn to service their clients more effectively with predictably better outcomes. Flexibility also is available on a very limited basis to reassign cases or employees to other units to give employees a different learning experience on an as-needed basis and with the consent of the University involved, student’s chain of command, MSW field instructor and DCF Academy for Family and Workforce Knowledge and Development ("the Academy").

Additionally, the program prepares students to look for opportunities to provide service "above and beyond the norm," identify gaps in service delivery and provide solutions, and gain better understanding of DCF as a whole. All of this is accomplished by adhering to a strength-based perspective in keeping with the agency's mission. To date, the program continues to be successful. It has been heralded by social work supervisors, participating universities and students as a whole as they appreciate the new perspectives on cases and learning opportunities for students.

DCF Stipend Program

Internship programs are one of the most effective recruitment strategies used by many professions. These programs are mutually beneficial to both the students and the agency, as the on the job experience is a perfect opportunity to determine suitability for the job. Special emphasis has been placed on marketing the internship program as a recruitment tool for child protective service workers. In the fall of 2010, the Academy launched its first student stipend program for external students interested in employment at the Department. In this competitive program, students in their final year of a BSW or MSW program are selected to participate in an internship process in a regional office where they receive orientation, training and real-time experience handling child welfare- related activities. Students receive a $3,000 stipend to offset the cost of their education and are required to meet agency practice standards. Upon graduation and receiving a recommendation from their field supervisor, students must repeat a background check and an interview process. If successfully completed, students are prioritized in the hiring process. If no positions are available three months after their graduation date, students are released from any obligation to wait for employment or repay the stipend. To date, 27 students have successfully completed the program. Unfortunately, due to a significant decrease in hiring, only two students from the program have been offered employment to date. However it is anticipated that the hiring process will resume in the very near future. The Department's Division of Human Resources has agreed to prioritize hiring to this intern cohort.

Training for new workers to ensure competencies

The DCF Academy offers a series of mandatory training modules over the course of 10 months to all new social workers hired to conduct child welfare-related case activities in the regional offices. The pre-service program is designed to prepare each staff member for effective protective service/child welfare practice. There are several components to the pre-service program: classroom training at the Academy, supervised casework experience in a training unit in the regional office, and practice level activities aimed at enhancing the transfer-of-learning process. Each new hire attends 25 classes and receives 34 total days of training.

During this review period, the Academy successfully integrated training related to the agency Practice Model into the pre-service training program. Specifically, this included training on family engagement, purposeful visits and family-centered assessments.

This year, the Academy only trained 8 new social workers in the pre-services program. This is a significant change and is attributed to the decrease in hiring of social workers.

In-service training for caseworkers

Per agency policy, all staff must attend five (5) days of in-service training per year. In-service training is available to all staff and is offered throughout the year. Training classes are posted in an online catalog, and staff can "self-register" with supervisory approval.

It is noteworthy that there is currently no infrastructure in place to determine staff training needs or monitor the compliance of this policy. In 2009, the Academy implemented the Learn Management

System (LMS), a data system to track training in a more efficient manner. LMS has the capacity to automate the registration process, develop learning plans and offer web-based training. In order to maximize the system to its full potential, an automated time card process needs to be in place for the approval process in LMS to be activated. This process is scheduled to be fully implemented by June 30, 2013, at which time the Academy will begin to maximize the Learn Management System.

In-service training continues to be a priority for the Department. The Academy offers an average of 15 in-service training classes per month when other mandatory statewide initiatives are not prioritized. Classes generally fill up quickly and are very well received by staff. The Academy continues to utilize the satellite office in New Haven to decrease travel time and distance for staff located in the southern part of the state.

Last year, the Academy continued to focus its attention on training staff on the "Strengthening Families" Practice Model. The first three days of the learning experience, commonly referred to as the "Partners in Change" (PIC) training, focused on the agency's paradigm shift towards family-centered practice. The training emphasizes six principles of partnership:

1. Everyone has strengths;
2. Everyone desires respect:
3. Everyone deserves to be heard;
4. Judgments can wait;
5. Partnership is a process; and
6. Partners share power.

Efforts have been made over this review period to offer PIC training to community providers with the intention of creating consistency in practice across systems. As the agency engages in a paradigm shift towards family-centered practice, continuity in knowledge and skills development with both internal and external staff is critical.

The Academy also has placed major focus on training and consultation regarding initiatives that builds on the agency Practice Model. This has included training of approximately 500 staff on Differential Response System, a major reform in practice that allows for a provision of assessment and supportive services for families with lower risk factors without substantiation of abuse or neglect. The Academy ensured community providers were made aware of this change in practice by offering training upon request and by adding information regarding DRS into the online and in-person Mandated Reporter Training.

Certification Programs

The Academy continues to offer certification training programs by functional assignment to ensure that staff are properly orientated to their assigned positions within the agency and are practicing with similar goals and values. During this period under review, the Academy successfully delivered certification training on working with adolescents (8 days) and investigations (10 days).

