

Connecticut Department of Children and Families



Executive Staff

- **JOETTE KATZ, Commissioner**
- **Janice Gruendel, Ph.D., Deputy Commissioner**
- **Fernando Muñiz, Deputy Commissioner**
- **Susan Smith, Chief of Quality and Planning**

Resources

- ***Established - 1970***
- ***Statutory authority - CGS Chap. 319***
- ***Central office - 505 Hudson Street, Hartford, CT 06106***
- ***Average number of full-time employees - 3,028***
- ***Recurring operational expenses - \$772,096,189***

Organizational Structure

- **Office of the Commissioner**
- **Division of Operations**
- **Division of Quality Improvement and Planning**
- **Division of Finance and Human Resources**

Mission

Working together with families and communities for children who are healthy, safe, smart and strong.

All children and youth served by the Department will grow up healthy, safe and learning, and will experience success in and out of school. The Department will advance the special talents of the children it serves and offer opportunities for them to give back to the community.

Seven Cross Cutting Themes

- *A family-centered approach* to all service delivery, reflected in development and implementation of a Strengthening Families Practice Model and the Differential Response System;
- *Trauma-informed practice* as related to children and families but also to the workforce that serves them;
- *Application of the neuroscience* of child and adolescent development to agency policy, practice and programs;
- *Addressing racial inequities in all areas of our practice*;
- *Development* of stronger community partnerships;
- *Improvements* in leadership, management, supervision and accountability; and
- *Establishment* of a Department culture as a learning organization.

Regional/Area Offices

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Bridgeport Norwalk/ Stamford	Milford New Haven	Middletown Norwich Willimantic	Hartford Manchester	Danbury Torrington Waterbury	Meriden New Britain

Facilities

- Connecticut Juvenile Training School (CJTS)
- The Albert J. Solnit Children's Center -- North Campus (formerly Connecticut Children's Place)
- The Albert J. Solnit Children's Center -- South Campus (formerly Riverview Hospital)
- Wilderness School

DEPARTMENT DATA AND INFORMATION

Children and Families Served

- At any point in time, the Department serves approximately 35,000 children and 15,000 families across its programs and mandated areas of service.
- Approximately 14,000 cases are open on a given day.
- Approximately 2,000 investigations and 1,000 family assessments are underway at a point in time.
- Approximately 4,000 children are in some type of placement.
- Positive Trend: There are 780 fewer children in care as of July 1 2013 compared to January 2011. That is a reduction of 16.3 percent.
- Approximately, 535 children receive voluntary services and are not committed to the Department. The vast majority of these children receive services at home.
- Adoptions were finalized for 550 children, and subsidized guardianships transferred for 261 children during SFY2013.

- Positive Trend: The % of children overall placed with relatives, has risen to 24.4% in July 2013 compared to 17.3% in January 2011. If we count kin placement, that number is 29.8%. This is a 41.8% increase compared to January 2011.
- Education: Post secondary (2 or 4 year colleges or other full time school) program provided financial support for 602 youths in SFY13 up to age 23.

Reports of Abuse and Neglect

The Careline (formerly “Hotline”) received approximately 96,000 calls in CY2012. Of those, 46,390 were reports, and 27,890 reports were investigated. In SFY2013, 1,042 allegations of physical and sexual abuse were substantiated as were 12,313 allegations of physical, emotional, educational and/or medical neglect.

Adoptions and Subsidized Guardianships

Adoptions were finalized for 550 children. Guardianship was transferred for an additional 261 children whose new family is receiving a subsidy from the Department.

Supporting Success through Post-Secondary Education

602 youth attended a post-secondary education program with the department's support in SFY2013.

IMPROVEMENTS / ACHIEVEMENTS 2012-2013

Strengthening Families Practice Model

- Experience and research indicate that the quality of family participation is the single most important factor in the success of our interventions.
- The Strengthening Families Practice Model and Differential Response – which is an important component of the practice model -- will substantially improve how we support families to take control and responsibility of their own treatment and their own lives.
- Trained 2,000 DCF employees in the new Strengthening Families Practice Model.
- Statewide implementation began in 2011 under the current administration.

The core components of the practice model include:

- Family Engagement
- Purposeful Visitation
- Family Centered Assessments
- Supervision and Management
- Child and Family Teaming
- Effective Case Planning

- Individualizing services

Differential Response System (DRS)

- On March 5, 2012, CT DCF launched its Differential Response System (DRS) -- the capacity to treat reports differently based on the level of risk.
- 30 jurisdictions have this dual or alternate response system.
- Studies indicate lower rates of removals and repeat maltreatment and greater family satisfaction – with no decrease in safety.
- The dual-track system enables DCF to respond to low and moderate risk families in a less adversarial manner shown more effective in dealing with prevalent issues of neglect and poverty.
- The Careline initially determines the track: investigation or assessment.
- Area offices utilize nationally-established, evidence-based tools to determine safety and risk levels and either confirm or override the initial determination of the assessment track.
- If a child is found to be unsafe, the case is switched to investigations.

DRS: Traditional Investigations

- High-risk cases, as well as cases with police involvement, sexual abuse and serious physical abuse, or multiple reports receive traditional forensic-style investigations.
- Investigations occur within 45 days, include contacts with collaterals (medical, educational) & interviews with all household members.
- Result is either substantiation with an identified perpetrator (16% of investigations in SFY13) or an unsubstantiation.
- Both substantiated and unsubstantiated investigations can be transferred to services.

DRS: Family Assessment Response (FAR)

- The Family Assessment Response (FAR) track is an alternative to the traditional investigation for reports involving low and moderate levels of risk.
- Not an investigation focused on an accusation
- Does not identify a perpetrator
- Does not substantiate abuse or neglect
- Not compulsory or forensic
- FAR is a strengths-based, family-focused model that works together with families to identify their strengths and needs and to help connect families with services and supports in the community.

