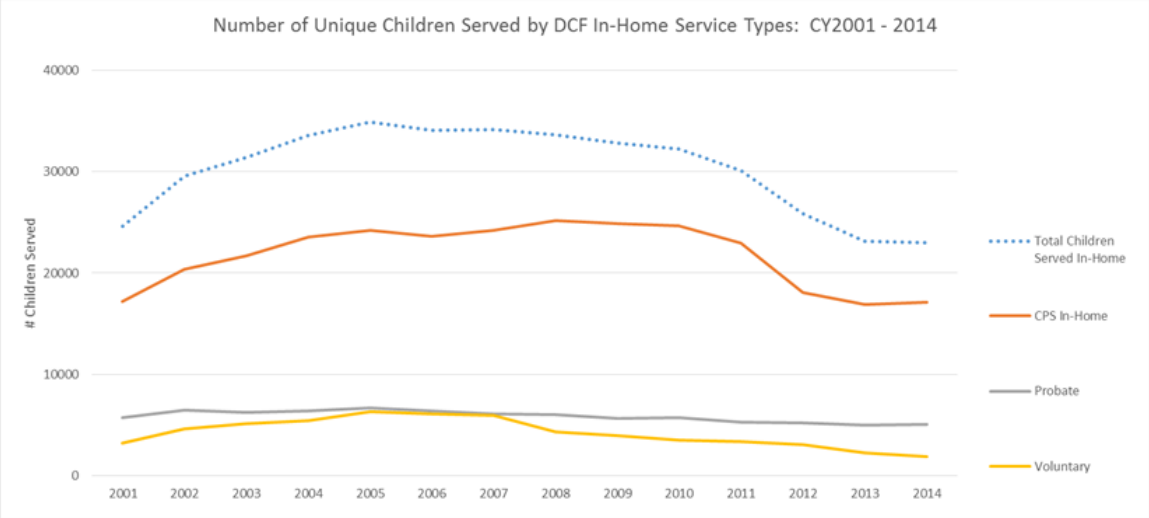
Connecticut's Department of Children and Families: Transformation of the State's Child Welfare and Children's Behavioral Health System From January 2000 to January 2015

March 9, 2015

INTRODUCTION

From the period of January 1, 2000 – January 1, 2015, over 3,300 fewer children were in DCF placement. This reduction can be attributed to shifts in philosophy, policy, practice, and investment. While the number of children being served through out-of-home placements has steadily declined, both in Connecticut and nationally the Department of Children and Families (DCF/Department) has introduced a variety of initiatives and community-based supports that allow children to be served in-home with their families of origin. The chart below illustrates that change.

Chart 1



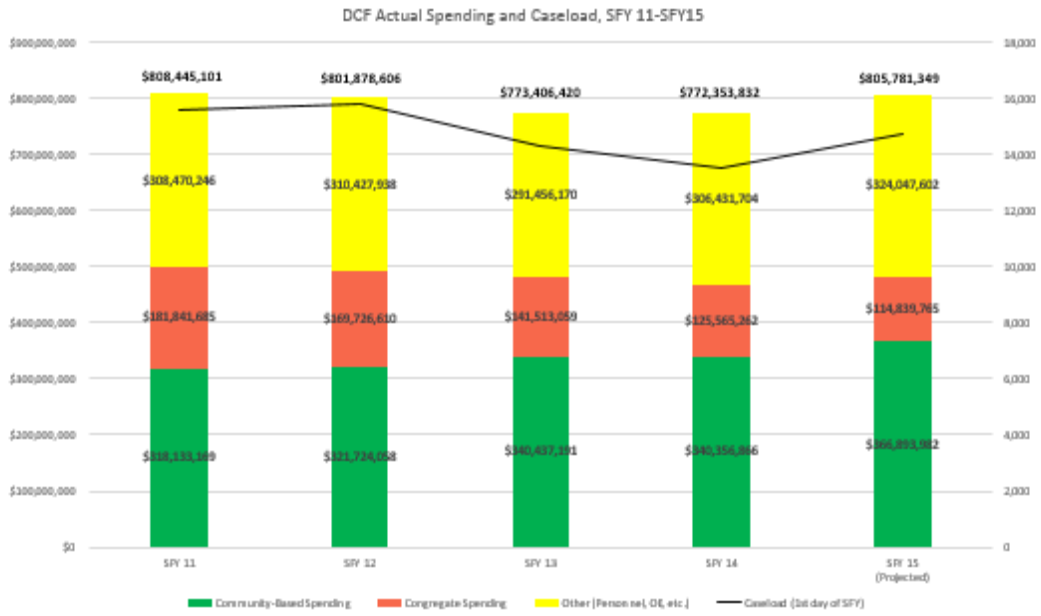
The shift in care approach is also reflected in the increases in the number of children served in DCF funded behavioral health services (e.g., Outpatient Clinics for Children, Emergency Mobile Psychiatric Services, and Extended Day Treatment). For example, federal Mental Health Block Grant data shows that 7,280 more children were served during Federal Fiscal Year (FFY) 2013 versus FFY 2006.

The Department's focus on community based care has also be influenced by the 2002 *W.R.* lawsuit and subsequent 2007 settlement. This is a lawsuit that was filed by several plaintiffs (youths in DCF's care and/or their parents) who claimed that the DCF discriminated against them on the basis of their mental illness and that they were harmed by DCF's failure to put into place policies and procedures to make sure that mentally ill youth in the care of DCF had placements available to them which would help them to live

in the community. The lawsuit further asserted that the Department failed to provide appropriate community-based placements and relied on overly restrictive institutional placements.

In addition, in the spring of 2012, the Department introduced the Differential Response System (DRS). This allowed the department to support families outside of the DCF caseload through a Family Assessment Response (FAR) approach. In 2012, 860 families were referred to Community Partner Agency under FAR. In Calendar Year 2014, that number more than doubled to 1878. 740 more families were referred for other services. The impact of DRS can be seen in Chart 1 whereby the in-home caseload decreased in 2014, reflecting the ability to increasingly serve families through community service agencies.

Chart 2



The Department has also invested $58,942,899 more spending in community-based services from 2011 to present. The below chart illustrates the changes in caseload and the shifts in DCF funding from congregate settings to increased investment in community-based supports over the past four years:

In sum, these data underscore the fact that over the past decade the Department has been attempting to comport with national best practice and research to safely serve children within family settings, and evolve its service array to support that approach.

CONGREGATE CARE FACILITY CLOSURE PROCESS

The Department engages in a thoughtful and deliberative process before and as it closes congregate care facilities. At least 60 days' notice is given before a program is taken offline. The DCF Senior Leadership makes a determination after examining data on several

variables including: service delivery (i.e., number of treatment hours provided), acceptance rates, utilization and occupancy, and quality indicators (e.g., arrests of youth). The Department also considers geographic locations of programs (i.e., service access and geographical saturation). We also incorporate feedback from DCF Region staff, our Licensing Unit, and other Central Office staff involved with congregate care programs. Once data and feedback is collected, Senior Managers make a final determination and programs are notified as soon as possible, but no less than 2 months in advance.

Value Options, the contracted Behavioral Health Administrative Services Organization, and DCF Regional staff work with the youth and family to develop individualized transition plans. Teaming meetings are held so that various alternatives can be explored. Central office staff collect and review the plans once a week. Licensing staff visit the closing programs during the final months to ensure staffing is in place and that services are provided. At times, the timeframe for closing a program has been extended to allow for individualized planning services.