In addition to the agency-mandated training such as the Practice Model initiative, and the currently-developed certification training by functional assignments, identification of training needs of staff is determined by the employee's direct supervisor and the quality improvement staff assigned to each location. The direct supervisor determines training needs based on staff performance. The local quality improvement personnel assess staff training needs based on data and outcomes at the office level. Offices routinely hold training according to their identified training needs and subsequently report that information to the Academy for data entry into LMS.

In-Service for Supervisors

The DCF Academy continues to offer a number of training curricula to current and newly promoted supervisors. These trainings for new supervisors include:

- Effective Leadership;
- Making the Transition from Social Worker to Supervisor;
- Building Staff Capacity;
- Promoting Excellence in Performance;
- Building the Foundation for Unit Performance;
- Achieving Client Outcomes; Case Consultation and Supervision.

Transfer of learning activities are integrated into all training content. Supervisory trainings are provided by a combination of Academy staff and consultants from outside the division and the department, and are offered on an ongoing basis. Supervisory staff prioritized their training needs to comply with agency mandated training related to the Practice Model. Training for newly promoted supervisors is provided by academy staff and is ongoing as needed. During this review period, the academy trained 4 new supervisors.

Coaching for Regional Office Supervisors

The Department made a decision to embed coaching into the Practice Model very early in its development. The primary purpose of the coaching was to support the supervisor role in implementing principles of the Practice Model. During this period under review, seven offices and approximately 60 supervisors participated in coaching activities. Each office had its own coach hired as a consultant to the Department. While group supervision was the primary mode of coaching, many supervisors (particularly those in Region 3) requested and made good use of individual coaching. Supervisors met twice a month on average. Initially, supervisors expressed reservations with the process, and all coaches reported a period of testing. However, over time, this dissipated and supervisors began to effectively engage with the coaches and each other. In general, the supervisors enjoyed meeting as an affinity group and used the time to strengthen their relationships. The supervisors, acting as a team, used these meetings to effectively trouble shoot office dynamics and common struggles with their supervisees. The supervisors often shared common experiences with the implementation of the practice model and discussed ways to manage the multiple practice changes. Coaches used an “appreciative inquiry” approach to build on what is currently working well.

In-Service for Managers

Program Managers from the area offices, central office, and the facilities participated in one of several two-day events on Strengthening Supervision offered by consultants from the *Yale Program on Supervision.* The purpose of the program was to support the current organizational development work by increasing managers' competency in structuring supervision to undergird the current organizational change process. The training program has received both buy-in and feedback from Area Directors, Regional Directors, and the Commissioner's office. Feedback from the training sessions was very positive with managers specifically noting that the opportunity to brainstorm ideas and share and learn from colleagues was extremely valuable. Subsequent meetings with leadership resulted in recommendations for changes to the policy on supervision. This policy is currently being reviewed by key leaders in the agency and is expected to be implemented by the end of the year.

The Academy is currently in the process of developing a comprehensive training plan to address the on-going learning needs of the managers. Future training topics for fiscal year 2013- 2014 will include the following:

- Managing Change
- Building Collaboration
- Managing for Results
- Managing People
- Managing Domestic Violence

How skill development of new and experienced staff is measured

Evaluations are distributed at the end of each class in an effort to gather specific information regarding overall feedback, relevance and application of class content. In addition, all new employees take a pre-test on day one of their training program and a post-test on the last day to assess knowledge and retention of class content. Academy staff also partner with supervisors and managers of new employees to coordinate the learning process for staff. Bi-monthly meetings are held to discuss skill development and to trouble-shoot any barriers to the learning process. Transfer of learning activities also is built into the pre-service training programs to ensure content is applied to the practice.

In addition, the Academy has begun to build in transfer-of-learning opportunities for in-service class offerings. For example, "Partners in Change" conference calls are held bi-monthly to assess implementation of the practice model training, identify barriers and celebrate successes related to practice improvements. An average of 60 staff volunteer to participate on the call, and the overall feedback has been very positive.

Section E. FINANCIAL INFORMATION

Payment Limitations - Title IV-B, Subpart 1:

- The Department did not expend Federal Title IV-B, Subpart I funds for child care, foster care maintenance, and adoption assistance payments in either FY 2005 or 2014.
- Therefore, no non-Federal funds expended for foster care maintenance were applied as a match for the Title IV-B, Subpart I program in FY 2005.

Payment Limitations - Title IV-B, Subpart 2:

State of Connecticut - Department of Children and Families
Maintenance of Effort
Child and Family Services Plan for June 30, 2014 submission

	FY 2012	FY 1992
Program Type	State Expenditures	State Baseline
Family Preservation	50,501,192	12,983,241
Family Support	54,041,872	5,278,088
Totals	104,543,064	18,261,329

State share of Title IV-B, subpart 2 expenditures for comparison to 1992 base as required for evidence of compliance with non-supplantation requirements in Section 432 (a) (7) (A) of the Social Security Act