- The FAR track relies upon family participation in assessing strengths and needs.
- FAR utilizes a Family Team Meeting to engage the family in the assessment, planning and treatment.
- FAR utilizes a strengths-focused approach that looks to the natural supports in the family and the community.
- If the family wishes to participate and there is a need for continued support, the family will be transferred to a community partner agency and DCF will close its case.
- If a safety factor has been identified, DCF will continue case management.
- In 2012, 36% of accepted reports were tracked to FAR.
- In the first six months of CY2013, 38.3% tracked to FAR. In June 2013, it was 39%.
- FAR is used for families at low or moderate risk unless any of 15 “rule outs” apply. Rule outs include:
 - Potential criminal child abuse or neglect
 - Sexual abuse
 - Open protective service cases
 - Incapacitated caregiver
 - Newborn or mother of newborn with positive drug screen
 - Two or more substantiated investigations in the last 12 months
 - Previous adjudication of abuse/neglect
 - Previous risk assessment of high

Academy for Family and Workforce Knowledge and Development

- Reflects the belief that collaboration among interdisciplinary professionals (1) improves services and client outcomes and (2) ensures that workforce knowledge and development remains a continuous and coordinated process within and across agencies.
- In addition to mandatory 10-month training modules for all new social workers, new offerings include (1) strengthening families through engagement; (2) purposeful visits and family-centered assessments; (3) fatherhood engagement; and (4) human trafficking.
- Concentrated efforts on a 5-day program supporting the "Strengthening Families" Practice Model. The first three days, referred to as the "Partners in Change" (PIC) training, focuses strengths-based, family-centered practice. Approximately 1,660 staff completed the training, which emphasizes six "principles of partnership":
 - Everyone has strengths;
 - Everyone desires respect;
 - Everyone deserves to be heard;

- Judgments can wait;
- Partnership is a process; and
- Partners share power.
- Several training initiatives were implemented in SFY2013 to build on the practice model:
 - Differential Response System training was provided to 442 staff
 - Training in Child and Family Teaming, a process that brings families together with their natural supports to find solutions to family challenges, was provided. This includes training for 58 facilitators who support team meetings in cases where children are being considered for removal
 - A mandatory two-day training program on trauma-informed practice has been provided to 342 managers and supervisors, and all staff are slated to receive the training by the end of 2013.
- Regional staff also attend a two-day training on family-centered assessment and purposeful visitation. This training covers the assessment of protective factors and capacities -- both of which are prominent features of the national Strengthening Families model. It also teaches use of assessment tools to holistically gather information and assess child and family needs. As of the end of 2012, more than 1,250 staff participated in the two-day training.
- Online mandated reporter training reached approximately 27,000 individuals during SFY2013.

Strengthening Families Commissioner Directives

- Announced visits whenever possible consistent with child safety.
- Out-of-state placements must receive Commissioner approval.
 - Out-of-state placements fell to 42 as of July 1, 2013 compared to 362 on January 1, 2011 – a reduction of 88.4%.
- Reduce the use of congregate settings for children – especially young children
 - Team Decision Making/Child and Family Team Meetings– initially for younger children and, subsequently, for adolescents -- brought together families and natural supports in a strength-based, solution-focused effort to find family settings for children in congregate care.
 - The percentage of children in congregate care as of July 1, 2013 declined to 23.1% compared to 29.8% of all children in care on January 1, 2011. That represents a decrease of 22.6%.
 - # of children ages six and under in congregate care settings declined to 8 as of July 1, 2013 compared to 38 in January 2011.
 - # of children ages 12 and under declined to 60 as of July 1, 2013 compared to 200 on January 1, 2011.

Strengthening Families Commissioner Directive: Relative Care

- Increase placements with relatives
 - Prior to the present administration, CT lagged far behind the national average in using relatives as a resource for children in care. Research indicates that children in relative and kinship homes have greater stability and permanency as well as greater prospects for remaining with siblings.
 - Relative care was made a top priority in January 2011. A staff directive followed to make relative care and kinship care the expected option when a child must enter care.
 - Work with the Child Welfare Strategy Group of the Annie E. Casey Foundation identified improvements in the licensing process. Staff training was conducted, and resource guides for staff and relatives were produced.
 - As a result, changes to expedite assessments of kinship homes, to license homes with only technical barriers to licensing, and to institute quality improvement systems also were implemented.
 - During the month of June 2013, 23.1% of the children who entered care were placed with a relative and 26.9% were placed with kin (relative and special study).
 - The % of children overall placed with relatives, has risen to 24.4% in July 2013 compared to 17.3% in January 2011. If we count kin placement, that number is 29.8%. This is a 41.8% increase compared to January 2011.
 - Work with the legislature resulted in a \$3 million addition in SFY2014 for support services dedicated to relative and kinship homes.

Team Decision Making/Child and Family Teaming

- Working together with the Annie E. Casey Foundation, the Department is implementing Team Decision Making (TDM), a process that convenes families, their natural supports, service providers, and DCF staff to identify strength-based solutions and enhance case planning and outcomes for children.
- The Department first used TDM to significantly reduce the use of congregate care for younger children and subsequently to transition older children to lower levels of care.
- Also known as Child and Family Teaming, the process is a core component of the Strengthening Families Practice Model.
- In February 2013, DCF expanded Teaming to include application for families at the point when decisions are made about removing children from their homes.
- In 2014, teaming will be utilized to find permanent homes and/or connections for children whose permanency needs remain unmet.
- The Annie E. Casey Foundation's Child Welfare Strategy Group is working with staff at all levels and from all disciplines to develop Connecticut's teaming model.