In the past, some providers have given the Department notice of a closure sooner than 60 days. This has usually been due to financial reasons. When this has occurred (most recently with two fee for service pass group homes) DCF has worked with the provider to establish a ramp down rate and keep the program open for at least 60 days.

BRIEF AGENCY OVERVIEW

Connecticut's DCF is legislatively responsible for prevention, child protective services, children's mental health and 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 Department thinks that children do best when living safely at home, with their family of origin. When living at home with a parent or other caregiver 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 Department seeks to ensure that the child receives care and services in an appropriate foster home until timely permanency can be achieved through reunification, transfer of guardianship or adoption. While in foster care, regular and ongoing contact with parents and siblings is maintained. It is the Department's goal that all youth exit from the Department's care do so with legal and/or relational permanency.

In keeping with the Department's and national best practices, congregate care (e.g., group homes and residential treatment centers) are not viewed to be ideal settings nor are need to be used for the vast majority of children are on DCF's caseload. Young

children especially, should not be placed in congregate care settings. For older youth, treatment in congregate care is only sought to be used on a short-term basis, with extensive family involvement in the treatment process, as clinically appropriate.

The Department attempts to ensure that services, both community based and congregate care, are individualized, culturally and linguistically competent, trauma informed and gender specific. We are cognizant that services must be based on a full assessment of the strengths and needs of children and their families. Assessments must be made through engagement and partnership with family members and children as age and developmentally appropriate. 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, and to live in a family home (e.g., parent, family member or another permanent family).

These beliefs have been shaped by ongoing multidisciplinary research into effective practices that best address the needs of the children and families in our state. This vision, however, has not always guided DCF and our contracted providers' work. Earlier policy and practices were far more risk averse, and less willing to try and were often less able to safely maintain children in their own homes or other non-restrictive settings. Following several high-profile child fatalities in the mid-1990's, DCF caseloads, particularly that for children in placement, quickly swelled. Data from January 2000 reveals that over 7,000 children were in placement. That effectively is equivalent to nearly 1%[1] of Connecticut's total 2013 child population being in placement under DCF.

Since January 1, 2000 through January 1, 2015, there have been 3,319 fewer children in DCF placement. This comports with national trends whereby child protection in-care caseloads have steadily declined. The below information will detail the philosophical shift, best practices, investments and various initiatives that have occurred with Connecticut's DCF during the past 15 years to reduce the number of children needing to be placed outside of the home and increase the system's capacity and ability to serve children in families in their homes and communities. While the majority (e.g., 79%) of the children in placement reduction occurred prior to January 1, 2011, increased efforts over the past four years have further allowed the Department to meet the needs of children without taking them into care.

HISTORY OF DCF SYSTEM AND SERVICE IMPROVEMENTS

Between 2002 and 2004, DCF negotiated an agreement in the *Juan F.* case that identified 22 outcome measures for which the agency had to demonstrate sufficient performance in order to be released from the Consent Decree. During that same time period, the federal government began a series of Child and Family Service Reviews (CFSR) built on a set of similar national outcome measures and case practice standards. Adequate

[1] A 2013 Connecticut Population Projection of Children estimates the total number to be 745,972.

performance by states under these performance standards were tied to receipt of federal funding, and penalties in instance of failure to achieve substantial compliance. This began an intense period of quality improvement and monitoring efforts that had not been previously occurred. The agency's quality improvement staffing was increased during this time, and an automated reporting system, the Results-Oriented Management (ROM) system, was implemented in July 2005 to allow for easy access to agency performance on Exit Plan, CFSR, and other related outcome measures.

January 2005: Family Conferencing

The agency sought to enhance the engagement of families in the development of their case plans through Family Conferencing. This approach assembles family members, their friends, and other community members and relevant professionals to jointly develop an individualized plan that strengthens family capacity, assures child safety, stability and permanency, and builds natural supports that will sustain the family over time.

January 2007: Structured Decision-Making

In an effort to enhance practice and achieve better outcomes for children as it pertains to safety, permanency and well-being, the Department implemented Structured Decision Making (SDM). SDM® provides a framework to increase child protection decision making consistency and validity; targets limited resources to families most at risk of maltreatment; assists in identifying service needs for all family members; and expedites permanency for children in out-of-home care. SDM was not intended to replace social work staff member's professional judgment. The structure and research that SDM provides, in partnership with their social work skills, enabled staff to make better informed decisions relative to case acceptance, report response, removal of children, case opening, reunification or the need to develop an alternative permanency goal and case closing. The SDM system is comprised of several standardized instruments that workers complete and utilize in supervision to make case decisions. The instruments include:

- Safety Assessment
- Risk Assessment and Risk Re-assessment
- Family Strengths and Needs Assessment
- Reunification Assessment

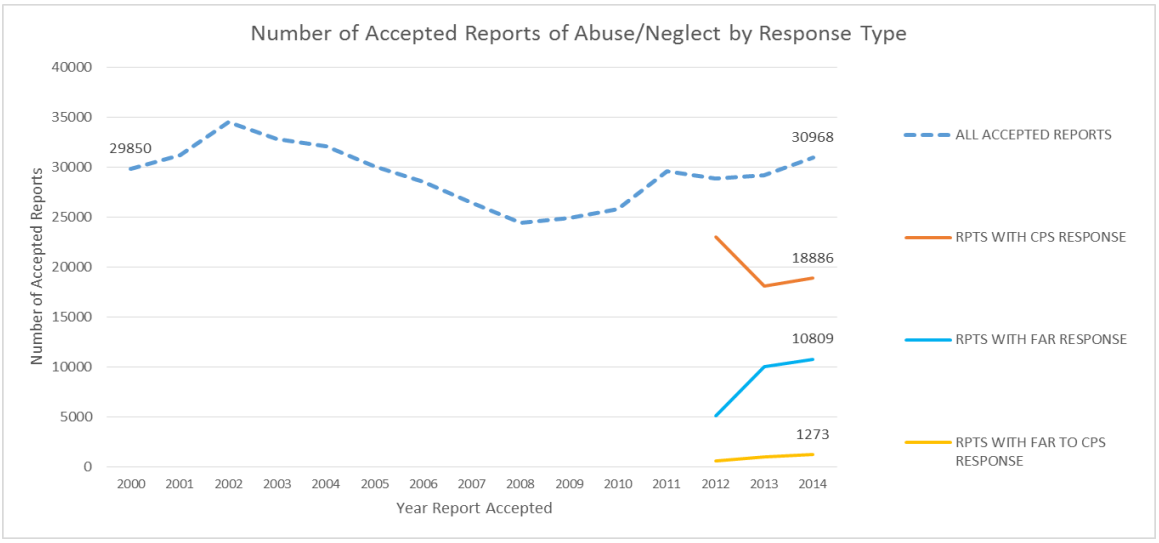
When SDM was introduced in 2007, there were 6081 children in DCF placement. Since the introduction of this decision making tool, the number has dropped to the January 2015 level of 3691. This is a 39% reduction. SDM has allowed the Department to more confidently distinguish between risk and safety. Thus, having a clearer means to assessing risk versus safety, the Department has been better able to provide supports and interventions that are more tailored to children and families' needs. That has meant greater investment in community based services and lesser use of out of home placements.

March 2012: <u>Differential Response System</u>

The implementation of a Differential Response System has been a core part of DCF's move to implement a Strengthening Families Practice Model. This practice model defines and supports a purposeful, intentional, respectful and supportive engagement with families who are served by the Department.