- This includes a review of current policies and practices, the development of a training curriculum and coaching for staff in the area offices. All-staff training is ongoing and the full continuum of teaming meetings will be implemented in 2013.

Considered Removal Child and Family Teaming

- Considered removal CFTMs were begun February 11, 2013 to prevent child removals or to identify a relative or kin as caregiver when child safety could not be ensured at home.
- During the period ending July 29, 2013, 350 of 505 children who were considered for removal were NOT removed as a result of a family team meeting finding a safe alternative.
- Nearly 70 percent did not enter state care, and about half of those who did enter care were placed with a relative.

Trauma Informed Practice

- Children and families involved in child welfare commonly have experienced trauma that profoundly affects well-being and that must be addressed if our interventions are to be effective.
- DCF made trauma-informed practice one of its six cross-cutting themes, and, in 2012, received a five-year, \$3.2 million federal competitive grant award to improve trauma-focused care for children in the child welfare system.
- This entails trauma training for DCF staff and private providers, building screening, assessment and referral systems, and expanding access to evidence-based, trauma-informed treatments.
- As of June 2013, a two-day training in trauma, its effects, and how to respond was provided to all administrators and managers. By the end of 2013, all social workers and supervisors will have completed the two-day foundational trauma training.
- Training on the CT trauma screen – a tool customized for CT child welfare – also will be completed by the end of 2013. Staff will learn how to administer, document, and follow up on this screen in the LINK data system.
 - This screen will be administered for each child at time of transfer to ongoing services following a child abuse/neglect investigation and every six months after transfer at time of case plan reviews (subject to limited exceptions).
 - The screen will identify children who demonstrate child traumatic stress symptoms, general mental health symptoms and/or substance abuse symptoms.
 - Based on LINK data-system scoring, recommendations will be made for a trauma-specific assessment or other assessment as appropriate.
 - If a trauma-specific or other assessment is recommended, a referral will automatically be made to community-based providers.

- Ten to 12 behavioral health provider agencies will receive specialized training to conduct trauma-specific assessments and to deliver evidence-based, trauma-specific treatments, specifically Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
- By 2014, 28 provider agencies will have TF-CBT Teams.
- By 2016, 12 provider agencies will be trained to deliver Child and Family Traumatic Stress Intervention (CFTSI), a short-term, acute trauma treatment.
- DCF staff will continue to monitor the results of trauma screening and follow-up treatment as well as document completion of treatment through the child and family's LINK case plan. Administrative follow up will assure services are received and treatment goals met.
- The SFY14 budget includes \$3.5 million to train private clinicians and enhance access to trauma-informed services.

Pediatric Child Abuse Subcommittee of the State Trauma Committee

- DCF and the Pediatric Child Abuse Subcommittee are developing guidelines for optimal child abuse screening to:
 - Improve screening by ED triage nurses through education and/or establishing a formal screening process.
 - Improve physician recognition of red flags of child abuse through continuing education and hospital grand rounds and seminars provided by professional societies and associations.
 - Overcome physician and nursing barriers to reporting cases of suspected child abuse.
 - Ensure clinical evaluation of pediatric patients (6 years old and younger) with significant traumatic injuries includes removal of clothing (to permit thorough physical examination) and evaluation of their available medical record to identify prior visits with suspicious/unexplained injuries.
 - Evaluate the DCF Sentinel Injury Project as a way to identify abuse cases before children present with more serious injuries.

Child Abuse Recognition Education Workgroup

- The DCF Academy for Family and Workforce Knowledge and Development has formed a workgroup with a diverse group of medical professionals dedicated to education on child abuse recognition.
- The workgroup includes medical leaders from across CT including several from the Yale School of Medicine.

- The workgroup is developing a plan to educate the medical community on the new guidelines adopted by the State Trauma Committee for assessing child injuries for possible abuse
- The workgroup also is developing plans to improve overall communication with DCF.
- The DCF Provider Academy, part of the larger Academy for Family and Workforce Knowledge and Development, will play a key role in the education campaign.
- The Department is looking to continue and expand upon the practice of using medical experts to inform decision making at the Careline upon intake, by Careline primary investigators, and by Area Office staff.

Partnership with the Medical Community

- CT Chapter of the American Academy of Pediatricians
 - DCF continues ongoing teleconferences to develop knowledge on critical issues related to pediatric health and to raise awareness about reporting and the reporting process.
 - Four teleconferences were offered in 2012, including topics such as improving communication and collaboration, medications and behavioral health, mandated reporting, and recognizing physical abuse of infants. 370 participants included community providers and their office staff.
 - March 2013 teleconference covered preventing child abuse by supporting parents. Future topics will include roles and responsibilities in providing health services to children in care and caring for children with complex medical needs
- Work with Emergency Departments on Human Trafficking
 - Providing education to providers about the needs of youth who are victims of human trafficking including identification and how to respond in the ED.

New Health Framework

- A new Health and Wellness Unit was established that reports directly to a Deputy Commissioner.
- Reflects a higher priority for child health and wellness
- Goal is to collaborate with our community providers for services and guidance around children's needs.
- Includes education for medical providers about DCF and the needs of children and families we serve.
- Developing a "health advisory board" comprised of members of CT Chapter of American Academy of Pediatrics and CT Council of Child and Adolescent Psychiatry, DSS, DPH, and DDS to help guide development and implementation of policy and practice pertaining to health of children in our care

- Establishment of regional system of providers working with our DCF regions to ensure access to services for children in care. The goal is to develop practices consistent with AAP and Child Welfare League guidelines for health care.
- Re-procured Multi-Disciplinary Examinations (MDE) to include a new requirement that MDE clinics communicate with a child's Primary Care Provider (PCP) before MDE and that they provide them with copy of the MDE report. Expectation that Area Office Regional Resource Group nurse will work with PCP to review MDE and develop recommendations for a child's treatment plan.
- DCF convened a MDE workgroup to complete enhancements to this critical tool to ensure it fully informs case planning. Key changes include updating and standardization of screening tools for mental health and development. Changes include inclusion of trauma screen. Revised process to ensure inclusion of foster parents, birth parents as well as ensure that providers receive copy of report.

Community Behavioral Health and Substance Abuse Services

The three largest programs provide more than 41,000 episodes of care annually.

Psychiatric outpatient clinics for children	23,760
Emergency Mobile Psychiatric Crisis Service (EMPS)	15,574
IICAPS (Intensive In-home psychiatric services)	2,200

DCF benefits from numerous Federal grants and research partnerships:

- Federal ACF \$3.2 million Trauma Services in Child Welfare grant
- 2 NIDA funded research projects on effectiveness of adaptations of evidence-based models (MST and MDFT).
- 2 federal SAMHSA Service to Science Awards with Yale and CHDI
- \$5 million, 5-year ACF funded supportive housing grant

DCF Voluntary Services

- The Voluntary Services (VS) program is a voluntary, non-emergency program for children and youth with serious emotional disturbances, mental illnesses and/or substance dependency.
- VS emphasizes a community-based approach and coordinates service delivery across multiple agencies.
- Parents and families are critical participants in this program and are required to participate in the planning and delivery of services for their child or youth.

- VS is designed for children and youth who have behavioral health needs and who are in need of services that they do not otherwise have access to. Parents do not have to relinquish custody or guardianship under this program.
- Careline received 5,250 VS Inquires.
- Careline forwarded 905 inquires to DCF regional offices statewide for assessment and servicing.
- Careline referred 4,345 inquires to other state and community agencies, including emergency responders, Families With Service Needs, Emergency Mobile Psychiatric Services, and Info Line.
- New VS policy gives the Careline an intensified social work role in vetting and servicing cases at the start to enable the regions to better assess and serve VS families.
- Regional Voluntary Service units are now accepting 4 out of 5 cases for treatment.
- As of August 2, 2013, DCF was serving 535 Voluntary Service cases or children

In-Home Community Based Behavioral Health Services

- Outpatient Psychiatric Clinics for Children
 - A multi-disciplinary team of psychiatrists, psychologists, APRNs, clinicians and case managers at 26 contracted outpatient clinics provide psychosocial assessments, psychiatric evaluations/medication management, and clinical treatment through individual, family and group therapies
 - In SFY 2013, the outpatient clinics served 23,760 children and their caregivers.
- Emergency Mobile Psychiatric Services (EMPS)
 - EMPS Crisis Intervention Service is Connecticut's crisis intervention service for children and their families. More than 90% of children are seen at their home, at school or in the community and 85% within 45 minutes of receiving the crisis call.
 - More than 15,574 calls to the EMPS system SFY2013, which developed into 11,550 episodes of care.
- Intensive In Home Child & Adolescent Psychiatric Services (IICAPS)
 - A 6-month home-based intervention addressing psychiatric disorders of the child, problematic parenting and other family challenges that affect the child and family's ability to function. Teams of professionals average 4 to 6 hours per week of intervention with the child and caregivers to prevent hospitalization or to return the child to community based outpatient care.
 - In SFY2013, 2,200 families received services.
- Care coordination

- Care coordination uses an evidenced-based child and family wraparound team meeting process to develop a plan of care that uses both the formal and informal network of care to meet the identified needs of the child and family.
- In SFY2013, 1,211 families were served.
- **Family advocacy**
 - Family advocates provide support and assistance to the parent/caregiver of a child with a serious mental or behavioral health need. The family advocate works with the care coordinator (above) in the child and family wraparound team meeting process and focuses on providing support to the parent/caregiver. In SFY2013, 404 episodes of care were delivered.
- **Extended day treatment**
 - A multi-disciplinary team of psychiatrists, APRNs, clinicians and direct care staff at 19 program sites deliver an array of integrated behavioral health treatment through individual/family/group therapies, therapeutic recreation, and rehabilitative support services, for a minimum of 3 hours per day/5 days per week through a milieu-based model of care.
 - In SFY2013, this program served 1,096 children/youth and their caregivers.
- **Community Bridge**
 - Youths and families receive intensive in-home therapeutic support on a 24/7 basis from a clinical team of licensed clinicians and paraprofessional mental health support workers. The clinical team engages with family members and provides necessary support to the youth in all aspects of community functioning for up to 2 years. Youth without adequate family resources are served in foster homes. The community based service is supplemented by the availability of brief residential placement for purposes of assessment and behavior stabilization.
 - This prototype run by the Village for Children and Families in Hartford has provided clinical interventions to 20 youth and families in its first five months of operation.
- **Respite care**
 - Respite care is a non-clinical intervention, which provides stress relief to parents of children and youth who have serious mental or behavioral health needs. Community or home-based respite is provided for up to 4 hours per week for 12 weeks. In SFY2013, 147 families and 172 children were served.
- **Functional family therapy**
 - An empirically grounded, family-based intervention to improve family communication and supportiveness while decreasing negativity, delivered within the family setting by 4 providers, 5 teams that are grant-funded. In SFY2013, 567 youth and families were served.
- **Multi-dimensional family therapy (MDFT), including “special population”**