The below chart (Chart 3) shows the number of abuse/neglect reports accepted for some form of response by the DCF Careline. Throughout most of the 15 year time period displayed, DCF had only one mode of response to such reports, a Child Protective Services (CPS) Investigation. In March 2012, however, DCF initiated a Differential Response System (DRS) that affords the agency the opportunity to customize its response by using one of two response tracks. For higher risk cases, the response continues to be a CPS Investigation, while for lower risk cases a Family Assessment Response (FAR) is offered to families. It is also possible for a report initially handled through a FAR response to change tracks to be handled as a CPS Investigation under a number of conditions that are discovered to be of high enough risk to warrant the more traditional response.

Chart 3

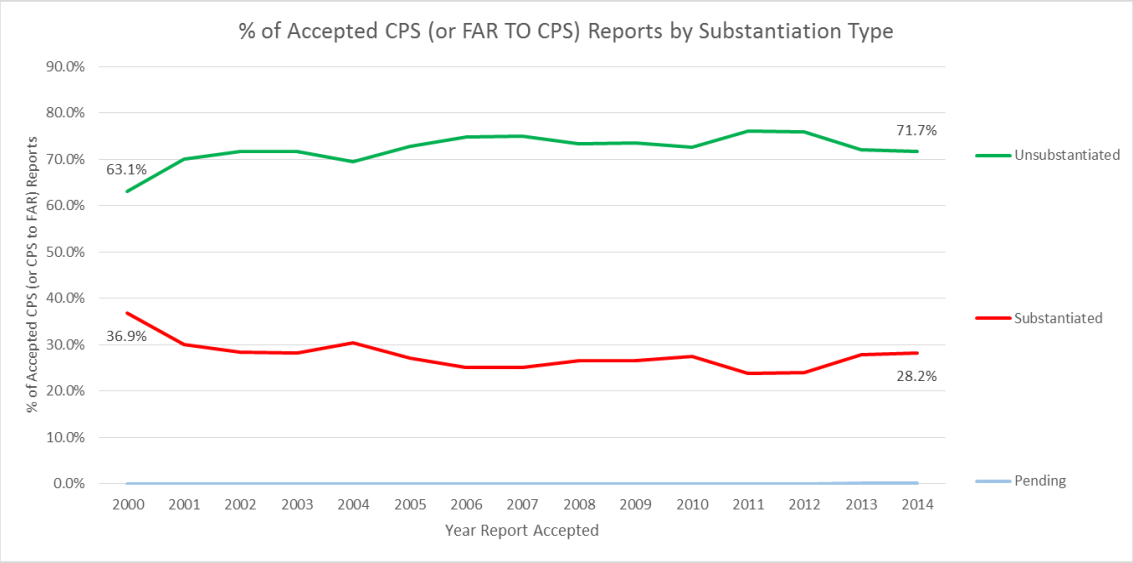


Between 2002 and 2008, the total number of abuse/neglect reports accepted trended downwards, but has been rising since; though report data as of 2014 is less than 5% above the 15-year median number of accepted reports. The number of reports handled with a FAR response increased by 7.8% from 2013 to 2014, while those handled by CPS increased by only 5.3%. As of 2014, almost 35% of all accepted reports are handled with a FAR response and are almost entirely diverted from requiring more intrusive involvement with DCF in order to ensure child safety and well-being.

Reports handled with a FAR response do not receive a determination of whether abuse or neglect occurred, but instead DCF social workers and community providers work with families to engage them in services and supports that are focused to meet their identified

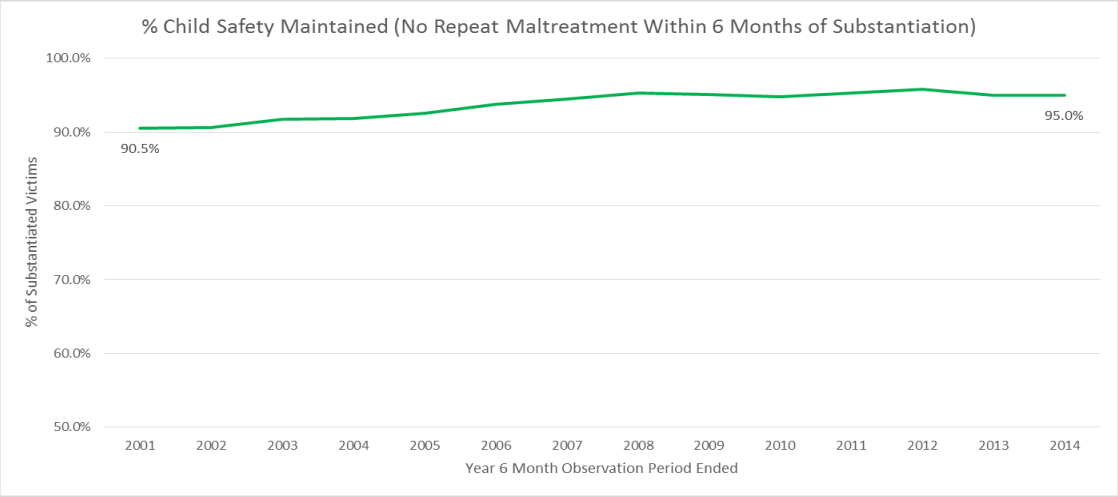
needs. For cases that receive a traditional response, such an abuse/neglect determination is still made by DCF. The proportion of reports that are determined to be substantiated has dropped from over 36% to just over 28% in 2014. It is not surprising that after handling more than a third of the lowest risk reports with a FAR response that the substantiation rate for the higher risk reports that continue to be handled with CPS investigations has risen somewhat from 24% in 2011 to 28.2% in 2014.

Chart 4



Another way of examining the impact of such an initiative is to see whether or not children are protected from repeated maltreatment over time. The following chart shows the results over the past 14 years, which show a strong positive trend (from 90.5% in 2001 to 95% in 2014) in children's safety being maintained for at least 6 months following any substantiation of abuse or neglect.

Chart 5



February 2013: Considered Removal- Child and Family Team Meeting (CR-CFTM)

Congruent with our Strengthening Families Practice Model, DCF evolved its child and family team meetings continuum to be built around the principle that families have strengths and can help identify and implement solutions to presenting challenges that might otherwise result in children coming into DCF care. Staff have embraced CR-CFTM and reported the transforming quality of participating in meetings where families change the trajectory of care based in large measure on their own resolve and strengths.

CR-CFTM's are held for children who are being assessed for removal because the Department has identified safety concerns that may warrant placement. In instances where a child has been removed due to a determined emergency, the CF-CFTM is held within two days of the removal. Family members help the Department seek the least restrictive option that reasonably ensures safety and stability for the children and that has the greatest likelihood of leading to a permanent, stable living arrangement. Trained facilitators lead the teams working closely with staff and families in partnership to develop plans that ensure safety and promote stability and permanence. Teaming embodies family empowerment and requires shared and collaborative decision making, recognizing that each situation comes with its own unique factors.

The initial results of CR-CFTM's have been very positive. During Calendar Year '14, DCF held 1,233 meetings concerning 1,171 families prior to the removal of any of the 1,801 children involved in those families. The families were able to formulate a plan to mitigate risk and prevented the removal of 815 (45.3%) children. Of those removed, almost half (48.5%) were placed in a kinship foster home. These results mean that of the total number of children who were the subject of a CR-CFTM only about one-quarter were placed in a home where they did not have a previous relationship or bond. The institution of CR-CFTM is a huge development because, as research confirms, children do best when living with their parents, a relative or kin. It should also be noted that an additional 530 meetings were held concerning 507 families after children had already been removed from their homes. Of the 716 children who were the focus of those meetings, 137 (19.1%) have been discharged from DCF care, and another 202 (28.2%) have been placed with a kinship foster home.