- Family-based intensive in-home treatment for adolescents with significant behavioral health needs and either alcohol or drug related problems, or who are at risk of substance use. Provides individual, caregiver and family therapy, and case management. In SFY2013, 899 youth and their families were served.
- **Multi-systemic therapy (MST)**
 - Intensive family- and community-based treatment program that addresses environmental systems that impact chronic and violent juvenile offenders -- their homes and families, schools and teachers, neighbourhoods and friends. In SFY2013, 209 youth and families were served.
- **Multi-systemic therapy (MST) for special populations**
 - Special populations include problem sexual behavior, transition age youth, and parole youth re-entering the community. In SFY2013, 117 youth and/or families were served.
- **Multi-systemic therapy (MST) “Building Stronger Families”**
 - Intensive in-home treatment for families with maltreatment and substance abuse issues. In SFY2013, 38 families were served.
- **Re-entry and family treatment**
 - MDFT for parole youth with substance abuse treatment needs. In SFY2013, 93 youths and their families were served.
- **Recovery case management for families with substance abuse**
 - Intensive recovery support services for families with children at risk for removal or at the point of removal. In SFY2013, 251 families were served.
- **Family-based recovery**
 - Intensive in-home family treatment combining evidence-based substance abuse treatment with a preferred practice to enhance parenting and parent-child attachment. In SFY2013, 124 families received services.
- **Juveniles Opting To Learn Appropriate Behaviors (JOTLAB)**
 - Rehabilitative treatment for youth with problem sexual behaviors that provides comprehensive clinical evaluation, individual psychotherapy, family counseling, psycho-educational therapy groups, and social skills building groups.
 - Annual capacity to serve 91 children.
- **Integrated family violence program**
 - In-home and clinic-based services for families where domestic violence has been identified. Core services include safety planning for survivor and child, trauma focused work with children, interventions focused on repairing and healing relationships, and batterer interventions. In SFY2013, 454 children received services.
- **Adolescent substance abuse outpatient**

- Substance abuse screening/evaluation, individual, group and family therapeutic interventions in a clinic based setting. In SFY2013, 343 youths received services.

Early Identification of Problems

- DCF executed an agreement with the Department of Developmental Services to implement federally mandated referrals to the Connecticut IDEA Part C Birth to Three System.
- DCF implemented a federal grant to expand access to Head Start programs for DCF young children.
- DCF launched *First 1000 Days: Getting it Right from the Start*, an initiative with Governor's Office and six state agencies to identify the state's most vulnerable young children and expand coordinated access to family-based intervention and prevention services.
- DCF provided state funding for *Child FIRST*, an evidence-based early intervention program for very young children and their families with significant mental health and child welfare needs.
- DCF and the Judicial Branch Court Support Services Division entered an agreement to work together to serve children 12 years old or younger and their families with early interventions that will decrease the likelihood of future involvement in the juvenile justice system.

Domestic Violence

- Child abuse is 15 times more likely to occur in families beset with domestic violence (DV).
- The Center for Disease Control reports that studies from countries around the world -- including the United States -- has established the relationship between DV and child abuse
- The Department is in the midst of making major changes in how we respond to domestic violence.
- While the Department for more than a decade has used private DV experts to consult with our regional and area offices, we are building upon that foundation in a variety of ways.
- Last year, DCF established a new Division of Substance Abuse and Domestic Violence.
- The division is creating a new training, consultation, service delivery and evaluation model based on the most current research and practice serving families impacted by DV.
- Resources have been reallocated to increase support for service delivery. Funding will be doubled to approximately \$1.5 million in the current fiscal year.
- New DV specialists will be working in every region to provide internal expertise. Training is underway and will be ongoing.

- In the spring of 2013, the Department initiated a formal process to obtain input on how to improve the Department's work with families and community stakeholders regarding DV.

Albert J. Solnit Children's Center -- North Campus (East Windsor)

- 107 youths received care, treatment and educational services in SFY2013
- Solnit North achieved Joint Commission Accreditation
- Increased percentage of youth discharged back to families
- Decreased average length of stay
- Weekly clinical case rounds implemented
- A new milieu program was developed, and cottage based psycho-educational groups were implemented.
- Dialectical Behavioral Therapy and Affect Regulation, Self-regulation and Competency programs were implemented.

Albert J. Solnit Children's Center -- South Campus (Middletown)

- 257 youths received care, treatment and educational services in SFY2013.
- Treating youths 13 years old and older.
- Received successful Joint Commission review.
- Opened three adolescent girl step-down (sub-acute) PRTF units.
- Eliminated the use of mechanical restraints and reduced the use of restraints overall.
- Increased direct admissions from hospital emergency departments.

2013 Law Requires New Statewide Mental Health Plan for All Children and Families

PA 13-178 requires DCF to develop a comprehensive plan to (1) meet children's mental, emotional, and behavioral health needs of all children and to (2) prevent or reduce the long-term negative impact of mental, emotional, and behavioral health issues on children.

Key plan requirements include:

- Prevention-focused techniques including early identification and intervention;
- Access to developmentally-appropriate services;
- Comprehensive care within a continuum of services;
- Engaging families, youth and communities in planning, delivery and evaluation;
- Sensitivity to diversity re race, culture, religion, language and ability;
- RBA measures to track progress and data-informed QA strategies;
- Improving integration of school and community-based services;

- Collaboration with DPH re family and youth engagement in medical homes;
- Collaboration with DSS to increase awareness of 2-1-1; and
- Collaboration with each program that receives public funding to address mental health needs of children, including data collection re response times, provider availability and access.

Fatherhood Matters

- Research indicates that the unique way fathers interact with their children contributes to the healthy development of children from infancy through early adulthood.
- Fatherhood engagement is a critical component of family-centered practice.
- The overarching goal is to promote positive outcomes for children through the meaningful involvement of fathers.
- More than 180 community fathers have participated in regional Fatherhood Listening Forums to better understand fathers within cultural and community contexts.
- Key areas of practice include engaging non-resident and incarcerated fathers.
- Some additional areas of emphasis in case practice have been:
 - Early and ongoing efforts to identify, locate, and engage fathers;
 - Assessing the needs and strengths of fathers as a crucial piece to a holistic assessment of risk and protective factors;
 - Exploring the attitudes, perceptions and personal biases held by both agency staff and community fathers;
 - Establishing Fatherhood Engagement Leadership Teams (FELT) in the regional offices
 - Forming partnerships with community provider agencies to offer support services; and
 - Coordinating learning forums across sister agencies and New England child welfare jurisdictions aimed at sharing successes, challenges, and lessons learned.

Girls Services

Girls Provider Network

- The Girls Provider Network forms a partnership between the Department and private service providers who work with girls.

- Girls Provider Network programs completed self-assessments – giving programs baselines to evaluate progress over the next year.
- Network membership was expanded to all program types, including foster care. DCF’s Albert J. Solnit Center and the Connecticut Juvenile Training School also participate.
- DCF and providers participate in “continuum events” such as a special soccer event at Central CT State University in recognition of Women and Girls in Sports Day.
- Youth projects/competitions were held among providers. For example, girls developed sex trafficking awareness bracelets that were voted on by the Girls Provider Network.

“Understanding Girls” Training Curriculum

- A two-day curriculum was developed and trainings initiated with multiple program types.
- The training creates awareness among DCF staff and provider staff on the special complexities of working with girls, including emotions, relational aggression, and vicarious trauma.
- A “train the trainer” process is being implemented to expand training capacity.

Prevention

- Keeping Infants Safe and Secure (KISS)
 - CT Shaken Baby Prevention and Safe Sleep Initiative. Involves multiple agencies, increasing public awareness, training to providers and public
 - DCF is developing guidelines for Safe Sleep Environment focused on education and prevention. Goal is to increase public awareness, train social workers, providers and public about risks and approaches to prevention.
- Circle of Security
 - Circle of Security Parenting is a grassroots, DVD-based, innovative, and attachment-based parenting intervention starting to take hold in CT communities and programs under DCF’s collaborative leadership to help more children have a secure attachment.
 - Kids who have a secure attachment are more likely to have successful close relationships, develop desirable personality traits, and have better social problem-solving skills.
 - DCF supports training for community based service providers who in turn educate parents
- DCF-Head Start partnership
 - All 14 DCF Area Offices have established and strengthened a working partnership with Head Start and Early Head Start programs.

- Goal is to ensure children's access to high-quality early care and education, enhancing stability and supports for young children and families, and preventing family disruptions and foster care placements
- Parents with Cognitive Limitations
 - Estimated 1/3 of families involved with child welfare are headed by a parent with cognitive limitations
 - DCF-led workgroup trains service providers across the state on how to identify and serve this population, including the use of plain language for effective communication.
 - Fall of 2013, DCF is hosting and co-sponsoring an international conference on Innovative Partnerships and Practices: The Path to Success for Parents with Learning Disabilities and Other Cognitive Limitations.
- Positive Youth Development Initiatives
 - Afterschool programs for youth 8-14 or older to prevent children from entering the DCF system.
 - Support parenting, provide recreational and enrichment activities for children, tutoring, social skill building, parent engagement and support
- Early Childhood Consultation Partnership
 - A nationally recognized, evidenced-based early childhood mental health consultation program to meet the social, emotional needs of infants, toddlers, and preschoolers.
 - Builds the capacity of families, providers and systems to prevent and treat social & emotional issues.
 - 99% of children at risk of suspension or expulsion were not suspended or expelled at the one-month follow up of their classroom teacher receiving ECCP consultation services.
 - Served approximately 21,000 children, 7,400 early childhood educators, and 927 early childhood education centers since 2003.
- Early Childhood Parents in Partnership
 - Provides in-home and community-based support and intervention to strengthen parenting practices in high-risk families.

Prevention -- Housing

- DCF Supportive Housing for Families
 - Provides housing assistance and intensive case management services to DCF families who are homeless or at risk of homelessness.

- SHF is designed for families with housing barriers that jeopardize the safety, permanency and well-being of their children.
- The program serves over 500 DCF families per year to prevent children from coming into foster care or to enable reunification for families whose children are otherwise unable to leave foster care due to housing barriers.
- DCF was awarded a new \$5 million, 5-year grant from ACF to expand and enhance SHF services in September 2012.
- The new grant will target families with severe housing and child welfare needs in the Middletown, Willimantic, and Norwich areas (Region 3).

DCY Young Adult Supportive Housing Pilot (YASH)

- The pilot program serves young adults ages 18-23 that do not meet DCF re-entry criteria and are homeless or at risk of homelessness.
- The YASH program is designed to help youth gain and maintain safe and stable housing.
- The program serves 36 DCF youth annually with case management and housing assistance.

CT Child Justice Foundation

- The Connecticut Child Justice Foundation (CJF) provides pro bono legal representation for children with educational needs under the care of DCF and who lack the financial resources and/or parental support to fulfill this role.
- Many of the children in care have physical disabilities or challenging mental health treatment needs, and providing the support services that will enable them to receive a proper education is costly.
- Federal and state laws require school districts to provide the support and other services necessary for children in foster care to receive an education.
- Despite the law, many children do not receive these services.
- Attorney Ernie Teitell, who has practiced criminal and civil trial law for 35 years, and Commissioner Katz co-founded the CJF to ensure these children have effective legal representation.
- Approximately 45 top-flight attorneys and retired judges agreed to represent pro bono DCF kids who need legal assistance to get school districts to meet their critical obligations.
- The roster of attorneys includes former Superior Court Judges Elaine Gordon and Robert Holzberg.
- The Foundation began with a kickoff in January 2013, and, as of June 2013, more than 50 children have benefitted from a favorable resolution resulting in appropriate educational services.