March 2013: Trauma Informed Practice

Trauma-informed practice is a core component of the Strengthening Families Practice Model. DCF introduced trauma training to increase the understanding of the impact of trauma on children and families, as well as the "best practices" that support early identification and effective intervention, essential to promoting social and emotional well-being for the children in our care. The DCF Workforce Development Academy trained staff and community providers on the Child Welfare Trauma Training Toolkit (CWTTT), which supports the Department's goal of being a trauma-informed system that promotes safety, permanency and well-being, and helps to ensure children and youth who are traumatized are provided a strong opportunity healthy growth and development.

DCF staff assure that the child has access to evidence-based trauma treatments and services, as appropriate. DCF staff provides support and guidance to the child's family and caregivers about the impact of trauma on the child and family system, and recognizes that many of the child's adult caregivers may be trauma victims as well (recent and childhood trauma). These individuals are referred to trauma-specific treatments and services, as appropriate. In addition a trauma screening tool has been embedded into the multi-disciplinary evaluation (MDE) conducted for all children that enter care to inform needs and service delivery. All of this work has helped to enhance the protective capacities of caregivers, thus increasing the resiliency, safety, permanency and well-being of the children.

2014: Child and Family Permanency Teaming

Building on the agencies Strengthening Families Practice model and assuring child and family teaming is the practice framework we apply, the Department began full implementation of Child and Family Permanency Teaming. Early teaming efforts began with Team Decision Making followed by Considered Removals and is evolving to a full teaming approach that supports inclusive and collaborative planning with and on behalf of children, youth and their families. Key components include maintaining essential supports and reestablishing those that may have been previously lost. The teaming approach convenes all the people in the child and family's life who may help maintain or establish permanent relationships that will sustain them over time. The team meets regularly until the child achieves the highest level of legal permanence recognizing that the outcomes for children that age out of care are at risk for a range of negative outcomes. Because the commitment to achieving positive permanent outcomes for children and youth is not only the responsibility of the Department, in collaboration with the regions, providers were trained alongside their regional partners. The practice of permanency teaming is underway throughout the Department.

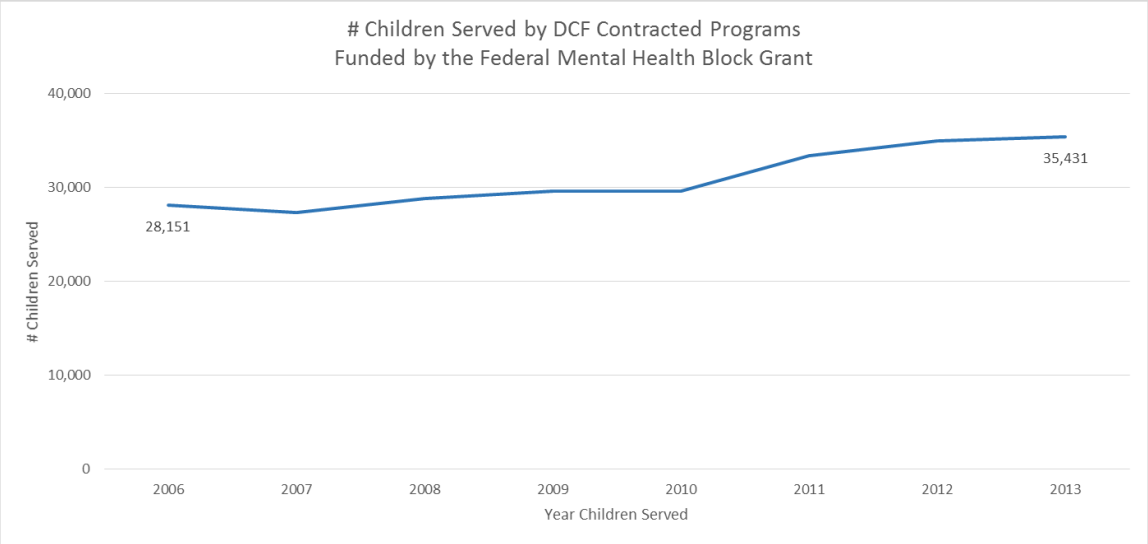
Family Search and Engagement and Recruitment Supports:

Wendy's Wonderful Kids (WWK) a program sponsored by the Dave Thomas Foundation, was expanded and now is working with about 50 children to find permanent resources among the people who know or have a connection with the specific child. While the program in Connecticut dates back to 2007, DCF and the Dave Thomas Foundation for Adoption expanded the number of recruiters to meet this important need. As of July 1, 2014, WWK increased from one statewide recruiter to four. The child-specific recruiting efforts came as DCF established other improvements in the foster care system that is making it both smaller and more reliant on relatives and kin overall. In addition, DCF sponsored two trainings with model developers to be delivered to a number of private providers and a small number of DCF staff. The first was Extreme Recruitment, a model of practice to enhance recruitment efforts and identify permanent resources for children and care and the second was the 3-5-7 model, developed to support the delivery of permanency preparation work.

DCF CONTRACTED BEHAVIORAL HEALTH SERVICES ARRAY ENHANCEMENTS

Another set of key improvements has to do with the array of contracted services provided and made available to Connecticut's children and families. As a consolidated agency, DCF has the responsibility for managing all publicly funded children's Behavioral Health services. These services are funded in large part by a federal Mental Health Block Grant, and the following chart shows the number of children served by programs receiving funding from this grant between 2006 and 2013. During that time period, the total number of clients served increased by over 25% to 35,431 children.

Chart 6



The following is a set of key milestones along the evolution of Connecticut's behavioral health services for children. They illustrate how the system has changed since 2001 to serve more children, and with more effective treatments and administration.

2001: The Department of Social Services led a planning effort in 1999-2000 that resulted in Connecticut Community KidCare and the formation of the Connecticut Behavioral Health Partnership (BHP). This report identified all public funding sources supporting children's behavioral health and recommended a new structure for improving services through an Administrative Services Organization (ASO).

2004: The Managed Service System structure was added in 2004. This represents a consortium of DCF staff and DCF-funded provider agencies convened under the authority of the 15 DCF local area offices to assure that a comprehensive and coordinated array of services are available at the local level to meet the needs of the DCF target population, especially those clients with the most complex behavioral health needs. The goal is to reduce the number of children in residential care and manage access to appropriate levels of care in a timely manner.

2006: DCF and the Department of Social Services launched the Behavioral Health Partnership, carving out behavioral health services from the HUSKY managed care contracts and blending it with DCF funding through an ASO (i.e., Value Options, Inc.) retained to manage development of and access to an integrated continuum of services.

2007: More than $250,000,000 was expended for behavioral health services during that year. There was significant growth in various community-based services and a continued expansion of evidence-based practices. This included expansions' of therapeutic groups homes, development of Enhanced Care Clinics, standardization of Extended Day Treatment Programs, training began for the Trauma Focused learning collaborative for Out Patient Clinics and there was transition from youth shelters to a focus on respite and short term assessments. The Enhanced Care Clinics expansion was for specifically designated mental health and substance abuse clinics, established by the CT BHP for the purposes of improving timelines of access to behavioral health care and improving the quality of care.

The CT BHP continued to make advances in strengthening an integrated behavioral health services system for Medicaid Husky Part A and Part B children, and children enrolled in the voluntary services program. Progress was made in the following areas: identification of quality indicators such as access to care and outcomes of care that will constitute a report card for children's services; development of a web-based outpatient care registration system to enable collection of key data elements for future quality studies; review of performance targets including reducing emergency department length of stays and discharge delays; reducing prolonged inpatient stays due to placement delays; and a new study to examine the correlation between foster care disruptions and behavioral health disorders for DCF-involved children.
The Department continued to work in partnership with 14 state agencies, the Judicial Branch and the broader stakeholder community to focus on transforming the behavioral health system under the aegis of the MHT-SIG. Also children/youth who are subject to Families with Service Needs (FWSN) complaints then had to be referred for services before any court action was taken. These youth could no longer be detained for violating a court order.

2008: Passage of the Mental Health Parity and Addiction Equity Act of 2008 occurred during this year. A re-design of the Emergency Mobile Psychiatric Services (EMPS) program was completed, resulting in six regions, with six lead providers and various subcontractors. All calls are triaged through a statewide call center for consistent response. There are standardized program standards including a 90% mobility expectation, longer hours of mobility, and increased capacity to handle multiple calls. Outreach to specific populations includes emergency departments, foster families, group homes/STAR facilities/Safe Homes, and schools.

Regional offices ensured there was a Program Director for Behavioral Health in each region to report to the Service Area Director and who would be responsible for overseeing

and managing services and supports across that Service Area. This structure continues to support an integrated behavioral health/child welfare/juvenile justice/prevention approach in working with children and families.

2009: The statewide network of Extended Day Treatment Programs engaged in a program and performance improvement project for the past 3 years. The project has introduced evidence-based and best-practice interventions to achieve a higher level of clinical care and greater consistency in quality across programs.

In addition, DCF began collection of client-level data into the Program and Services Data Collection and Reporting System (PSDCRS). This allows the agency to improve our monitoring of contracted services in terms of program utilization, fidelity and outcomes. The core reporting in PSDCRS is configured in a Results Based Accountability format to allow for program assessment under the rubric of "How Much," "How Well" and "Is Anyone Better Off." See Figure 1 for a screenshot.

2010: A Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry issues Mental Health Care 'Blueprint' for Children in Connecticut in June. DCF utilized federal funding to provide training, consultation and support relating to evidence-based trauma informed treatment for both staff at outpatient psychiatric clinics for children (Trauma-Focused Cognitive Behavior Therapy) and congregate care providers (Dialectical Behavior Therapy).

Next, Child First began a new, evidence-based, early childhood in-home parent-child intervention, which targets very high risk, young children (ages 0-5 years) and their families. The goal is to prevent serious emotional disturbance and abuse and neglect.

Figure 1: PSDCRS

There was also expansion of ICAPPS teams, and DCF continued to strengthening the System of Care approach using state and federal funds. Care Coordination and the wrap-around service delivery model through training, technical assistance, and pilot projects were enhanced. DCF supported thee (3) Managed Service Systems in the local area offices and continued to fund the care coordinator positions through the Systems of Care/Community Collaboratives.

In addition, DCF continued to fund family advocate positions to enhance effective consumer and family participation in the overall system. A family engagement model of practice was a critical focus of intervention and care, with continued support of this initiative with Extended Day Treatment providers and planning to advance family outreach and engagement with outpatient psychiatric clinic providers. In order to maintain services and supports, DCF-funded care coordinators continued to have access to flexible funding. These flexible funds are an integral resource to ensure that children and their families have the services, supports and other resources needed to successfully remain in their homes and communities, and/or facilitate children's return from inpatient and residential levels of care.

2011: Some of the key resource and initiative highlights during this year are as follows:

- DMHAS joined the BHP, adding management of adult services.
- Implementation of Rehabilitation Option in Medicaid allowing for reimbursement for in-home services and expansion of IICAPS.
- DCF leadership redirected the agency to work much more closely with families and communities to assure children's health, safety, learning, and success. DCF policy shifted away from congregate care with a concomitant reemphasis on supporting birth families and relative foster family care when a child must be placed out of home. Services for the evidence based model MultiDimensional Family Therapy (MDFT), MDFT - FSATS (MultiDimensional Family Therapy - Family Substance Abuse Treatment) program were now as provided by 5 teams in 4 agencies offering MDFT to youth aged 12 - 16 years who were in detention and returning home to their families. The families received a full course of 6 months of MDFT and then 2 - 4 months of recovery support services. Expansion of MST-PSB (Multisystemic Therapy - Problem Sexual Behaviors) occurred for this evidenced-based practice that provides intensive in-home services for youth aged 12 - 18 years with problem sexual behaviors and their families.

2012: Trauma-informed practice is one of DCF's seven 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 included trauma training for DCF staff and private providers, building screening, assessment and referral systems, and expanding access to evidence-based, trauma-informed treatments. There are 29 agencies trained to deliver TF-CBT (Trauma Focused Cognitive Behavioral Therapy) and in the final two years of the grant 10-12 agencies will be trained to deliver CFTSI (Child Family Traumatic Stress Intervention).

During this year, enhancement to DCF Supportive Housing for Families (SHF) also occurred. The Department was awarded a new $5 million, 5-year grant from the federal Administration for Children and Families to expand and enhance SHF services in September 2012. The new grant focuses on families with severe housing and child

welfare needs in the Middletown, Willimantic, and Norwich areas. An Intensive Supportive Housing for Families (ISHF) Project began in December 2013.

SAFERS (Substance Abuse Family Evaluation Recovery and Screening), a three-year federal grant from the federal Children's Bureau to enhance treatment services for families at risk of losing their children due to their incapacity to appropriately provide care as the result of substance abuse was awarded to the Department. SAFERS expanded Recovery Case Management (RCM) in two regions. Last, additional resources were allocated to the MultiDimensional Family Therapy service.

2013: The Department is currently funding 29 agencies to offer the Level 4 Standard and Standard Teen Triple P interventions with an annual caseload goal of approximately 2,100 families. Level 4 Triple P is a 10-session program focusing on children's behavior problems, strategies to address the behavior problems, children's development, and limited case management services.

The Department continues to hear many positive reports of parents shifting their parenting as a result of Triple P. Parents are gaining more tools for addressing problem behaviors, feeling stronger and more in control and becoming more nurturing with their children.

A Triple P Planning group has been established consisting of Triple P supervisors and DCF gatekeepers that meet every few weeks to identify and address issues that help strengthen the program and its effectiveness.

2014:
During this year, the Department introduced the Adolescent Community Reinforcement Approach - Assertive Continuing Care (ACRA-ACC). ACRA is an evidence based program that provides substance abuse interventions for adolescents and their families in a clinic-based setting. The ACC portion provides community-based recovery support services for youth who have been in the ACRA program.

MATCH-ADTC is a therapy that has combined the most effective *evidence-based practices for outpatient treatment* of children 7-15 years old who are having problems with anxiety, depression, traumatic stress, disobedient, aggressive, and/or disruptive behavior. DCF began dissemination of MATCH-ADTC through a research clinical trial being conducted in four outpatient clinics. The second phase of dissemination for MATCH will begin in April 2015 to bring another 6 clinics online with an expectation of a total of 18 clinics training in MATCH by 2017.

Infant Mental Health Training has also been provided. An eight session series conducted in four DCF regions was made available to DCF staff and private providers. Two DCF regional trainings will also be completed in 2015.

The ACCESS-MH program began in June, 2014. The contract was executed with Value Options and includes three consultation hubs. As of December 31, 2014, the hubs have been actively meeting with primary care practices and as a result have 310 practices with 1247 providers enrolled in the program. 1,832 consultative activities have been completed.