Education: United School District #2 and Regional Educational Consultants and Specialists

- During the 2012-13 school year, the DCF Education Division, including the Unified School District (USD) #2, and DCF regional education consultants and specialists, made the following improvements in the education of children at DCF facilities and in DCF care:
 - Established a new "Framework" with a more prominent role for DCF in the education of the children for whom we are responsible;
 - Expanded outreach to local school systems, meeting with superintendents and other school leaders and collaborating with the Connecticut Association of Public School Superintendents to enhance communication and cooperation;
 - Implemented an MOU with the Department of Education regarding the sharing of data about student performance, which resulted in the first report to Department and General Assembly leadership on the academic status of children in foster care;
 - Established the Connecticut Child Justice Foundation, including recruitment and training of several dozen volunteer attorneys and the pursuit of some fifty initial cases in which we suspected that the educational rights of children under DCF care were in;
 - Initiated professional development for USD#2 staff on the improvement of school climate and the promotion of student motivation and engagement through “choice theory” and the Positive Behavior & Interventions System (PBIS);
 - Highlighted racial justice as one of the overarching priorities in the improvement of educational services for our clients;
 - Appointed well-qualified individuals to the important leadership positions of assistant superintendent for USD#2 and school principal at the Solnit South Campus (formerly known as Riverview School);
 - Completed the staffing of six Regional Education Unit teams and facilitated the work of these teams in pursuit of the educational interests of DCF students enrolled in public schools throughout the state;
 - Enhanced management efficiency and quality of information through implementation of two new student data systems for USD#2;
 - Commenced implementation of the "Student Success Plan" process through which every USD#2 student in grades 6 -12 is to develop a personal plan for education and career success; and
 - Assisted faculty and staff in the Newtown Public Schools in the wake of the December tragedy.

Adolescent Services: Post Secondary Education

- 602 youths (up to the age of 23) attended college or other post secondary education (PSE) program in SFY13 with financial support from the Department.

- Data and quality improvement systems were established to track and provide feedback on the system and office/worker levels.
- Comprehensive assessments assist in matching youths to PSE programs, and area office consults assist youth entering or facing challenges in the programs.
- During the 2012-13 school year, more than 200 computers were provided to youths in the post-secondary program.
- A partnership with the University of Connecticut was established to provide foster youths with a timely introduction to PSE opportunities.

Adolescent Services: Work and Employment

Summer Youth Employment

- Approximately 350 youths participated in the summer youth employment program during summer 2013. This six week work experience teaches good work habits to youths.
- Participation has substantially increased compared to 212 youths in 2011 and 280 youths in 2012.
- Juvenile justice involved youth comprised 83 of the 350 youths in 2013 compared to 12 in 2011.
- The completion rate for the six weeks of summer employment averaged over **93%** for the three years the program has been in existence.

Work to Learn

- Assesses youths and establishes comprehensive services to meet educational, work skills, internship and employment, fiscal literacy needs, and incentives to save for education and other practical needs. Also offers leadership opportunities.
- Work to Learn expanded to serve southeastern CT with a 35-slot program beginning in June 2012.
- This brings the total number of Work to Learn slots to 431 statewide.
- Client utilization has steadily increased from 327 in Q2 2012 to 443 in Q3 2013.

Department of Labor/Job Corps

- The Department helps youths access Department of Labor job training opportunities, including “job funnels,” apprentice programs, and GED construction programs.
- The Department also assists youths obtain federal Job Corps opportunities at in state or out of state centers to access training in trades including plumbing, carpentry, manufacturing, and medical assistant.

Juvenile Review Board Youth

- 91 youths referred to juvenile review boards across the state attended summer school and camp and/or received stipends during the spring of 2013 through DCF juvenile justice prevention funding.

Adolescent Services: Juvenile Justice Parole Services

- Completed parole policy and procedures to align parole practice with the agency's philosophy and national best practice.
- Developed the Fostering Responsibility Education and Employment (FREE) model and implemented the program statewide with services from private providers.
 - The goal of FREE is to successfully re-integrate youths back to their community.
 - This program is available to adolescents on parole and includes a comprehensive array of community services to support the adolescent's growth in all areas of functioning (life skills and well being, social, educational, vocational preparation and employment).
 - FREE also achieves supervision of this high-risk population through daily programming and active communication between providers and parole staff.
- Vocational training and paid internships are provided to qualified youths who have graduated from high school and shown aptitude to successfully complete a vocational certification program that leads to a sustainable career.

Adolescent Services: Juvenile Justice, Connecticut Juvenile Training School (CJTS)

- During Calendar Year 2012, CJTS served 185 youths ages 12 through 18 who are committed as delinquents by Juvenile Court to the Department. The average age at time of admission was 16.2 years old.
- Youths receive behavioral health (mental health and substance abuse) treatment, educational, vocational, recreational, and residential services
- CJTS implemented a health and wellness plan that promotes healthy eating and activities. Food service and medical staff instituted "Healthy Choices" meals (lower salt, sugar, and fat), provided educational programming to youths on good nutrition, and began to change the way the youths view food, health and nutrition.
- An authorized leave process was re-instituted at CJTS for youths with confirmed discharge dates who are returning home. A series of three progressive passes is offered (4 hour community, 8 hour home, and 24 hour home). Over 25 youth have had varying degrees of authorized leave to assist with their transition home.
- All youth at CJTS are screened for trauma as part of the admission process. Youth assessed with significant trauma based upon the UCLA -Index are offered trauma-focused cognitive behavioral therapy.