The Department is also part of the New Haven Trauma Coalition. This is a partnership with Clifford Beers, the New Haven Board of Education, United Way of Greater New Haven and other community partners focusing on four key components: (1) Care Coordination; (2) Trauma Screening and assessment and direct clinical services in 6 NH schools; (3) Network development support; (4) Workforce development activities

The Department has continued with investment in Multi-Systemic Therapy (MST) and MST-Building Stronger Families (BSF):

MST is an intensive family- and community-based treatment program that uses an evidence-based model that addresses environmental systems that impact chronic and violent juvenile offenders -- their homes and families, schools and teachers, neighborhoods and friends. In SFY2014, expansion added capacity to half the state

MST-BSF is an iintensive in-home treatment for families with maltreatment and substance abuse issues. In SFY 2014, that service expanded from one to four teams.

The Department also continued investment in Family Based Recovery (FBR). FBR is an intensive home based program that provides individual, family and group therapy to parents who are experiencing current problems with substance abuse / parent attachment issues and have a child two years old or younger living in the home.

Other service expansion and investments during CY 2014 included:

Additional Emergency Mobile Psychiatric Services resources specific to CCMC and Yale Emergency Departments.

Development of the Caregiver Support for Families services, which provides enhanced support for kinship families,

Finally, the Department also made investment in the DCF Homeless Youth Project- Start Program. The program serves young adults ages 18-23 that do not meet DCF re-entry criteria, but who are homeless or at risk of homelessness.

The Start program is designed to help youth gain and maintain safe and stable housing by providing case management services, hands on assistance with obtaining basic needs, navigating systems, employment search and placement, education/vocational resources and financial literacy.

The program was expanded to include capacity for DCF and non-DCF involved youth and provide the case management and housing assistance as well as provide crisis response services, including; respite care, host homes, family mediation, and emergency services to any homeless youth in the Hartford area.

THE RESULTS –*WHO IS BETTER OFF*

As outlined above, various major practice, policy and service array changes over the past 15 years have resulted in a system that respects the safety of children, while also meeting their needs in their own homes as often as possible.

Children enter DCF care because their caregivers are unable to ensure their children's safety and well-being; they remain in care when they and/or their caregivers are either not provided, or are unable to benefit from, effective treatment services that address their individualized needs. The enhancements made to both our direct and contracted service systems have resulted in a reduction in the need for children to enter our care by over 32%, and in the number of children remaining in DCF care on any given day by over 47% since January 2000.

Chart 7

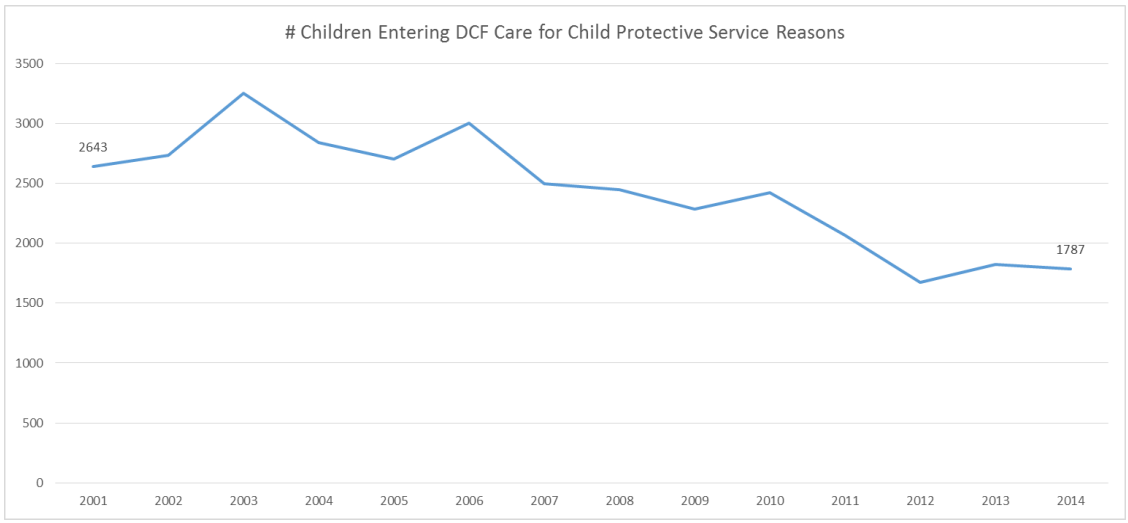
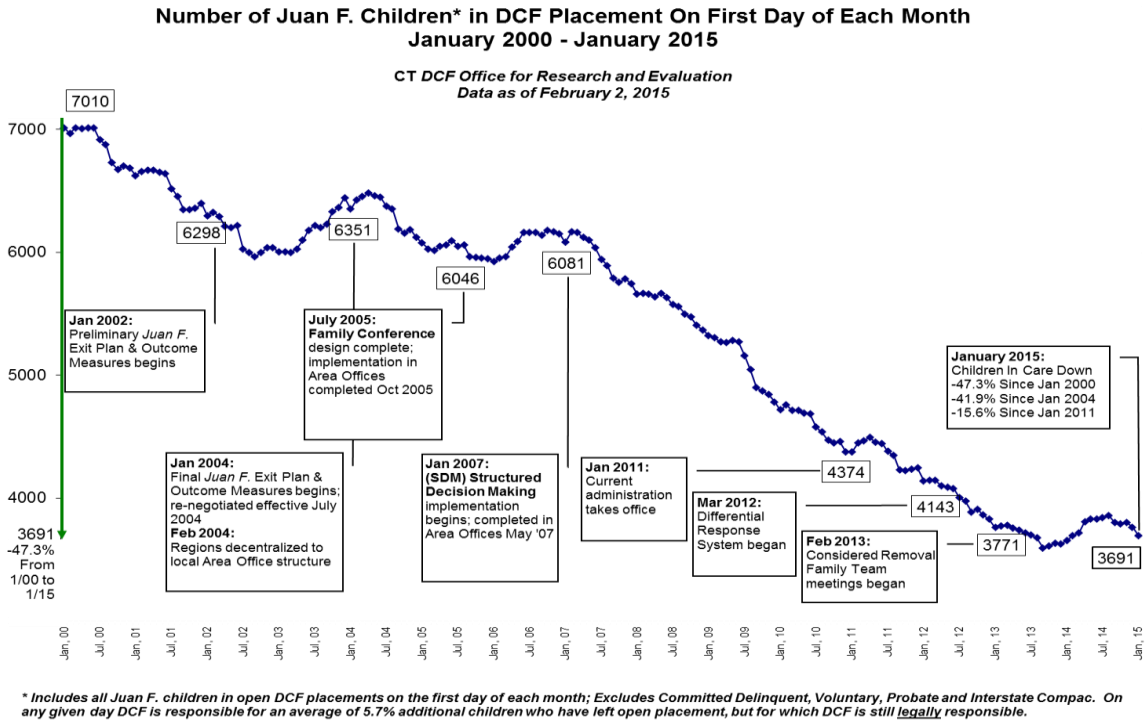


Chart 8



** Includes all Juan F. children in open DCF placements on the first day of each month; Excludes Committed Delinquent, Voluntary, Probate and Interstate Compac. On any given day DCF is responsible for an average of 5.7% additional children who have left open placement, but for which DCF is still legally responsible.*

At the same time, most indicators of positive child welfare outcomes have remained steady or improved. Federal child welfare outcomes measures include:

- Reduce recurrence of child abuse and/ or neglect
- Reduce the incidence of child abuse and/or neglect in foster care
- Increase permanency for children in foster care
- Reduce time in foster care to reunification without increasing reentry
- Reduce time in foster care to adoption
- Increase placement stability
- Reduce placements of young children in group homes or institutions

DCF data for CY 2014 reveals the follows outcomes as it relates to federal and *Juan F.* Consent Decree measures:

1. **Entry Rates:** There were 1833 (rate 2.3/1k in child pop) children who entered DCF care during CY '14 who met the AFCARS definitions.