- In June 2013, CJTS hosted its first group graduation ceremony with 10 high school graduates receiving diplomas. School representatives, family and friends attended to honor the graduates.
- Under the “Raise the Age” law, older youth are now served at CJTS. In 2012, CJTS served 66 17-year-old youths and 10 18-year-old youths. A designated unit has been created for high school graduates to receive meaningful programming.
- CJTS rehabilitation staff collaborates with the DCF Wilderness School (“outward bound” program) to offer unique hiking, climbing, rope course, and day and overnight camping trips for some CJTS youth.
- The CJTS football team has continued to expand and plays other high schools throughout Connecticut. Important lessons are taught each day during breakfast about life, being a man and decision making.

Adolescent Services: Wilderness School

- The Wilderness School (WS) Expedition and Short Course Programs serve 1,000 youths annually.
- Current research in the field of experiential, wilderness-based programming demonstrates significant positive impact upon the resilience of adolescents, which is essential for children and youths recovering from trauma.
- WS increased program capacity and created new programs for DCF youths receiving adolescent services, girls' services, congregate care services, juvenile services, and prevention services, as well as youths served by the Albert J. Solnit North and South campuses.
- As a result, attendance at spring and fall short course programs increased 35 percent in 2012 and 2013 through initiatives targeting greater access to services, establishing outreach and collaboration with DCF caregivers and community providers, and in the development of strengths-based, ally-oriented programs for DCF youth.

Fighting Child Sex Trafficking

- The U.S. Dept. of Justice estimates 200,000 American children are potentially trafficked each year into the sex trade.
- In CT since 2008, there have been approximately 130 children confirmed as victims of Domestic Minor Sex Trafficking (DMST).
- 98% have been involved with child welfare services, and many of these children have been victimized while in DCF care.
- Since 2011, DCF collaborates with local, state and federal law enforcement to better coordinate our response, particularly as it relates to the children in our child welfare system.

- The most significant barriers are the identification of victims, development of appropriate responses and enforcement of the laws leading to the prosecution of the perpetrators.
- To raise awareness, DCF has trained hundreds of staff, law enforcement, medical providers, court and school personnel, and other community service providers from across CT.
- DCF Careline accepts all reports of DMST regardless of the status of the perpetrator.
- CT law now ensures law enforcement refers minor victims to DCF rather than arrest any exploited youth for prostitution
- During the 2013 legislative session, the legislature approved a bill enhancing criminal penalties, protecting child victims and adopting a criminal justice framework for investigation and prosecution.
- A recent U.S. Senate committee hearing (June 2013) cited CT as a national model in responding to DMST and other states confer with CT on how to improve their responses.

Innovative Strategies for Funding and Collaboration

- DCF and CT were selected as one of just six states to participate in the Harvard Kennedy School's Social Impact Bond (SIB) Technical Assistance Lab.
 - Harvard will provide technical assistance to CT in its pursuit of “pay-for-success” private funding for innovative approaches to improving and enhancing substance abuse services.
 - The majority of families DCF serves are impacted by substance abuse or co-occurring issues such as domestic violence, mental illness, unemployment and/or lack of stable housing.
 - Under a SIB model, government partners with service providers and private investors to fund prevention-focused social programs.
- DCF also was selected by the National Governor's Association as one of just seven states to participate in the Three Branch Institute on Child Social and Emotional Well-Being.
 - The Three Branch Institute will help states develop a comprehensive framework and innovative strategies to promote and measure the well-being of children in foster care by more effectively aligning the work of the three branches of state government.
 - The goal is to promote long-term self-sufficiency through increased access to supportive services from DCF, the Department of Social Services (DSS) and other human service agencies.

Results Based Accountability

- A collaborative effort with the CT General Assembly, Results Based Accountability (RBA) involves the development of performance measures answering three key questions:
 - How much did we do?

- How well did we do it?
- Is anyone better off?
- The Legislature's CTKids Report Card and the DCF strategic plan address four domains: health; stability; safety; and future success.
- DCF is developing RBA performance measure for its contracted services. The process should be completed in 2014.

SFY2014 Budget Highlights

- A major area of improvement at DCF is that the percentage of children in care living with a relative or other person they have a relationship with increased from 21% in January 2011 to 29.5% in June 2013 – an increase of 40%. The new budget contains an additional \$3 million to help these kinship homes get services necessary to meet the often complex needs of the children in their care.
- Another major success at DCF is that there are 758 fewer children in care on June 1, 2013 than on January 1, 2011. The new budget contains \$2 million in new in-home treatment services for children with behavioral health treatment needs so that they do not need to be placed outside their home to get the help they need.
- One of the lessons of the terrible events at Newtown is that Connecticut's children need greater access to mental health services. The new budget contains \$2 million to ensure that primary care providers get timely access to child psychiatry consultation, care coordination, and transitional services while ongoing behavioral health services are established.
- Many of the children and families involved with the Department have experienced significant trauma that must be addressed if our intervention is to be effective in helping them meet challenges. The new budget supports the Department's focus on trauma-informed service by adding \$3.5 million for Trauma-Focused Cognitive Behavioral Therapy.
 - Training will be provided to private clinicians and out patient clinics.
 - The number of clinicians and private agencies that can provide this therapeutic model will be expanded.
 - A performance improvement center will be established to improve data collection and outcomes.
 - A statewide registry of certified providers will be maintained to facilitate access to effective treatments.