2. **Kinship Care:** Of the 1833 entries, 748 (40.8%) were initially placed into a Kinship Foster home.

3. **Reduction in Congregate Placement:** There were a total of 5,100 children who spent any amount of time in DCF care during CY' 14 who met the federal AFCARS definitions.

Of those, 904 (17.7%) spent any amount of time in a Congregate Care setting , which includes Safe Homes, Shelters, Group Homes, Residential Treatment Centers, DCF Facilities or Hospitals (for medical and/or psychiatric reasons). The number of days spent in a Congregate Care setting, however, accounted for only 13.3% of all the days that these 5,100 children spent in DCF care during CY'14.

In addition, on January 1, 2011, 200 young children between the ages of 0 and 12 were in a congregate setting. As of March 1, 2015, however, that number has been reduced to 41. That is a change of 79.5%.

4. Timely Reunification under the Federal Child and Family Service Review (CFSR) Measure C1.3

Definition: Measure C1.3: Of all children who entered foster care for the first time in the 6-month period just prior to CY 2014*(as requested), and who remained in foster care for 8 days or longer, what percent were discharged from foster care to reunification in less than 12 months from the date of latest removal from home? (This includes the "trial home visit adjustment.")

Of the 949 children who entered DCF care for the first time between 7/1/2013 and 12/31/2013, and whose episode lasted at least 8 days, 208 (21.9%) were discharged to Reunification in less than 12 months.

5. Re-Entry CFSR Measure C1.4

Definition: Measure C1.4: Of all children who were discharged from foster care to reunification in the 12-month period prior to CY 2014*, what percent re-entered foster care in less than 12 months from the date of discharge?

Of the 694 children who were discharged from DCF care to Reunification between 1/1/2013 and 12/31/2013, 105 (15.1%) re-entered DCF care in less than 12 months from the date of their discharge. While as a percentage this is an increase from the previous year, it should be noted that DCF analysis indicates that the level has remained relatively stable since 2005. Moreover, a decreasing denominator does more greatly impact the percentage and is a factor that must be considered when looking at 2013 (N= 687) in comparison to other years (N range from 1467 – 808). In addition, Differential Response System (DRS) began in the Spring of Calendar Year 2012. DRS allows families who come to the attention of the Department who are assessed to be of low risk and do not have observed safety issues to be served by a DRS contracted community partner agency. Thus, the population of families currently served by the Department and those in 2013 would likely have a host of more complex issues that might impact the re-entry percentage when reunification is attempted for those families.

6. Achieving Permanency for Longer Stayers CFSR Measure

Measure C3.1: Of all children who were in foster care for 24 months or longer on the first day of CY 2014*(as requested), what percent were discharged to a permanent home prior

to their 18th birthday and by the end of the year? A child is considered discharged to a permanent home if the discharge reason is adoption, guardianship, reunification, or live with relative.

Of the 1792 children in placement on 1/1/2014 that had been in care for 24 months or longer, 432 (24.1%) were discharged to a permanent home by the end of the year.

7. Absent of maltreatment recurrence CFSR Measure

Of all children who were victims of a substantiated or indicated maltreatment allegation during the first 6 months of CY 2014*, what percent were not victims of another substantiated or indicated maltreatment allegation within the 6-months following that maltreatment incident?

Of the 3308 unique children with at least one maltreatment allegation substantiated between 1/1/14 and 6/30/14, 3180 (96.1%) were not victims of another substantiated maltreatment allegation within the next six months.

8. *Juan F.* Consent Decree Measures

2014 *Juan F.* data also indicates the following outcomes with respect to Child Safety, Stability, Permanency and Wellbeing:

- 95.4% of children in in-home cases were not victims of repeat maltreatment
- 99.7% of children in foster care were not victims of repeat maltreatment
- 94% of children entering care did not have a foster care episode in the previous 12 months
- 96% of children in foster care did not experience multiple placements
- 68% of reunifications in 2014 happened within 12 months (exceeding *Juan F.* standard)
- 34% of adoptions in 2014 happened within 24 months (exceeding *Juan F.* standard)
- 72% of transfers of guardianship happened within 24 months (exceeding *Juan F.* standard)

Further, of the twenty-two (22) Juan F. Outcome Measures, the Court Monitor has Pre-Certified eleven (11) of them. This means that if DCF has sustained compliance as required for at least two consecutive quarters (6 months) for any Outcome Measure ("OM"), the Court Monitor may, in his discretion, conduct a "pre-certification review" of that OM ("Pre-Certification Review").

The Pre-Certification Review is to recognize DCF's sustained improved performance, to identify and provide a prompt and timely opportunity to remedy any problem areas that are affecting the well-being of Juan F. class members, and to increase the efficiency of DCF's eventual complete compliance and exit from the Consent Decree.

The twelve Outcomes Measures in which the Department has demonstrated the requisite compliance for Pre-Certification are as follows:

***Juan F.* Pre-Certification Review**		
Outcome Measure	**Statement of Outcome**	**Status**
OM 4: Search for Relatives	If a child(ren) must be removed from his or her home, DCF shall conduct and document a search for maternal and paternal relatives, extended formal or informal networks, friends of the child or family, former foster parents, or other persons known to the child. The search period shall extend through the first six (6) months following removal from home. The search shall be conducted and documented in at least 85.0% of the cases.	Pre-Certified October 2013
OM 5: Repeat Maltreatment of Children	No more than 7% of the children who are victims of substantiated maltreatment during any six-month period shall be the substantiated victims of additional maltreatment during any subsequent six-month period. This outcome shall begin to be measured within the six-month period beginning January 1, 2004.	Pre-Certified* July 2014
OM6: Maltreatment of Children in Out-of-Home Care	No more than 2% of the children in out of home care on or after January 1, 2004 shall be the victims of substantiated maltreatment by substitute caregivers while in out of home care.	Pre-Certified October 2014
OM 8: Adoption	At least 32% of the children who are adopted shall have their adoptions finalized within 24 months of the child's most recent removal from his/her home.	Pre-Certified January 2013
OM 9: Transfer of Guardianship	At least 70% of all children whose custody is legally transferred shall have their guardianship transferred within 24 months of the child's most recent removal from his/her home.	Pre-Certified January 2013
OM 12: Multiple Placements	Beginning on January 1, 2004, at least 85% of the children in DCF custody shall experience no more than three (3) placements during any twelve month period.	Pre-Certified April 2012
OM 14: Placement within Licensed Capacity	At least 96% of all children placed in foster homes shall be in foster homes operating within their licensed capacity, except when necessary to accommodate sibling groups.	Pre-Certified April 2012
OM 16: Worker/ Child Visitation (Child in Placement)	DCF shall visit at least 85% of all out-of-home children at least once a month, except for probate, interstate, or voluntary cases. All children must be seen by their DCF Social Worker at least quarterly.	Pre-Certified April 2012
OM 19: Reduction in the Number of Children Placed in Residential Care	The number of children placed in privately operated residential treatment care shall not exceed 11% of the total number of children in DCF out-of-home care. The circumstances of all children in-state and	Pre-Certified December 2014

* Pre-Certification granted subject to verification of correction to ROM system reporting - release delayed to June 2014.

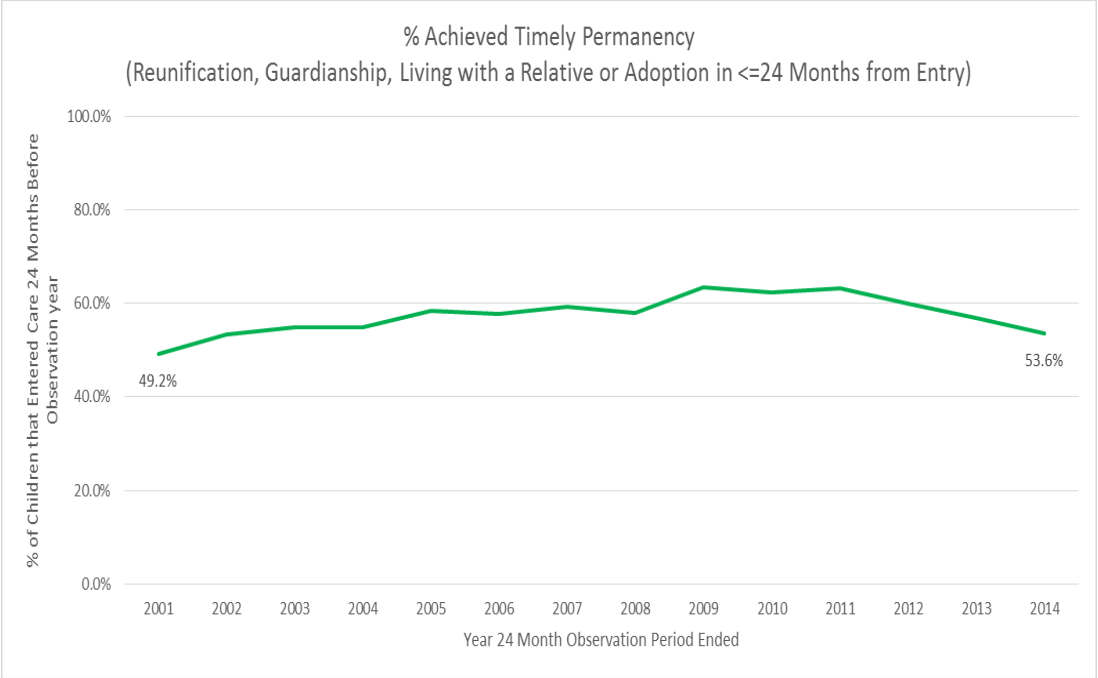
	out-of-state residential facilities shall be assessed after the Court's approval of this Exit Plan on a child specific basis to determine if their needs can be met in a less restrictive setting.	
OM 20: Discharge Measures	At least 85.0% of all children age 18 or older shall have achieved one or more of the following prior to discharge from DCF custody: (a) Graduation from High School; (b) Acquisition of GED; (c) Enrollment in or completion of college or other post secondary training program full-time; (d) Enrollment in college or other post secondary training program part-time with part-time employment; (e) Full-time employment; (f) Enlistment full-time member of the military.	Pre-Certified September 2011
OM 21: Discharge of Mentally Ill or Developmentally Disabled Youth	DCF shall submit a written discharge plan to either/or DMHAS or DDS for all children who are mentally ill or developmentally delayed and require adult services."	Pre-Certified September 2011
OM22: Multi-disciplinary Exams	At least 85% of the children entering the custody of DCF for the first time shall have an MDE conducted within 30 days of placement."	Pre-Certified January 2013

It is expected that the following additional Outcome Measures (OM) will be Pre-Certified over the course of Calendar Year 2015:

- OM 1: Commencement of Investigation
- OM 2: Completion of the Investigation
- OM 7: Reunification
- OM 10: Sibling Placement
- OM 13: Foster Parent Training
- OM 18: Caseload Standards

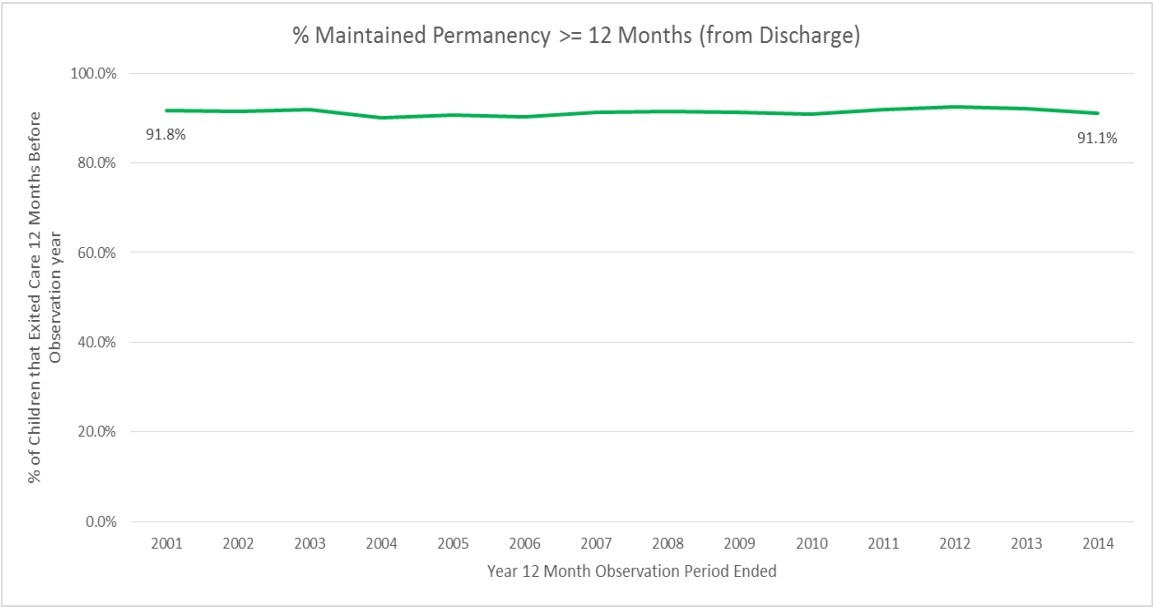
Next, we have also focused on ensuring that children who have to come into DCF care are afforded the shortest possible stays in our care. Over the past 14 years, we have increased our performance in achieving a preferred permanency exit (to either Reunification, Guardianship, Living with a Relative or Adoption) in a timely (less than 24 months) manner from 49.2%% in 2001 to 53.6% in 2014.

Chart 9



In order to ensure that such achievements do not result in traumatic re-entries to care, we also measure the proportion of those children that exit care that re-enter DCF care within 12 months of their exit. Performance on this measure has not significantly changed over the same time period, so while individual results vary, in general our exits from care are just as stable now as they had been before our systems changes during the past 15 years.

Chart 10



SUMMARY

Over the past 15 years, the Department has made tremendous investment in philosophy, policy, practice and resource to better and in majority serve children and families in and through the community. January 1, 2000, where nearly twice the number of children and youth were placed out of home in comparison to today, is the watershed of a child welfare system that was too risk adverse and was not sufficiently steeped in best practice with respect to serving children in their families of origin and other family like settings. Connecticut, as well as many jurisdictions across the nation, knows that children do better in families. Thus, we are committed to ensuring that our child welfare system continues to evolve and transform to support in-home and community-based care.

In closing, the above accounting of the various initiatives and supporting data evidence that the Department has been steadily increasing and enhancing its service array and treatment modalities, and equally attending to outcomes to ensure that these shifts are sound, and most importantly support children's safety, permanency and well-being. While fewer children are served through out of home placement, the Department has ensured that children and families are effectively and well-served through other, lesser restrictive avenues.